

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Howard, a prisoner at HMP Long Lartin, on 13 April 2021

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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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 David Howard died of cancer on 13 April 2021 at HMP Long Lartin. He was 53 years old. I offer my condolences to Mr Howard's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Howard received at Long Lartin was equivalent to that he could have expected to receive in the community. She commended the prison for the care and support they provided to Mr Howard throughout his illness.
5. While the prison contributed to the costs of Mr Howard's funeral, we found that the family liaison officer (FLO) did not follow the correct process. He incorrectly advised the family to pay for the funeral deposit and apply to be reimbursed rather than arranging for the prison to pay direct.
6. We also found that the healthcare section of the escort risk assessment was not completed when Mr Howard was taken to hospital on 1 April. Therefore, the authorising manager made the restraints decision without healthcare input.

Recommendations

- The Governor should ensure that family liaison officers are aware of the correct procedures for paying funeral expenses and that they seek advice from a senior manager if there is any reason why these procedures cannot be followed.
- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand that in all cases:
 - Healthcare staff should complete the medical information section of the escort risk assessment to say whether the prisoner's current medical condition affects their mobility and risk of escape.
 - Authorising managers should show that they have taken this information into account when assessing a prisoner's current level of risk.

The Investigation Process

7. NHS England commissioned an independent clinical reviewer to review Mr Howard's clinical care at Long Lartin.
8. The PPO investigator has investigated non-clinical issues, including Mr Howard's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
9. The PPO family liaison officer wrote to Mr Howard's next of kin, his niece, to explain the investigation. She did not respond to our letter.
10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP Long Lartin

11. Mr Howard was the eighth prisoner to die at Long Lartin since April 2019. Of the previous deaths, five were from natural causes, one was self-inflicted, and one was drug-related. We have previously made a recommendation about the lack of healthcare input into escort risk assessments at Long Lartin.

Key Events

12. In November 2010, Mr David Howard was sentenced to life imprisonment for murder. On 10 December, he was moved to HMP Long Lartin.
13. On 30 January 2020, Mr Howard told a prison GP that he was feeling unwell, and that food was sometimes getting stuck in his throat. The GP noted that Mr Howard's recent blood test results were abnormal, and he made a hospital referral for suspected cancer.
14. Between February and May, Mr Howard underwent various scans and tests at hospital. On 13 May, a hospital consultant told Mr Howard that he had a malignant tumour in his oesophagus. Mr Howard agreed to chemotherapy followed by surgery to remove the tumour.
15. On 10 November, Mr Howard underwent an oesophagectomy (removal of part of the oesophagus to remove the cancer). On 7 January 2021, he returned to Long Lartin.
16. On 1 April, a prison nurse requested an ambulance for Mr Howard as he was in pain, struggling to eat and reported feeling hardness near his breastbone. He was taken to hospital and admitted. On 4 April, he was diagnosed with inoperable metastases (growths) in his liver. He was told he had up to six months to live.
17. On 6 April, Mr Howard said he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect. He was discharged and returned to Long Lartin later that day.
18. On 9 April, a prison nurse reviewed Mr Howard's condition. The nurse assessed that he may need further medication to ease his symptoms, and there was not a GP due at Long Lartin until 13 April. Mr Howard agreed to go to hospital and returned that night with antibiotics.
19. Mr Howard died in the palliative care unit at Long Lartin on 13 April at 5.35pm.

Post-mortem report

20. A post-mortem examination was not conducted as the Coroner accepted the cause of death provided by a hospital doctor. The doctor gave the cause of death as carcinomatosis (a condition in which cancer is spread widely throughout the body), caused by carcinoma (cancer) of the oesophagus.

Non-Clinical Findings

Liaison with Mr Howard's family

21. When a death in custody occurs, the family of the deceased are entitled to financial support of up to £3,000 towards funeral expenses from the prison. Prison Service Instruction (PSI) 64/2011 says that any funeral expenses should be paid directly by the prison to the funeral directors once an original invoice is received.
22. On 14 April 2021, the family liaison officer (FLO) told Mr Howard's family that the prison would provide financial support for funeral arrangements. He said that the family should appoint a funeral director and he would then contact them to get a quote.
23. On 20 April, the FLO contacted the family to say he had spoken with the appointed funeral director. He told them the funeral director required an upfront payment using a payment card that was in the name of the individual ordering the funeral. The FLO said that normally a quote was provided directly to the prison which was then paid. As an alternative, he recommended the family paid the funeral director themselves and the FLO would raise a cheque once he received an invoice from them.
24. This issue resulted in the family having to use their own funds and await a cheque to cover this expense. Whilst on this occasion the family do not appear to have been put in any financial difficulties, we remain concerned that these actions have the potential to cause financial hardship. Long Lartin's Business Hub Manager told us that the custodial manager would be speaking with FLOs to remind them of the process to prevent any future occurrences.
25. After we shared the initial report with the prison, they told us that the funeral director had refused to deal with the prison and would only accept payment from the next of kin, which is why the FLO asked the family to write a cheque, which the prison reimbursed later. We accept that the FLO was faced with an unusual situation. However, there is no evidence that the FLO sought advice from a senior manager to see if there was an alternative to requiring the family to pay the funeral costs upfront. We consider that FLOs should be reminded of the correct procedures for paying funeral costs and to seek advice if there is any reason why they cannot be followed. We recommend:

The Governor should ensure that family liaison officers are aware of the correct procedures for paying funeral expenses and that they seek advice from a senior manager if there is any reason why these procedures cannot be followed.

Restraints, security and escorts

26. 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.

27. 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 he has 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. These requirements are reflected in PSI 33/2015 on external prisoner movements, as well as on the prison's risk assessment form.
28. When Mr Howard was taken to hospital on 1 April 2021, the medical section of the escort risk assessment was not completed. However, when Mr Howard was taken to hospital on 9 April, this was completed. We are concerned that healthcare staff at Long Lartin are not consistently completing the medical section of escort risk assessments. This means that authorising managers are taking decisions on restraints in the absence of information about the prisoner's current medical condition and its impact on their risk of escape. We recommend:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand that in all cases:

- **Healthcare staff should complete the medical information section of the escort risk assessment to say whether the prisoner's current medical condition affects their mobility and risk of escape.**
- **Authorising managers should show that they have taken this information into account when assessing a prisoner's current level of risk.**

**Louise Richards
Assistant Ombudsman**

December 2021

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