

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Ms Karen Hindley a prisoner at HMP Eastwood Park on 12 December 2018

A report by the Prisons and Probation Ombudsman

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions I oversee can improve their work in the future.

Ms Karen Hindley died in hospital on 12 December 2018 while a prisoner at HMP Eastwood Park. She died of throat cancer. She was 54 years old. I offer my condolences to Ms Hindley's family and friends.

I am satisfied that the healthcare Ms Hindley received at HMP Eastwood Park was good and equivalent to that she could have expected to receive in the community.

She had been treated for throat cancer in the community in late 2014/early 2015 and prison healthcare staff referred her promptly to a hospital specialist for monitoring.

When the cancer returned and she was given a terminal diagnosis in late November 2018, prison staff worked with the palliative care team at the hospital to support her and the prison's family liaison officers provided excellent support to Ms Hindley and her family.

I make no recommendations.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Sue McAllister CB
Prisons and Probation Ombudsman

July 2019

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Summary

Events

1. On 13 April 2018, Ms Karen Hindley received a three-year sentence for theft and was sent to HMP Eastwood Park.
2. When Ms Hindley arrived at Eastwood Park, she had a number of health concerns, including both alcohol and substance misuse. It also emerged that in late 2014/ early 2015, she had been diagnosed with and treated for throat cancer. A referral was, therefore, made to a specialist at St Michael's Hospital, Bristol and Ms Hindley was seen by the hospital every six weeks.
3. On 21 November 2018, at a routine outpatient appointment, it was discovered that Ms Hindley had developed new symptoms and she was admitted to hospital for further investigation. The investigations revealed that Ms Hindley's cancer had returned and had now spread to her bones, lungs and spleen. No further treatment would be appropriate.
4. Ms Hindley remained at St Michael's Hospital and died there on 12 December 2018.

Findings

5. The clinical reviewer considered that the clinical care Ms Hindley received at Eastwood Park was of a good standard and equivalent to that which she could have expected to receive in the community.
6. We commend the work of the prison's family liaison officers who provided a high standard of support for Ms Hindley and her family.
7. We make no recommendations.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Eastwood Park informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
9. The investigator obtained copies of relevant extracts from Ms Hindley's prison and medical records.
10. NHS England commissioned a clinical reviewer to review Ms Hindley's clinical care at the prison.
11. We informed HM Coroner for Avon of the investigation. She gave us the results of the Report of Death to Coroner notice and we have sent the coroner a copy of this report.
12. The investigator wrote to Ms Hindley's son to explain the investigation and to ask whether he had any matters he wanted the investigation to consider. He responded to our letter to state his interest in the investigation. He did not, however, raise any concerns.
13. The investigation has assessed the main issues involved in Ms Hindley's care, including her diagnosis and treatment, whether appropriate palliative care was provided, her location, security arrangements for hospital escorts, liaison with her family, and whether compassionate release was considered.
14. We shared our initial report with HM Prison and Probation Service (HMPPS). They did not find any factual inaccuracies.

Background Information

HMP Eastwood Park

15. Eastwood Park is a closed prison in Gloucestershire which holds up to 442 women. It has 10 residential wings, two of which specialise in dealing with prisoners with substance misuse issues. Healthcare is provided by Inspire Better Health.

HM Inspectorate of Prisons

16. The most recent inspection of Eastwood Park was conducted in November 2016. Inspectors reported that care and support for prisoners was strong. The substance misuse strategy was well managed.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to October 2017, the IMB reported that it was impressed with the professional and caring approach of managers and staff at the prison. Levels of violence and self-harm were high but management showed a consistently detailed knowledge of, and concern for, individuals involved.

Previous deaths at HMP Eastwood Park

18. Ms Hindley was the 14th prisoner to die at Eastwood Park since 2013. None of the previous deaths have similarities to the death of Ms Hindley.

