Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Horace Nix, a prisoner at HMP Elmley, on 15 June 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*

# Summary


1. 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.

2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

3. Mr Horace Nix, who was 88 years old, died of bronchopneumonia caused by ampullary cancer on 15 June 2019, at HMP Elmley. We offer our condolences to Mr Nix's family and friends.

4. The clinical reviewer concluded that the clinical care that Mr Nix received at Elmley was equivalent to that which he could have expected to receive in the community. She made four recommendations about clinical issues.

5. We found two non-clinical issues of concern.


## Recommendations

- The Head of Healthcare should ensure that residents who are frail and/or elderly receive the supervision and support they need with medical and hospital instructions following investigations and treatment.

- The Head of Healthcare should ensure that the inpatient unit is fully equipped and stocked with special cups and nutritional aids so that a prisoner's hydration is maintained and that timely care and support can be given.

- The Head of Healthcare should ensure that the prison's Inpatient Unit meets the infection prevention, control, cleanliness and maintenance standards at all times.

- The Head of Healthcare should undertake a quality assurance visit around the prison's inpatient unit and review how conducive the environment is for high quality end of life care.

- The Head of Healthcare should ensure that early day attendance and admission to a hospice for prisoners with life limiting long term conditions and illnesses is considered before a prisoner actively approaches the end stages of life.

- The Governor and Head of Healthcare should review the compassionate release process to ensure that a nominated person is identified and is responsible for coordinating, reviewing and progressing applications without delay.

## Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Nix's clinical care at HMP Elmley. The clinical review is attached to this report as Annex 1.

7. The PPO has investigated the non-clinical issues in Mr Nix's care, including his location, family liaison, the security arrangements for his hospital escorts and whether compassionate release was considered.

8. We wrote to Mr Nix's next of kin, his daughter, to explain the investigation. Mr Nix's daughter had concerns about Mr Nix's clinical care at Elmley. The clinical reviewer has addressed these concerns in her report.

9. We shared our initial report with HM Prison and Probation Service (HMPPS). They did not identify any factual inaccuracies. They provided an action plan which is annexed to this report.

10. We sent a copy of our initial report to Mr Nix's daughter. She did not identify any factual inaccuracies.

## Previous deaths at Elmley

11. There have been 11 deaths from natural causes at HMP Elmley in the last two years. There are no similarities between our findings in the investigation of Mr Nix's death and the other deaths.

## Key Events

12. Mr Nix was serving a ten-year sentence for sexual offences and arrived at HMP Elmley in September 2015.

13. On 4 March 2019, Mr Nix was diagnosed with ampullary cancer. On 12 June, he was told that his condition was terminal and that he was not suitable for treatment. Mr Nix was identified as being suitable for palliative care only.

14. Mr Nix attended many outpatient appointments and was admitted to hospital on several occasions while at Elmley. He was not restrained during these visits.

15. There was no post-mortem examination but the Coroner established that the provisional cause of Mr Nix's death was bronchopneumonia, caused by ampullary cancer.

## Non-clinical Findings

### Location

16. Mr Nix shared a cell with his son on a residential wing. On 26 May, when his condition deteriorated, Mr Nix was moved to the prison's healthcare inpatient unit.

17. On 9 June, Mr Nix was very unwell and was frail. He told a prison GP that he would like to go to a hospice. The GP noted Mr Nix's request in his medical record. Healthcare staff decided to wait for a definitive prognosis of Mr Nix's condition before considering hospice care.

18. On 14 June, prison healthcare staff contacted two local hospices but because there were no beds available, Mr Nix could not be transferred to a hospice.

19. Later that day, Mr Nix's health deteriorated and he became unresponsive.

20. On 15 June, it was confirmed that Mr Nix had died.

21. The clinical reviewer considers that hospice care includes care for long-term conditions as well as end of life care. She concluded that healthcare staff could have considered Mr Nix's move to a hospice or a palliative care suite at another prison such as HMP Swaleside, as early as April, before his prognosis was known and before his condition had significantly deteriorated. We make the following recommendation:

    **The Head of Healthcare should ensure that early day attendance and admission to a hospice for prisoners with life limiting long term conditions and illnesses is considered before a prisoner actively approaches the end stages of life.**

### Compassionate release

22. 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.

23. On 22 March, staff started Mr Nix's compassionate release application. On 17 April, the Deputy Governor rejected the application because Mr Nix did not meet

the criteria for compassionate release at that time. He arranged for a review of the application in four weeks' time.

24. An administrator from the prison's Offender Manager Unit emailed the healthcare administrators to ask for an updated medical report for 13 May, ready for the Deputy Governor to review the application on 15 May. There was no record of this request in Mr Nix's medical record. There was also no evidence to suggest that a medical report was prepared for 13 May, or that the compassionate release application was reviewed after four weeks.

25. On 14 June, staff started to reapply for compassionate release on Mr Nix's behalf. The Head of Healthcare reviewed the medical section of the compassionate release application and recorded that Mr Nix had just days to live and was bedbound. Mr Nix died the next morning, before the application could be progressed.

26. The investigation found that the compassionate release process was poorly managed. The application was restarted two months after the original application was rejected by the Deputy Governor on 7 April. There is no evidence that any one person was responsible for collating and chasing the information to ensure that the application was progressed quickly.

27. It is not possible to say if Mr Nix would have been granted compassionate release, however we consider that application was not sufficiently prioritised as it should have been. We make the following recommendation:

**The Governor and Head of Healthcare should review the compassionate release process to ensure that a nominated person is identified and is responsible for coordinating, reviewing and progressing applications without delay.**

**Lisa Burrell** **December 2019**
**Assistant Ombudsman**