Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Derek Lemmon a prisoner at HMP Winchester on 24 November 2018

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 020 7633 4141

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*

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 we oversee can improve their work in the future.

Mr Derek Lemmon died of multiple organ failure as a result of pneumonia caused by disseminated lung cancer on 24 November 2018 at HMP Winchester. He was 85 years old. I offer my condolences to his family and friends.

The care that Mr Lemmon received at Winchester was equivalent to that which he could have expected to receive in the community.

However, I am concerned that although Mr Lemmon was elderly, frail, had terminal cancer and poor health generally, and used a wheelchair, it was considered appropriate for him to be restrained with an escort chain when he went to hospital. We made a recommendation about the inappropriate use of restraints on sick prisoners in a previous report on a death at Winchester and the prison agreed to implement our recommendation. It is, therefore, disappointing to have to repeat our concerns in this report.

There were also deficiencies in the family liaison process. While his family were told that Mr Lemmon had died, this was not done by the family liaison officer as she was on leave. A deputy family officer had not been appointed so the family were told by telephone.

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 7 June 2017, Mr Derek Lemmon was convicted of sex offences and remanded to HMP Winchester. On 7 July, he was sentenced to 13 years and six months in prison.

2. Mr Lemmon had lung cancer which was diagnosed in November 2016. Before he went to Winchester, Mr Lemmon had had chemotherapy to reduce his symptoms and increase his life expectancy. In April 2017, it was decided that further treatment would not be beneficial.

3. Mr Lemmon had other serious health problems, for which he had been prescribed a number of medications in the community, and a prison GP re-prescribed them.

4. The nurse who completed Mr Lemmon's initial health assessment said that he was not fit to live in a cell on a standard wing and he was sent to the prison's inpatient unit, where he lived until his death. A nurse created a palliative care plan and a healthcare manager completed a social care assessment.

5. On 18 October, Mr Lemmon went to hospital, where he saw a consultant oncologist who told him that the cancer had grown and that he needed palliative care.

6. On 4 April 2018, a palliative medicine consultant reviewed Mr Lemmon. She put in place plans for Mr Lemmon's end-of-life care and medication if his condition were to get worse. Mr Lemmon said that he did not want to be resuscitated if his heart or breathing stopped, and signed an order to that effect.

7. At 4.05am on 24 November, an officer went into Mr Lemmon's cell to check on his welfare and found him unresponsive. A nurse responded promptly and saw that Mr Lemmon was not breathing and had no pulse. Paramedics went to the prison and at 4.26am, confirmed that Mr Lemmon was dead. A post-mortem examination established that he had died of multiple organ failure caused by pneumonia which in turn was caused by disseminated lung cancer.

Findings

8. The care that Mr Lemmon received at Winchester was equivalent to that which he could have expected to receive in the community.

9. Although the guidance on resuscitation decisions does not say when a patient's wish not to be resuscitate should be made, Mr Lemmon had a serious illness and healthcare staff should have documented his wishes as soon as possible. It took ten months after Mr Lemmon went to Winchester before a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form was completed.

10. Mr Lemmon had terminal cancer, poor health generally, and was elderly, immobile and frail. There is no evidence to explain why prison managers frequently decided that he should be restrained by an escort chain when he was taken to hospital. We have previously made a recommendation about the use of

restraints which Winchester said that they had implemented in early November 2018.

11. When the Head of Safer Custody appointed a family liaison officer, he did not appoint a deputy. When Mr Lemmon died, the family liaison officer was on leave. A member of the healthcare team telephoned Mr Lemmon's son and told him that his father had died. An officer who had no training or experience in the role was asked to visit Mr Lemmon's son two days later. The officer should not have been put in this position because she was not confident or trained to carry out this task.

Recommendations

- The Head of Healthcare should ensure that prisoners with a serious illness are given the opportunity to decide whether they want to be resuscitated if their heart or breathing stops soon after diagnosis or on arrival at Winchester, and that staff record their decision promptly.
- The Governor and Head of Healthcare should ensure that all staff who undertake risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk that the prisoner presents at the time.
- The Governor should ensure that when a prisoner is seriously ill or diagnosed with a terminal illness, a family liaison officer and a deputy family liaison officer are promptly appointed to act as a point of contact and support.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Winchester informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

13. The investigator obtained copies of relevant extracts from Mr Lemmon's prison and medical records.

14. NHS England commissioned a clinical reviewer to review Mr Lemmon's clinical care at the prison.

15. We informed HM Coroner for Hampshire Central of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

16. The investigator wrote to Mr Lemmon's son to explain the investigation and to ask if he had any matters that he wanted us to consider. He did not respond to our letter.

