Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Lowe a prisoner at HMP High Down on 4 August 2018

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 John Lowe died on 4 August, of bone marrow cancer while a prisoner at HMP High Down. He was 86 years old. I offer my condolences to Mr Lowe's family and friends.

After Mr Lowe was diagnosed with cancer, the care he received at High Down was equivalent to that he could have expected to receive in the community.

However, the standard of care Mr Lowe received before he was diagnosed was unacceptably poor and not equivalent to the care he could have expected to receive in the community.

Mr Lowe was frequently referred to hospital for investigations because of unusual blood test results or illness. Yet despite making many appropriate referrals, healthcare staff at High Down persistently failed to act on information in discharge summaries or other correspondence. No action was taken in response to a letter informing healthcare staff that Mr Lowe had cancer until a GP learned of the diagnosis by chance two weeks later. This lack of organisation was completely unacceptable.

I am concerned that family liaison also lacked basic organisation and that family queries went unanswered.

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 **February 2019**

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Summary

Events

1. On 31 October 2014, Mr John Lowe was sentenced to life imprisonment for murder. He had been at HMP High Down since 26 February. Mr Lowe had a number of health complaints including heart disease and osteoarthritis.

2. In 2014, blood tests identified low levels of certain components and unusual prostate specific antigen (PSA) levels. Although an eventual diagnosis ruled out cancer, a specialist recommended that Mr Lowe's PSA levels be monitored regularly. They were not tested again until a prison doctor identified the error two years later, in August 2016.

3. Tests were then immediately carried out. They showed no change in PSA levels since 2014, but showed high levels of a protein, which is sometimes indicative of cancer. A GP made a fast-track cancer referral and Mr Lowe had tests in hospital. These, again, ruled out cancer but confirmed Mr Lowe was anaemic and recommended a treatment plan. The hospital did not inform the prison of the outcome of these investigations and the prison did not identify this or take any action to follow up the referral for six months.

4. Regular blood tests were completed in April and May 2017, but after that no blood tests were completed until August. Results continued to show abnormalities and there continued to be a lack of organised follow-up after referrals or hospital admissions.

5. In April 2018, a hospital specialist wrote to the prison saying that Mr Lowe had been diagnosed with a form of bone marrow cancer. The letter was seen by healthcare staff in mid-April but not actioned until a prison doctor spoke to hospital staff about another matter, and learned of Mr Lowe's diagnosis by chance, at the beginning of May.

6. Mr Lowe's condition was not curable. He was also assessed as lacking sufficient capacity to make decisions about his treatment because of his dementia. Mr Lowe was cared for in the prison's inpatients unit, intermittently in hospital and finally in a hospice. He died at 10.40am on 4 August.

Findings

7. We are not satisfied that that the standard of clinical care Mr Lowe received at HMP High Down before his diagnosis was equivalent to that which he could have expected to receive in the community. There were frequent lapses in blood testing and recurrent failures to follow-up tests and hospital referrals - this was unacceptable.

8. After diagnosis, the care Mr Lowe received at High Down was equivalent to that which he could have expected to receive in the community.

9. Although a family liaison officer (FLO) was apparently appointed in May 2018 after the prison learned of the cancer diagnosis, the task appears to have been

devolved to healthcare staff, and family correspondence was not answered. A formal FLO log was not started until August. This was also very poor practice.

10. The use of restraints and the possibility of compassionate release were also discussed when the prison learned of the diagnosis and we are satisfied that appropriate decisions were made on both.

Recommendations

- The Head of Healthcare should ensure that patients are promptly reviewed after external appointments or admissions and any correspondence relating to diagnoses, treatment and monitoring is scanned onto the prisoner's medical record and actioned.
- The Governor should ensure that a Family Liaison Officer is appointed when a prisoner is diagnosed with a serious or terminal condition and that they make contact with the next of kin and complete the FLO log.

The Investigation Process

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

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

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

14. We informed HM Coroner for Surrey of the investigation. The coroner gave us the cause of death. We have sent the coroner a copy of this report.

15. The investigator wrote to Mr Lowe's named next of kin, a friend, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not respond to our letter.

16. The investigation has assessed the main issues involved in Mr Lowe'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.

17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HM Prison High Down

18. HMP High Down is a local prison in Surrey which holds up to 1,203 men. Central and North-West London NHS Foundation Trust provides primary health services and in-reach mental health care. The healthcare unit has inpatient facilities with 24-hour nursing cover.

