Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Tommy Hanks a prisoner at HMP Wakefield on 3 April 2019

A report by the Prisons and Probation Ombudsman

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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 Tommy Hanks died on 3 April 2019 of pneumonia arising from lung cancer, while a prisoner at HMP Wakefield. He was 46 years old. I offer my condolences to Mr Hanks' family and friends.

Mr Hanks' death was expected. I am satisfied that healthcare staff promptly investigated his symptoms to obtain a diagnosis and provided a good standard of compassionate care, at least equivalent to that he could have expected to receive in the community. However, a formal end of life policy would have further enhanced decision-making.

I am concerned that as Mr Hanks' condition worsened, he was restrained for hospital visits and admissions without appropriate justification, and that our request for clarification of apparent anomalies in his final risk assessment document was unresolved.

I am also concerned that there was a significant delay in notifying Mr Hanks' family of his death, as his personal records had not been kept up to date.

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 **November 2019**

Contents

Summary

Events

1. Mr Tommy Hanks had been at HMP Wakefield since 31 October 2014. He was a smoker, with a history of chronic obstructive pulmonary disease.

2. On 17 January 2017, Mr Hanks reported shortness of breath, wheezing and unplanned weight loss. A prison GP requested an urgent X-ray, which revealed an abnormality in Mr Hanks' left lung. Further tests, including a bronchial biopsy confirmed that Mr Hanks had lung cancer and he was informed of this on 26 April.

3. Hospital specialists found that the cancer was inoperable. During 2017 and 2018, they gave Mr Hanks palliative chemotherapy and radiotherapy to relieve his symptoms and extend his life expectancy. In early 2019, he received immunotherapy, a new treatment to help the immune system fight cancer.

4. Prison healthcare staff held a monthly multidisciplinary meeting to monitor Mr Hanks' treatment and care. Attendees included a consultant in respiratory medicine and a Macmillan palliative care specialist, as well as several clinical and prison staff.

5. On 23 March 2019, Mr Hanks' condition worsened and he was admitted to hospital. He died on 3 April. The Coroner confirmed that Mr Hanks' death was due to pneumonia, secondary to lung cancer. Small pulmonary emboli (blood clots in the lung artery) also contributed to his death.

Findings

6. The investigation found that prison GPs took prompt and appropriate action to investigate Mr Hanks' symptoms and diagnose his illness.

7. Healthcare staff were caring and compassionate. They delivered a good standard of care, at least equivalent to that Mr Hanks could have expected to receive in the community. However, there was no advance care plan to document Mr Hanks' preferences for treatment and his wishes for end of life care.

8. Prison and healthcare staff who completed risk assessments took insufficient account of Mr Hanks' physical deterioration and reduced mobility when completing security risk assessments. His restraints were removed at the request of a doctor, five days before he died.

9. Mr Hanks' next of kin details were not kept up to date, causing a delay of almost a month before his family were informed of his death.

10. Prison staff raised the possibility of early release on compassionate grounds soon after Mr Hanks' initial diagnosis, when he was considered to have a life expectancy of less than a year. However, there is no evidence that they discussed this with Mr Hanks, or tried to obtain a clearer estimation of his life expectancy, which is a requirement for applications for early release. We have not made a recommendation on this issue, as we think it is unlikely that Mr Hanks would have been granted early release, but prison staff should remember

to fully document actions and decisions on the consideration of compassionate release.

11. The prison did not provide a complete copy of Mr Hanks' final risk assessment, or clarify inconsistencies found in the document.

Recommendations

- The Head of Healthcare should ensure that an advance care plan is in place for terminally ill prisoners who are likely to die within twelve months.
- The Governor and Head of Healthcare should ensure that
    - all staff completing and authorising risk assessments for prisoners taken to hospital understand the legal position on the use of restraints;
    - healthcare staff complete the healthcare section of the risk assessment form fully;
    - risk assessments fully take into account the health of a prisoner;
    - risk assessments are based on the actual risk the prisoner presents at the time; and
    - restraints are not used during serious or invasive treatment, unless there are exceptional reasons for doing so.
- The Governor should ensure that, in line with PSI 58/2010, the Prison and Probation Ombudsman is promptly provided with all requested documents following a death in custody.
- The Governor should ensure that emergency contact details for prisoners' next of kin are accurate and kept up to date and, in the event of a death, the prisoner's family is informed as soon as possible, in line with national guidance.