17. We have assessed the main issues involved in Mr Lemmon's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.

18. We shared the initial report with the Prison Service. There were no factual inaccuracies.

Background Information

HMP Winchester

19. HMP Winchester is a local prison, serving courts in Hampshire. It holds around 700 adult remanded and sentenced men. It includes a separate lower security unit, known as West Hill, which holds up to 129 sentenced men who are nearing the end of their sentence. Central and North-West London NHS Foundation Trust provides healthcare at the prison and 24-hour healthcare cover. There is a 15-bed inpatient unit for prisoners with complex care needs.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Winchester was conducted in July 2016. Inspectors found that overall, the quality of health services was good. There was an appropriate range of primary care services, with reasonable waiting times. The management of long-term conditions had improved, with a more systematic approach, regular reviews and an increase in the number of nurse-led clinics.

Independent Monitoring Board

21. 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 May 2018, the IMB noted that it had been a very challenging year because of staff shortages and a lack of funding, with prisoners often confined to their cells for 23 hours a day. They noted that the use and distribution of illicit substances, especially psychoactive substances, required urgent attention. They found that healthcare services had seen a slow but noticeable improvement.

Previous deaths at HMP Winchester

22. There have been seven deaths at Winchester since November 2016, two of which were from natural causes and five were self-inflicted. In a previous investigation into the death of a prisoner at Winchester in April 2018, we made a recommendation about the inappropriate use of restraints. The prison accepted this recommendation in November 2018 and agreed to implement it.

Assessment, Care in Custody and Teamwork (ACCT)

23. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Findings

The diagnosis of Mr Lemmon's terminal illness and informing him of his condition

24. On 7 June 2017, Mr Derek Lemmon was convicted of sex offences and remanded to HMP Winchester. On 7 July, he was sentenced to 13 years and six months in prison.

25. Mr Lemmon had been diagnosed with incurable lung cancer in the community in November 2016. The cancer had spread to the liver and adrenal glands. Before he went to Winchester, Mr Lemmon had chemotherapy to reduce the symptoms and increase his life expectancy but in April 2017, it was decided that further treatment would not be beneficial.

26. He also had chronic obstructive lung disease (COPD), heart failure, atrial fibrillation (an abnormal and often fast heart rate), hypertension, depression, confusion and chronic kidney disease. He had had a mini stroke in 2001 and a fractured femur (thighbone) in 2016, and had difficulty moving around and a history of falls since 2015. He had been prescribed a number of medications.

27. On 7 June, a nurse conducted Mr Lemmon's initial health screen and noted his medical history, including lung cancer. On 10 June, at his second health screen, a healthcare support worker, noted that Mr Lemmon was depressed and was not eating and drinking. Mr Lemmon's community GP records were promptly received and available at his second health screen.

28. On 11 June, Mr Lemmon told an officer that he wanted to die, that he was old, ill and that there was no point in living. She started ACCT procedures.

29. On 12 June, a prison GP reviewed Mr Lemmon's medication and noted that he should continue with the medication he had been prescribed in the community.

30. He went to hospital on 12 July for a CT scan which showed the cancer had grown. The hospital cancer team discharged him with advice to refer to the chest team or palliative care team if his condition got worse.

31. On 18 July, a mental health practitioner created a depression care plan.

Mr Lemmon's clinical care

32. On 20 July, a nurse created a palliative care plan which included reviewing Mr Lemmon's mobility, pain management, pressure sores, diet and medication, and checking that he went to his hospital appointments.

33. On 1 August, officers stopped ACCT procedures because Mr Lemmon had settled into prison life and was happier and not anxious.

34. On 23 August, Mr Lemmon told a nurse that he had fallen over in the night when he went to use the toilet. He fell over four more times in September. There was no falls risk assessment in place at the time although healthcare staff later looked at the issue and completed one.

35. On 14 September, a nurse noted that she spoke to a prison GP about whether Mr Lemmon needed to complete an order not to be resuscitated - a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form - if his heart or breathing stopped.

36. On 18 October, Mr Lemmon went to hospital, where he saw a consultant oncologist, who told him that the cancer had grown and that he would now need palliative care.

37. On 9 November, a modern matron (senior nurse), assessed Mr Lemmon's social care. Mr Lemmon asked for a DNACPR form. There is no evidence that he received it. On 18 January 2018, the mental health practitioner, chased the form because it had still not been completed.

38. On 8 February 2018, a prison GP, reviewed Mr Lemmon. She was concerned that he had a possible brain haemorrhage (a bleed in the brain). Mr Lemmon went to hospital, where he had a CT scan which showed that he did not have a brain haemorrhage.

39. On 19 February, healthcare staff completed a falls risk assessment for Mr Lemmon.

40. On 22 March, a prison GP reviewed Mr Lemmon because healthcare staff were concerned about his worsening health. She found that there were changes to the right side of Mr Lemmon's lung, the same side as the cancer, and prescribed antibiotics for a possible infection.