HM Inspectorate of Prisons

19. The most recent inspection of HMP High Down was unannounced and took place in May 2018. Inspectors reported that the prison had failed to meet 47 of the 80 recommendations made after their previous (2015) inspection. They made new recommendations for healthcare waiting lists to be regularly monitored and reviewed to ensure accuracy, and that non-attendance rates for all clinics should be continuously evaluated and addressed. The inspectorate also recommended a dedicated clinical lead be identified for the inpatient unit and multi-disciplinary team meetings be held to review all cases.

Independent Monitoring Board

20. 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 December 2017, the IMB said that the cancellation of outpatient clinics had reduced considerably due to the recruitment of many uniformed staff. The inpatient unit with 23 beds had been full for most of the year due in part to prisoners with challenging behaviour being assessed for possible transfer to mental health facilities.

Previous deaths at HMP High Down

21. Mr Lowe's death is the eighth from natural causes at High Down in three years. We have made recommendations in previous cases about the need for better follow-up after hospital appointments and admissions.

Findings

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

22. Mr Lowe was serving a life sentence, with a minimum term of 25 years, having been convicted of murder on 31 October 2014. He had been at HMP High Down since 26 February.

23. Mr Lowe was 82 when he started his sentence and his first night screen, conducted by a healthcare assistant, recorded that he had a number of complaints, including heart disease and osteoarthritis.

24. On 3 October 2014, a nurse took a sample of Mr Lowe's blood and the results showed low haemoglobin and lymphocyte levels. She also did a prostate specific antigen test (PSA), and it was abnormal. She asked a prison GP to review the results.

25. On 4 November, after reviewing the PSA results, a prison GP made an urgent urology referral under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks. The prison GP did not comment on the blood test results.

26. On 5 December, a nurse repeated the blood tests and the results matched those taken on 3 October. She noted the results as 'borderline' and requiring no further action.

27. On 8 December, a prison GP reviewed the urology department's letter about an appointment that had taken place on 2 December. In the letter a hospital specialist said that a cancer diagnosis was unlikely, but that staff should monitor Mr Lowe's PSA levels every six or twelve months and re-refer him if there was a significant increase. He noted that Mr Lowe's PSA levels should be monitored every three months but his PSA levels were not tested again.

28. On 16 August 2016, a prison GP reviewed Mr Lowe when blood tests showed that he had a low lymphocyte count (white blood cells). She realised that he had not had any PSA tests since 2014, so she tested Mr Lowe and the results showed no change in levels since 2014.

29. On 24 August, a health professional access role took blood tests. The results indicated that Mr Lowe was not iron deficient but had high levels of C reactive protein, which are sometimes elevated when cancer is present. A prison GP made a fast-track cancer referral on 25 August.

30. Mr Lowe was initially seen at hospital on 29 September, and went on to have a number of scans (abdomen, pelvis and thorax) and an endoscopy (a procedure to examine the inside of the body). Specialists identified a small hernia but nothing more, and diagnosed anaemia. They recommended iron supplements and that Mr Lowe be monitored until his blood tests returned to normal. However, the hospital did not write to the prison informing them of this and the prison did not identify that they had not been written to.

31. On 28 March 2017, a prison GP reviewed Mr Lowe and realised he had not had a blood test for six months and that the prison did not know the outcome of the fast-track cancer referral. She chased the hospital and they responded to her on 8 May.

32. Mr Lowe had blood tests on 4 April, 19 April and 19 May, and the results still showed anaemia and a low lymphocyte count.

33. On 24 May, a prison GP prescribed iron supplements once she had seen the hospital's letter of 8 May.

34. On 25 August, a prison GP reviewed Mr Lowe and noticed that recent blood tests had not been completed. He requested they be carried out along with kidney function tests. The results indicated anaemia, a low lymphocyte count and abnormal kidney function. The prison GP arranged a urine test and the results showed a possible urinary tract infection. The prison GP prescribed antibiotics.

35. Repeat blood tests were completed on 5 September, and reviewed by a prison GP on 6 September. She thought that the test results indicated acute kidney injury (damage to the kidneys, usually as a result of another illness) and mild pancytopenia (a reduction in white and red blood cells that can develop as a reaction to drugs, bone marrow failure or some cancers). Acute kidney failure can also be caused by drugs including ibuprofen and she stopped Mr Lowe's prescription.

36. On 14 September, a prison GP saw Mr Lowe and recorded that he was very concerned about his kidney function. He reduced the dosage of perindopril that Mr Lowe was on for vascular disease. He and another prison GP, saw Mr Lowe frequently over the following three months. His kidney function improved but no full blood count test was requested until 19 January 2018.

37. On 22 January, a prison GP telephoned a consultant haematologist (a specialist in diseases of the blood and bone marrow) at a hospital, who recommended a fast-track referral. The referral was completed by a prison GP the next day.