The Investigation Process

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

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

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

15. We informed HM Coroner for West Yorkshire (Eastern District) of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

16. One of the Ombudsman's family liaison officers contacted Mr Hanks' niece, who acted as his next of kin, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She had no specific questions but wanted a copy of our report.

17. The investigation has assessed the main issues involved in Mr Hanks' 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. Mr Hanks' niece received a copy of our initial report. She made no comments.

19. The initial report was shared with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies and accepted our recommendations. The HMPPS action plan has been annexed to this report.

Background Information

HM Wakefield

20. HMP Wakefield is a high security prison which holds up to 750 men. There are four main residential wings, a healthcare centre, a segregation unit and a close supervision centre (a small unit aiming to provide a supportive, safe, structured and consistent environment for some of the most challenging offenders).

21. Care UK provides health and social care services at Wakefield. The healthcare centre offers 24-hour inpatient care for prisoners with physical health problems and there is a dedicated palliative care suite.

HM Inspectorate of Prisons

22. The last inspection of Wakefield was in June 2018. Inspectors noted that clinical governance had improved since the last inspection, a health needs analysis informed the service and there was a comprehensive health improvement plan. Inspectors were impressed with the range of clinics and access to services was good. They also noted that staff were suitably trained to manage long-term conditions and that they were professional and caring. Joint working with a local hospital had improved the scheduling of appointments and reduced cancellations.

23. The palliative care suite had received external accreditation. End of life care pathways were used and provision for the terminally ill was dignified and patient-focussed.

Independent Monitoring Board

24. 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 30 April 2018, the IMB reported that the previous separate nursing teams had merged and extended their clinical roles to reduce unnecessary attendance at hospital. They considered that end of life care was of a very high standard and noted that the palliative care suite had been upgraded. The Board was concerned that the inpatient unit was inappropriately used to accommodate high profile and non-clinical prisoners.

Previous deaths at HMP Wakefield

25. Mr Hanks was the 13th prisoner to die at Wakefield since April 2017. There have been six subsequent deaths. Fifteen deaths were from natural causes, two were self-inflicted and two are awaiting classification.

26. We have previously raised the issues of risk assessments and the unjustified use of restraints, as well as notifying families promptly of a prisoner's death. We made a recommendation about the use of restraints in June 2019 and have not yet received the prison's response.

Findings

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

27. Mr Tommy Hanks was remanded to HMP Leeds on 9 January 2010. He was later convicted of attempted rape and theft and sentenced to Imprisonment for Public Protection, with a tariff of 24 months.

28. Mr Hanks was a smoker and he had been diagnosed with chronic obstructive pulmonary disease (COPD – the name for a group of lung conditions that cause breathing difficulties). He transferred to Wakefield on 31 October 2014 and health screens indicated that he was fit and well.

29. On 17 January 2017, Mr Hanks saw a prison GP. He reported shortness of breath with wheezing, that was worse at night and unplanned weight loss. Mr Hanks said he had stopped smoking two weeks before. The GP prescribed an inhaler and referred Mr Hanks for an urgent chest X-ray and a spirometry test to assess his breathing and lung function. The X-ray was taken on 24 January. The results were received on 27 January and revealed an abnormality in Mr Hanks' left lung.

30. On 30 January, a prison GP referred Mr Hanks for a computerised tomography (CT) scan to clarify the X-ray result. The CT scan took place on 1 March. A prison GP told Mr Hanks the results on 2 March. He said that there was a lump in Mr Hanks' chest that might be cancer and would need further investigation. He also noted that an urgent referral had already been made under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks.

31. On 3 March 2017, a consultant in respiratory medicine reviewed Mr Hanks at Wakefield. Mr Hanks told him that he had been coughing up blood in recent weeks and had lost three stone in weight in the previous three months. The consultant arranged additional tests, including a PET scan (a detailed scan of tissues and organs, which can show how far a cancer has spread). He also prescribed nutritional supplement drinks.

32. A bronchial biopsy taken on 6 April confirmed that Mr Hanks had lung cancer. On 26 April, the prison received the results of another scan. The same day, the consultant and a nurse explained to Mr Hanks the results of his tests and informed him that he had lung cancer.