41. On 3 April, an occupational therapist started ACCT procedures because Mr Lemmon was low in mood, upset because his wife had dementia, was concerned about his cancer and had fallen over and not told anyone.

42. On 4 April, a palliative medicine consultant reviewed Mr Lemmon. He told her that he was not in pain but was sleepy and sometimes felt muddled. She put in place plans for Mr Lemmon's end-of-life care and medication if his condition worsened.

43. That day, Mr Lemmon said that he did not want to be resuscitated if his heart or breathing stopped, and he signed an order to that effect. The palliative medicine consultant also completed a form about his wishes for clinical care in a future emergency if he was unable to make choices.

44. On 3 May, a prison GP reviewed Mr Lemmon, and they discussed his frequent falls and his risk of falling because of his frailty. The prison GP, noted that Mr Lemmon wanted to stay at Winchester and did not want to go to hospital. She explained the level of care that they could give him at the prison.

45. On 5 May, officers stopped ACCT monitoring because Mr Lemmon's mood had improved.

46. On 18 June, a healthcare technician started ACCT procedures because Mr Lemmon's mood was very low and he said that he wanted to take his own life. The next day, when his mood improved, officers closed the ACCT.

47. On 3 August, a healthcare technician, saw Mr Lemmon who had chest pain when he breathed. She took his medical observations which were all normal. A nurse reviewed Mr Lemmon and then asked for a prison GP to review him. His blood pressure dropped and was low (80/52) and there was no doctor available at Winchester. The on-call doctor therefore advised staff to send Mr Lemmon to hospital, where he was diagnosed with pneumonia. The next day, he went back to Winchester with antibiotics.

48. On 12 October, a senior healthcare manager spoke to the Head of Healthcare and a social worker. They discussed how to limit and prevent the frequency of Mr Lemmon's falls. She noted that she sent a letter to the Governor to ask for Mr Lemmon's cell door be open 24-hours a day to reduce the risk of injury from a fall.

49. On 16 October, a prison GP reviewed Mr Lemmon. He told her that he had severe back pain. She thought that this may be because of the spread of the cancer or a fracture from a previous fall and prescribed him pain relief medication. The following day, the senior healthcare manager, noted that Mr Lemmon had been moved to a different cell, with an electric bed and an air mattress due to his increased pain.

50. On 6 November, the senior healthcare manager had a multidisciplinary team meeting with the Head of Healthcare, senior nurse managers and prison managers. They discussed Mr Lemmon's worsening condition and how to manage his care. The chaplaincy team offered their support. They also discussed moving Mr Lemmon to a hospice, increased family visits, increased officer supervision and compassionate release. Later in the day, the palliative medicine consultant saw Mr Lemmon and his son. She talked to healthcare staff about Mr Lemmon's medication.

51. At 4.05am on 24 November, an officer went into Mr Lemmon's cell to check on his welfare and saw that he was unresponsive. A nurse saw that Mr Lemmon was not breathing and had no pulse. He switched off the machine which was giving him his medication. Paramedics went to the prison and at 4.26am, confirmed that Mr Lemmon was dead. A post-mortem examination showed that he died of multiple organ failure as a result of pneumonia caused by lung cancer which had spread.

52. We are satisfied that the care that Mr Lemmon received at Winchester was equivalent to that which he could have expected to receive in the community. Healthcare staff made care plans within two months of his arrival at Winchester. There was good communication between healthcare staff, the mental health team, prison officers and senior prison management. Mr Lemmon was prescribed medication to help with his pain and when he became very ill, a syringe driver (a small battery-powered pump that delivers medication through a needle under the skin) was used to give him his medication.

53. Mr Lemmon had a history of poor mental health and prison staff monitored him under ACCT procedures three times. He also had regular support from the welfare team, the in-reach mental health team and the occupational therapist.

54. The British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing published guidance on resuscitation decisions in 2016.

Although the guidance does not explicitly say when a decision not to resuscitate should be made, it says that if a patient has a serious illness, healthcare staff should ask about the person's wishes as soon as possible. Although Mr Lemmon had a terminal illness and healthcare staff had talked to him more than once about completing an order not to be resuscitated if his heart or breathing stopped, we are concerned that it took ten months after Mr Lemmon went to Winchester for staff to arrange this. We make the following recommendation:

The Head of Healthcare should ensure that prisoners with a serious illness are given the opportunity to decide whether they want to be resuscitated if their heart or breathing stops soon after diagnosis or on arrival at Winchester, and that staff record their decision promptly.

55. The clinical reviewer made a number of recommendations which, while not related to Mr Lemmon's death, the Head of Healthcare will need to address.