Findings

The diagnosis of Ms Hindley's illness

19. Ms Hindley was serving a three-year sentence and had been at HMP Eastwood Park since 13 April 2018. She had served two previous sentences between 2013 and 2015.
20. At her initial health screening, Ms Hindley screened positive for drugs. She was housed on the substance misuse wing and was placed on a detoxification programme.
21. It also emerged at the initial health screen that Ms Hindley had been diagnosed with cancer of the tonsil in late 2014/early 2015 while in the community. This had been treated with chemotherapy. As a result, a referral was made by the prison healthcare team to the Ear, Nose and Throat (ENT) outpatient department at St Michael's Hospital, Bristol.
22. Following the referral, Ms Hindley was seen every six weeks by the ENT department. The letters sent by the hospital after these appointments specifically said that there were no signs of a recurrence of her cancer.
23. On 21 November, at a routine ENT outpatient appointment, Ms Hindley said that she had some new symptoms, namely voice weakness and weight loss. Ms Hindley was admitted to St Michael's Hospital for further investigations into her symptoms.
24. These investigations revealed that Ms Hindley's cancer had recurred and spread to her bones, lungs and spleen. Ms Hindley was reviewed by a consultant oncologist (a cancer specialist). On 27 November, she was told her cancer was terminal, and 30 November, she was told that no further treatment would be appropriate and that she had only weeks to live.
25. Ms Hindley remained in hospital under palliative care. There is evidence to show that healthcare staff maintained good levels of contact with St Michael's Hospital.
26. Ms Hindley died of throat cancer on 12 December.

Ms Hindley's clinical care

27. The clinical reviewer is satisfied that Ms Hindley received a good standard of care at Eastwood Park before her admission to hospital and that the care was equivalent to that she would have received in the community.
28. The clinical reviewer commended the early referral that was made to the local ENT provider. Ms Hindley attended all her scheduled ENT outpatient appointments.
29. There is clear evidence of excellent partnership working between the prison staff, prison healthcare staff and the hospital team after Ms Hindley's admission to hospital in November 2018. All departments involved in Ms Hindley's care were well represented at multidisciplinary meetings.

Ms Hindley's location

30. Ms Hindley lived on the substance misuse wing at Eastwood Park before she was admitted to hospital. We are satisfied Ms Hindley's needs could be met on this wing before she became ill in November 2018, and that she was appropriately located.

Restraints, security and escorts

31. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility.
32. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.
33. On 21 November, when Ms Hindley was transferred to hospital, she was restrained using single cuffs. Although, she was showing signs of new symptoms, she was still mobile and we are satisfied that the decision to restrain her was not unreasonable. Restraints were removed for treatment, such as scans.
34. On 26 November, Ms Hindley was given a terminal diagnosis and after a risk review by prison management it was decided that restraints should not be used. We are satisfied that decisions made around the use of restraints were reasonable.

Liaison with Ms Hindley's family

35. On 26 November, HMP Eastwood Park appointed an officer as the prison's family liaison officer (FLO). Another officer was appointed as the deputy FLO. They both visited Ms Hindley in hospital that day. Ms Hindley was very upset and in denial about her condition and they provided support.
36. The following day, the FLO contacted Ms Hindley's partner to let him know about her condition. Ms Hindley wanted to speak to her son, who was a prisoner at HMP Exeter, so the FLO contacted Exeter to arrange a telephone call. The phone call took place on 28 November. The FLO also contacted Ms Hindley's estranged daughter at Ms Hindley's request and told her about Ms Hindley's condition.
37. The FLO liaised with Exeter to arrange for Ms Hindley's son to visit her in hospital. The visit took place on 1 December. Ms Hindley's daughter also visited before Ms Hindley's death and was offered ongoing support by the FLOs.

38. The FLO and her deputy made regular visits to Ms Hindley and tried to facilitate any requests that Ms Hindley had, including writing letters to family members. Regular meetings were held to ensure that Ms Hindley's needs were met. It was agreed that the hospital was the best place for Ms Hindley as her health continued to decline.
39. On 12 December, after the FLO had been notified that Ms Hindley had died, she contacted HMP Exeter so that they could pass the news onto Ms Hindley's son. Ms Hindley's daughter was also notified by phone as agreed.
40. Ms Hindley's son requested that the funeral arrangements were made by Eastwood Park because he was a serving prisoner. The funeral took place on 12 March 2019. The prison provided a financial contribution in line with national policy.
41. The two FLOs tried to attend the funeral but due to a problem with prison vehicles, they did not get there on time. However, they met with the family and were able to give them Ms Hindley's belongings, as requested.
42. We commend the efforts by staff to ensure that Ms Hindley and her family were well supported from the time of her diagnosis until her death.

Compassionate release

43. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.
44. Eastwood Park started to complete the paperwork to apply for compassionate release for Ms Hindley. However, Ms Hindley died so quickly after the diagnosis of her cancer that there was not enough time to submit the application. We are satisfied that compassionate release was appropriately considered in the circumstances.
45. On 4 December, Ms Hindley was granted release on temporary licence (ROTL). Due to her poor health, by healthcare staff at the prison and hospital decided that it was best for her to remain in the hospital to ensure all her medical needs were met. However, once the ROTL was granted, she no longer required an escort of two prison officers and only one officer remained to provide support for Ms Hindley and her visitors.

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