38. On 28 January, Mr Lowe collapsed, hurting his knee and was taken to hospital for two days. Hospital staff noted that appointments were in place following a prison GP referral and a letter from the hospital to the prison said that Mr Lowe had low blood pressure. The letter also said that the results of further investigations were needed before they could make a firm diagnosis.

39. On 31 January, Mr Lowe was readmitted to hospital until 15 February. He was experiencing dizziness and headaches. He received more treatment for his knee. A haematologist also saw him and noted that Mr Lowe probably had pancytopenia because of a vitamin deficiency, but follow-up would be needed.

40. On 1 March, Mr Lowe collapsed again and was taken to hospital but discharged the next day. The hospital had found that his potassium levels were low and he received treatment to correct this.

41. Mr Lowe had two further admissions to hospital during March. One from 10 to 14 March, when he presented with confusion and had not been eating and drinking properly, and again between 26 March and 30 March, after he lost

consciousness. His bloods were monitored and a 24-hour cardiac test was completed. No diagnosis was recorded on the discharge summary, presumably because the test results were pending.

42. On 3 April, a prison GP referred to the discharge summary in the medical record. He said that a member of admin staff needed to chase the cardiac results, although it is not clear if this happened.

43. On 10 April, a haematologist wrote to the prison. She said that Mr Lowe's recurrent hospital admissions had interfered with scheduling an appointment in response to the referral by a prison GP made in January. During Mr Lowe's last admission, however, hospital staff had taken bone marrow samples. Subsequent examination and discussion by the hospital's Multi-Disciplinary Team (MDT) on 29 March, concluded that that Mr Lowe had pancytopenia and a form of bone marrow cancer.

44. The Head of Healthcare at High Down told the investigator that the haematologist's letter was received by the prison and scanned onto the system on 17 April. It was stamped 'Seen by Dr' and was initialled underneath by an unknown person. (We have asked who initialled the letter and why the records indicate that they did nothing more but, at the time of writing this report, we had not received a response.)

45. There is no evidence in the medical record to indicate that any further action was taken.

46. On 3 May, a prison GP spoke to staff at a hospital (a secure mental health unit) about Mr Lowe. The prison had asked the hospital staff to consider whether their facility was appropriate for Mr Lowe given his increasing confusion. Staff told a prison GP, that they would not be accepting him and that a letter existed confirming that Mr Lowe had cancer. The prison GP brought the matter to the attention of another prison GP the same day and she contacted the hospital's haematology department about a treatment plan.

47. The clinical reviewer concluded that, in terms of his diagnosis, the care Mr Lowe received from healthcare staff at High Down was not equivalent to that which he could have expected to receive in the community. He found that although staff made appropriate fast-track referrals there was a systematic problem with follow-up:

- Staff did not monitor Mr Lowe's PSA levels when asked to do so in 2014, and this mistake was not noticed for two years.
- In September 2016, Mr Lowe underwent investigations at the local hospital and was diagnosed with anaemia, iron deficiency and a hernia. A recommendation was made for iron replacement medication and blood test monitoring. Healthcare staff were not aware of the hospital's diagnosis, until a prison GP chased the matter six months later in March 2017.
- In September 2017, further investigations confirmed that Mr Lowe had pancytopenia and acute kidney injury. Clinicians focussed on Mr

Lowe's kidney function and again did not take repeat blood tests to monitor his pancytopenia. No further blood tests were done until January 2018.

- The letter from the hospital saying that Mr Lowe had been diagnosed with cancer was received by the prison on 17 April, but no further action was taken until a prison GP learned of the diagnosis by chance on 3 May.

48. This lack of organisation was unacceptable and we make the following recommendation:

The Head of Healthcare should ensure that patients are promptly reviewed after external appointments or admissions and any correspondence relating to diagnoses, treatment and monitoring is scanned onto the prisoner's medical record and actioned.

Mr Lowe's clinical care

49. Mr Lowe was diagnosed with cancer in April 2018, and the prison were aware of his diagnosis by 3 May. A prison GP contacted the haematology team at the hospital who confirmed that there were no appropriate treatment options and any care would be palliative.

19. On 11 May, a MDT meeting was held to discuss Mr Lowe. The Deputy Governor, the Head of Healthcare, nurses, and representatives from the local palliative care team, probation and safer custody attended. They decided that a family liaison officer should be appointed, a referral to the palliative care team made, and a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order explored (which means that, in the event of cardiac or respiratory arrest, no attempt at resuscitation will be made).