Mr Lemmon's location

56. On 7 June 2017, a nurse conducted Mr Lemmon's initial health screen. He noted that Mr Lemmon should go to the healthcare wing because he was not fit to live in a standard wing. Mr Lemmon stayed in the inpatient unit. Even though healthcare staff and prison staff considered moving him to another prison with better inpatient facilities, Mr Lemmon stayed at Winchester. When he developed back pain, he moved to another cell, with an electric bed and an air mattress. When he was very ill and had frequent falls, the Governor authorised staff to leave his cell door open 24-hours a day.

57. Healthcare staff spoke to Mr Lemmon about going to hospital and a hospice but he wanted to stay at Winchester.

58. We are satisfied that that it was appropriate for healthcare staff to send Mr Lemmon to the inpatient unit, where he had access to a higher level of care.

Restraints, security and escorts

59. When prisoners travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk, taking into account factors such as the prisoner's health and mobility.

60. Mr Lemmon was a frail 85-year old Category C prisoner with terminal lung cancer who used a walking aid and a wheelchair. Officers assessed his risk and noted that he was a risk to the public, to children, a risk of being violent and a risk to himself as he had been monitored under ACCT procedures.

61. Mr Lemmon went to hospital for tests and treatment as an outpatient five times between July 2017 and August 2018. Escort risk assessments were completed and healthcare staff completed the medical section. Healthcare staff did not object to the use of restraints but noted that Mr Lemmon had limited mobility and used a mobility aid or a wheelchair.

62. On 17 October 2017, a nurse objected to the use of restraints because Mr Lemmon was weak, frail had poor mobility and used a Zimmer frame. Despite this, the Head of Security, decided that Mr Lemmon should be restrained with an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer) and that this level of restraint should only be reduced with the authority of the duty governor.

63. Apart from 8 February 2018, when the Head of Security noted that Mr Lemmon should not be restrained, prison managers decided that Mr Lemmon should be restrained with an escort chain each time he went to hospital.

64. 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 a prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

65. We are concerned that prison managers frequently decided that Mr Lemmon should be restrained by an escort chain despite his cancer diagnosis, advanced age, lack of mobility and frailty. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

Liaison with Mr Lemmon's family

66. PSI 64/2011 on safer custody requires prison staff to communicate with the next of kin of prisoners who are seriously or terminally ill. On 19 February 2018, the Head of Safer Custody, appointed an officer as Mr Lemmon's family liaison officer (FLO). He did not appoint a deputy family liaison officer. The FLO remained in regular contact with Mr Lemmon's son, who also visited Winchester to see his father and to talk to healthcare staff about his care.

67. When Mr Lemmon died, the FLO was on leave. At 10.00am on 24 November, the senior healthcare manager, telephoned Mr Lemmon's son, in the presence of the Head of Healthcare, to break the news of Mr Lemmon's death. She offered her condolences.

68. The senior healthcare manager, said that because there were no suitably trained prison staff available and because she had previously met Mr Lemmon's son and frequently spoken to about his father's care and condition, she offered to undertake the role.

69. The senior healthcare manager, said that Mr Lemmon's son was due to visit Winchester that day because he had not been able to visit his father during the previous four days. She said that she wanted to telephone Mr Lemmon's son before he arrived at the prison for the visit as that would have been a worse way of learning of his father's death.

70. Two days later on 26 November, The Prison Head of Healthcare asked an officer to visit Mr Lemmon's son. The officer and a chaplain, did so at 2.30pm that day, and offered their condolences.

71. The officer said that she was not qualified as a family liaison officer but had previously expressed an interest in being trained. She said that when she went to see Mr Lemmon's son, she felt uncomfortable because she did not know what to say or do and had not previously spoken to or met Mr Lemmon's family.

72. On 4 December, after she returned from leave, the FLO spoke to Mr Lemmon's son and offered her condolences. She remained in contact with Mr Lemmon's son to arrange Mr Lemmon's funeral, which took place on 18 December. Winchester contributed to the funeral costs in line with national instructions.

73. We consider that, even though the senior healthcare manager, said that she was happy to inform the next of kin of Mr Lemmon's death, this should have been done in person, and by a trained family liaison officer. We make the following recommendation:

The Governor should ensure that when a prisoner is seriously ill or diagnosed with a terminal illness, a trained family liaison officer and deputy family liaison officer are promptly appointed to act as a point of contact and support.

Compassionate release

74. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they have a terminal illness and a life expectancy of less than three months.

75. The Head of the Offender Management Unit, said that there was a multidisciplinary team meeting for Mr Lemmon on 6 November, because his condition had worsened. Mr Lemmon said that he wanted to stay at Winchester and did not want to be considered for compassionate release or to go to a care home. Prison staff did not therefore complete a compassionate release application. We are satisfied that this was appropriate.

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PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141