33. We are satisfied that when Mr Hanks became unwell, prison GPs promptly investigated his symptoms and informed him of the results, without delay.

Mr Hanks' clinical care

34. On 15 March 2017, Mr Hanks was placed on the Gold Standards Framework (GSF – a framework for early identification of life-limiting conditions and to help plan care in line with patients' needs and wishes). Multidisciplinary GSF meetings were held monthly to discuss Mr Hanks' care. Mr Hanks' consultant and a Macmillan specialist palliative care nurse attended the meetings, along with representatives from departments across the prison. (The meetings

continued until March 2019, when Mr Hanks was admitted to hospital for the last time. However, there is no evidence that a formal end of life care plan was in place.)

35. On 28 April, the consultant reviewed Mr Hanks, who said that he was coping well, eating and had no pain or breathlessness. Mr Hanks said he understood what he had been told and had no questions. Healthcare staff later gave Mr Hanks written information about his condition and prospective surgery. They also put in place a risk of malnutrition care plan, to include regular weight checks and nutritional supplements.

36. With Mr Hanks' agreement and without breaching medical confidentiality, the Macmillan nurse shared with a wing senior officer that Mr Hanks had received life changing news and might need extra support.

37. Mr Hanks was referred to a thoracic surgeon at St James Hospital, Leeds. On 17 May, he was admitted to hospital for a bronchoscopy (a test to look at the airways in the lungs) and surgery on his lungs. However, surgeons found that the tumour had spread into both heart chambers and possibly the major blood vessel into the heart, so they were unable to operate. On 19 May, the hospital's multidisciplinary team advised Mr Hanks' consultant that the tumour was inoperable and consideration would be given to chemotherapy and/or radiotherapy to shrink the tumour. The consultant explained this to Mr Hanks on 24 May and said he would refer him to an oncologist (cancer specialist), but was happy to review him at any time.

38. Healthcare staff managed Mr Hanks' pain and facilitated outpatient appointments. On 14 June, they began discussions about Mr Hanks' end of life care.

39. A consultant in clinical oncology arranged for Mr Hanks to have four cycles of palliative chemotherapy, with a view to delaying the onset of new symptoms and extending Mr Hanks' life expectancy. (This took place between August and October.)

40. On 15 September, the prison's multidisciplinary team noted that they had not discussed the issue of resuscitation with Mr Hanks, as they were waiting for the outcome of his chemotherapy.

41. At a review with his consultant on 21 November, Mr Hanks said that he had been coughing up blood since September, but had not told anyone. The doctor requested an urgent CT scan. On 7 December, the scan results revealed that Mr Hanks' tumour had grown and he was re-referred to the consultant in clinical oncology.

42. Mr Hanks completed palliative radiotherapy (to treat his symptoms) in December 2017 and February 2018. The consultant in clinical oncology discharged him on 26 April, noting there was no evidence that the cancer had spread and that his consultant should monitor him every 6 months at the prison's respiratory clinic.

43. GSF meetings in January and February 2019, assessed Mr Hanks' life expectancy as "months" and noted he was waiting for further treatment to shrink his tumour. On 28 February, Mr Hanks began immunotherapy (a relatively new treatment to help the immune system to fight the cancer).

44. At around 7.00am on 23 March, Mr Hanks reported breathing problems and was admitted to hospital. Over the next few days, his condition deteriorated. He developed pneumonia in his left lung and his right lung collapsed. On 29 March, Mr Hanks' consultant told him that he was on the maximum medical treatment, but his infections were not under control and it was unlikely that he would get better. He noted that Mr Hanks had full mental capacity and that an order was in place to ensure that staff would not attempt resuscitation if his heart or breathing stopped. Healthcare staff telephoned the hospital for updates and chaplaincy and safer custody staff visited Mr Hanks for wellbeing checks. Mr Hanks died on 3 April.

45. A post-mortem examination found that Mr Hanks' death was due to 1) bilateral bronchopneumonia; 2) small bilateral pulmonary emboli; 3) obstructing right bronchial tumour with subsequent collapse of right lung.