20. On 23 May, a prison GP undertook a capacity assessment and decided that Mr Lowe lacked capacity to make decisions about his treatment due to dementia. (There had been long standing concerns about Mr Lowe's memory since 2017, but referrals in January, March and July 2017 for him to attend a memory clinic were not followed up.)

21. On 24 May, a referral was made to a hospice requesting that they visit Mr Lowe and offer advice.

22. On 5 June, a nurse from the hospice visited Mr Lowe. He observed that Mr Lowe seemed settled and comfortable but advised that oramorph (a strong painkiller to treat severe pain) be available in case it was needed. The nurse also recommended they discuss DNACPR with Mr Lowe.

23. On 12 June, a DNACPR form was signed by a prison GP after discussion with an independent advocate who knew Mr Lowe well. The independent advocate was consulted because of Mr Lowe's diminishing cognitive abilities.

24. There is no evidence that healthcare staff devised a palliative care plan, but it is clear from Mr Lowe's record that his preferences and wishes were taken into account and detailed records were kept about his care. He received daily

assistance from nurses, nutritional supplements and pain management medication was available as and when he needed it.

25. Mr Lowe's condition deteriorated and, on 31 July, he was transferred to a hospice where he died on 4 August.

26. The clinical reviewer concluded that after diagnosis, the care Mr Lowe received at High Down was equivalent to that which he could have expected to receive in the community.

27. We are concerned, however, that there were issues around staff not following up on memory clinic appointments. We do not make a formal recommendation as Mr Lowe's dementia was not cited as contributing to the cause of death, but wish to draw this to the Head of Healthcare's attention.

Mr Lowe's location

28. Mr Lowe was cared for in the prison's inpatient unit until he was transferred to a hospice. We are satisfied that this was appropriate.

Restraints, security and escorts

29. When prisoners have to 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.

30. On 11 May, a joint decision was made between healthcare and prison staff that because of his poor health and significantly diminished risk, Mr Lowe should not be restrained at any point. We are satisfied that this decision was appropriate and commend the multi-disciplinary working as good practice.

Liaison with Mr Lowe's family

31. At a MDT meeting on 11 May, it was decided that a family liaison officer (FLO) should be appointed. Although there is evidence that Mr Lowe's named next of kin (a friend) was approached in June, it is not clear who by. The next of kin in turn contacted Mr Lowe's niece who was happy for the friend to continue with next of kin duties.

32. On 4 July, a prison GP recorded that he had received a letter from Mr Lowe's niece but it is not clear if he responded. On 5 July, a prison GP recorded that he had seen the letter from Mr Lowe's niece but did not feel in a position to reply and had asked admin staff to pass the letter to someone else to reply. There is no evidence that anyone did so.

33. Although Mr Lowe's named next of kin visited him at the healthcare unit, it is not clear how this was coordinated as the FLO log was not started until August. It seems the FLO role was, in part, being carried out by various healthcare staff for some of the time.

34. On 1 August, an officer started a family liaison log. Mr Lowe was in the hospice by this point. The officer contacted the named next of kin by phone and they visited that day. The officer stayed in touch with the next of kin and provided updates where necessary. When Mr Lowe died on 4 August, the officer met the next of kin at the hospice to provide further support and advice.

35. Mr Lowe's funeral was held on 4 September. An officer and a supervising officer attended. The prison contributed to the costs of the funeral in line with national policy.

36. Although it was decided in May that Mr Lowe should be appointed a family liaison officer, a log was not started until August and before that there was a lack of coordination and ownership about family queries and no record of what, if any actions, were taken or by whom. Although Mr Lowe's next of kin seems to have been kept informed and had opportunities to visit him, it is important that it is clear who the liaison point is and that proper records are kept.

The Governor should ensure that a family liaison officer is appointed when a prisoner is diagnosed with a serious or terminal condition and that they maintain contact with the next of kin and complete the FLO log.

Compassionate release

37. 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.

38. On 11 May, staff attending a MDT meeting discussed whether they should recommend Mr Lowe's early release on compassionate grounds. The meeting was attended by prison managers, healthcare and probation staff.

39. They noted that the judge was aware of Mr Lowe's age and medical needs at the time of sentencing and how strongly worded his summing up was. Although Mr Lowe had since been diagnosed with cancer and his mental health was deteriorating, the prognosis was vague and he possibly had up to a year to live. They also noted that Mr Lowe's suitability for a secure mental health unit had been explored, but a hospital decided it could not meet his needs. Prison healthcare staff felt that a move (on release or otherwise), unless absolutely necessary, would be more upsetting for Mr Lowe.

40. The meeting reached a unanimous decision not to recommend compassionate release, although the option was left open for further exploration in the future if appropriate. We are satisfied that the prison appropriately explored and considered compassionate release.

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