46. We are satisfied that Mr Hanks received a good standard of care at Wakefield, equivalent to that he could have expected in the community and staff were prompt, compassionate and supportive. However, we agree with the clinical reviewer that a formal advance care plan should have been in place to record Mr Hanks' treatment and care preferences, including end of life care and his views on cardiopulmonary resuscitation. We make the following recommendation:

The Head of Healthcare should ensure that an advance care plan is in place for terminally ill prisoners who are likely to die within twelve months.

Mr Hanks' location

47. Before Mr Hanks went to hospital for surgery on 18 May 2017, healthcare staff prepared for his return by reserving a bed for him in the prison's inpatient unit. As he was discharged to the prison straight from the high dependency unit, without first going to a ward, they considered it important to monitor him in the inpatient unit before sending him back to a wing. However, Mr Hanks insisted on returning to his wing and signed a disclaimer. Healthcare staff monitored him on the wing and he moved to the inpatient unit during chemotherapy in 2017.

48. On 1 March 2019, after immunotherapy, Mr Hanks was admitted to the inpatient unit for pain management until 4 March, when he returned to his residential wing. At a subsequent welfare check, he said that he was happy on the wing as he could go to work. Mr Hanks remained self-caring and did not need help. At the GSF meeting on 18 March, it was again recorded that he wanted to remain on his wing. However, if necessary, he would stay in the inpatient unit overnight after chemotherapy. When Mr Hanks' symptoms worsened on 23 March, he was immediately sent to hospital.

49. We are satisfied that healthcare staff respected Mr Hanks' wish to remain on his residential wing and were flexible in caring for him in that environment. They appropriately admitted him to the inpatient unit, when he needed and quickly arranged admission to hospital when his condition deteriorated

Restraints, security and escorts

50. 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.

51. 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.

52. Mr Hanks had numerous outpatient appointments and inpatient admissions during his illness and he was fully compliant throughout. From 2017 until his final admission in March 2019, the "specific factors of concern" elements on the security risk assessment were identical each time, regardless of Mr Hanks' state of health. The assessments indicated - high risk to the public (notably due to his security category and offence); medium risk in relation to hospital staff, hostage taking and escape potential (despite noting beside each of these factors that there was no intelligence to suggest any risk); and a low risk of outside assistance. Each time he went to hospital, Mr Hanks was escorted by two prison officers. With the exception of two instances in 2019, Mr Hanks was double handcuffed (when the prisoner's hands are handcuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs).

53. On 8 November 2017, Mr Hanks went to hospital for a CT scan. The escort officers would not remove the cuffs, or leave the room, as is required for scans, so it was postponed and re-booked for 13 November.

54. Mr Hanks' behaviour in prison had been generally good, with few instances of indiscipline. On 26 April 2018, following a hospital visit, escort officers noted that his behaviour had been "exemplary" and he had been fully compliant and polite. They added, "this behaviour is very good and … there needed to be some documented evidence of Tommy's continuous good behaviour in custody and his positive rapport/relationship with members of staff."

55. On 19 March, it was noted in Mr Hanks' medical record that he was struggling with his mobility and needed a wheelchair for hospital visits. The medical section of risk assessments completed around this time noted this requirement, but still concluded that Mr Hanks' condition did not restrict his ability to escape.

56. The copy of the risk assessment for Mr Hanks' final journey on 23 March was incomplete, so we were unable to verify the level of security authorised. However, the bedwatch logs showed that an escort chain was used until 29 March, including during invasive treatment. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.) On 29 March, Mr Hanks' consultant asked the escort officers to explore whether Mr Hanks' restraints could be removed for comfort reasons. They were removed at 4.30pm that day.

57. We are not satisfied that staff appropriately assessed Mr Hanks' risk. He had an advanced terminal illness which had reduced his mobility and he received

intravenous treatment in hospital. It seems that there was little meaningful input from healthcare staff in the risk assessments and prison managers took little or no account of how his ailing condition affected his risk of escape, as the High Court judgment requires. We make the following recommendation:

The Governor and Head of Healthcare should ensure that:

- **all staff completing and authorising risk assessments for prisoners taken to hospital understand the legal position on the use of restraints;**
- **healthcare staff complete the healthcare section of the risk assessment form fully;**
- **risk assessments fully take into account the health of a prisoner;**
- **risk assessments are based on the actual risk the prisoner presents at the time; and**
- **restraints are not used during serious or invasive treatment, unless there are exceptional reasons for doing so.**

58. The investigator requested the missing pages of the final risk assessment, but the prison did not provide them. There were anomalies in part 11 of the assessment, the section relating to authorising the removal of handcuffs. It had been completed in duplicate, but each copy had been signed by a different person – a prison manager on 30 March and the Governor on 1 April.

59. Despite the best efforts of the prison's liaison officer, the prison did not respond substantively to our request for clarification of the reason for the duplicates and confirmation of the substantive version and level of risk. The dates on the documents suggest that Mr Hanks might have been restrained until either 30 March, or 1 April, but the restraint check documents and bedwatch logs indicate no restraints were used from 29 March onwards. Without the documents, we were unable to fully explore this issue. We make the following recommendation:

The Governor should ensure that, in line with PSI 58/2010, the Prison and Probation Ombudsman is promptly provided with all requested documents following a death in custody.

Liaison with Mr Hanks' family

60. On 28 April 2017, Mr Hanks' consultant noted that Mr Hanks did not want his family to know about his illness at that time. At the GSF meeting in June 2017, the question of appointing a family liaison officer was raised and it was agreed that the deputy head of healthcare would discuss this with the consultant. There is no record of the outcome.

61. On 16 May 2018, Mr Hanks' keyworker tried to have a conversation with him about his wellbeing, including questions on family contact, but Mr Hanks would not engage with him and said he was not interested.

62. At the GSF meeting on 18 March 2019, it was noted that a family liaison officer had yet to be appointed, as Mr Hanks did not want one. On 29 March, Mr Hanks' consultant asked him if he wanted to speak to, or meet his family and informed him that the prison's family liaison officer could help to trace them. Mr Hanks said he wanted this and escort staff agreed to speak to prison managers.

63. On the same day, a custodial manager noted in Mr Hanks' personal records that, on the advice of the consultant, she had been appointed as a family liaison officer and advised of Mr Hanks' recent diagnosis. There is no record of any further action before his death five days later.

64. Shortly after Mr Hanks' death, an officer became the family liaison officer (FLO). She and another officer went to two addresses listed for Mr Hanks' sister, his nominated next of kin. They spoke to several neighbours to try to locate her, without success. The officers then made enquiries with Mr Hanks' probation officer and the police.

65. On 1 May, almost a month after Mr Hanks' death, the police provided an address and telephone number for his sister and advised that she wanted her daughter to act on her behalf. The same day, the FLO telephoned Mr Hanks' niece and they discussed the arrangements for Mr Hanks' funeral. Mr Hanks' family said they would not attend, but wanted him to be cremated and the FLO agreed to take the ashes to them.

66. A memorial service for Mr Hanks was held at the prison, on 13 May and Mr Hanks' niece attended. The prison also arranged and paid for Mr Hanks' funeral, which was held on 4 June.

67. Prison Service Instruction 64/2011, on safer custody, requires prisons to communicate with the next of kin of prisoners who are seriously or terminally ill. Prison Rule 22 instructs that prisons should inform the next of kin immediately if a prisoner dies, or becomes seriously ill. We recognise that the prison respected Mr Hanks' initial wishes not to contact his family and that he changed his mind only five days before his death. However, given his terminal condition, it was inevitable that staff would need to contact Mr Hanks' family in the event of his death. Staff should therefore have ensured that his next of kin details were up to date. We make the following recommendation:

The Governor should ensure that emergency contact details for prisoners' next of kin are accurate and kept up to date and, in the event of a death, the prisoner's family is informed as soon as possible, in line with national guidance.

Compassionate release

68. 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.

69. The possibility of early release was first raised at the GSF meeting on 29 March 2017, when it was noted that Mr Hanks had less than a year to live. However, there is no evidence that prison or clinical staff sought a formal prognosis of his

life expectancy, or that they had discussed with him the possibility of compassionate release. We acknowledge that as he had lost contact with his family, early release might not necessarily have been beneficial to Mr Hanks and it was unlikely that he would have met some of the other criteria, such as adequate arrangements for his care and treatment. However, in similar cases in the future, the prison might wish to record that they have considered but discounted the possibility of compassionate release and note the reasons why.

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