

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Hand, a prisoner at HMP Bure, on 25 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 John Hand died on 25 April 2021 of carcinomatosis (widespread cancer) at HMP Bure. Mr Hand was 62 years old. I offer my condolences to Mr Hand's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Hand received at Bure was of a good standard and equivalent to that which he could have expected to receive in the community. She made some recommendations about using the NEWS2 tool and ensuring care plans are created to manage long-term conditions, which we repeat below.
5. We are concerned that Mr Hand missed a hospital appointment because prison staff had not booked transport. This should not have happened, but we are satisfied it did not affect the outcome for Mr Hand.

Recommendations

- The Head of Healthcare should ensure that NEWS2 escalation is documented to reflect decision making against the NEWS2 policy. Documentation should also include when a decision is made that is not in line with policy.
- The Head of Healthcare should ensure that care plans are initiated and reviewed to support prisoner management.
- The Governor and Head of Healthcare should ensure that suitable transport is arranged in a timely manner for hospital appointments to avoid unnecessary cancellations.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Hand's clinical care at Bure.
7. The PPO investigator has investigated non-clinical issues, including Mr Hand's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. The PPO family liaison officer wrote to Mr Hand's next of kin, his wife, to explain the investigation. She raised no specific concerns but asked for a copy of our report.
9. Mr Hand's family received a copy of the initial report. They did not make any comments.

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

Previous deaths at HMP Bure

11. Mr Hand was the tenth prisoner to die at Bure since April 2019. Of the previous deaths, two were self-inflicted deaths and seven were from natural causes. Since Mr Hand's death, there has been one natural causes death which is currently under investigation.
12. There are no similarities between our findings in the investigation into Mr Hand's death and our investigation findings for the previous deaths.

Key Events

13. In April 2012, Mr John Hand was sentenced to 22 years in prison for sexual offences. In September 2017, he transferred to HMP Bure.
14. Mr Hand had several long-term health conditions including high cholesterol, high blood pressure and thyroid problems. He was prescribed appropriate medication for these conditions.
15. In August 2020, Mr Hand complained of right sided chest pain when coughing. Prison healthcare staff arranged a chest X-ray and blood tests. The blood tests results showed a high level of C-reactive protein (suggesting an inflammatory disorder). Healthcare staff arranged for Mr Hand to transfer to Norfolk and Norwich University Hospital for further investigations.
16. While Mr Hand was in hospital, he had a chest X-ray which showed that he had a shadow on his lung. The hospital arranged for a Computerised Tomography (CT) scan (which uses X-rays and a computer to create detailed images of the inside of the body). Mr Hand was treated for a pulmonary embolism (a blood clot in the artery in the lungs) and further tests for possible cancer were arranged.
17. On 4 September, Mr Hand was discharged from hospital and returned to Bure. The results of Mr Hand's hospital tests were received on 13 October and these showed stage four lung cancer with metastases (advanced lung cancer which had spread). The prison GP discussed the results with Mr Hand and noted that he had taken the news well.
18. Mr Hand was scheduled to go to hospital to discuss his diagnosis with a hospital consultant on 16 October. However, prison staff failed to arrange transport, so the appointment was rescheduled for the following week.
19. On 21 October, the prison appointed a family liaison officer (FLO). The FLO met Mr Hand to discuss his diagnosis. She rang his wife to introduce herself and offer support. As agreed, she frequently rang Mr Hand's wife to keep her updated. She also accompanied Mr Hand (at his request) for his hospital appointments and offered support.
20. The hospital oncology team reviewed Mr Hand on 23 October and arranged for him to have a biopsy. On 6 November, Mr Hand spoke over the telephone with the hospital respiratory consultant about his results. Mr Hand's cancer had spread to other parts of his body, including his lymph nodes, shoulders and bones, and was incurable. His prognosis was one year with treatment and six months without treatment. Mr Hand decided to have radiotherapy for symptom control.
21. On 26 November, Mr Hand requested a transfer to a prison near to his wife. Agreement was made for him to transfer to HMP The Verne once his care journey was complete. However, there was an outbreak of COVID -19 at The Verne, so his transfer was not possible at that time. Further consideration for the transfer was scheduled for May 2021.

22. On 7 December, a prison GP discussed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order with Mr Hand. He agreed that if he stopped breathing, he did not want to be resuscitated and signed an order to that effect.

2021

23. On 19 February 2021, Mr Hand received his first dose of the COVID-19 vaccine. Healthcare staff advised him to shield as he was clinically vulnerable and at very high risk of severe illness and death from COVID-19. Mr Hand declined to shield.
24. Throughout March, Mr Hand had episodes of deteriorating health. Healthcare staff arranged for him to go to hospital. The hospital oncology team told him that he was to receive palliative care only. They adjusted his medication and he returned to Bure.
25. On 18 April, a prison GP saw Mr Hand because he complained of shortness of breath and he said that he was sleeping sitting forward. After a discussion with Mr Hand, the GP arranged a referral to a local hospice. Arrangements were ongoing and a review was scheduled for 26 April.
26. On 19 April, healthcare staff started an application for Mr Hand's early release on compassionate grounds. Mr Hand died before the application could be completed.

Events on 25 April

27. At 8:20am, an officer unlocked Mr Hand's cell door and saw that Mr Hand was on his knees on the floor, with his upper body resting on his bed. He noted this was not an unusual position for Mr Hand to sleep in. Mr Hand was unresponsive and not breathing. As a valid DNACPR was in place, and to preserve Mr Hand's dignity, cardiopulmonary resuscitation was not performed. The officer immediately radioed a medical emergency code blue. Prison and healthcare staff responded.
28. Ambulance paramedics attended and confirmed that Mr Hand had died.

Cause of death

29. The Coroner accepted the cause of death provided by a doctor and no post-mortem examination was carried out. The doctor gave Mr Hand's cause of death as carcinomatosis (widespread cancer). He also had carcinoma of bronchus with lymph nodes and bone metastases which did not cause but contributed to his death.

Non-Clinical Findings

Mr Hand's missed appointment

30. On 16 October, Mr Hand had a hospital appointment to discuss his cancer diagnosis with a consultant. However, one of the escorting officers telephoned the hospital to inform them that a taxi had not been ordered to take Mr Hand to his appointment, but another taxi had been requested and that they would be around one hour late. The hospital Registrar in the clinic advised that the appointment should be rebooked. Mr Hand attended the following week.
31. Although we are satisfied that the delay did not contribute to Mr Hand's death, it was regrettable that Mr Hand was unable to attend such an important appointment for reasons beyond his control. We recommend:

The Governor and Head of Healthcare should ensure that suitable transport is arranged in a timely manner for hospital appointments to avoid unnecessary cancellations.

Lisa Burrell

Assistant Prisons and Probation Ombudsman

March 2022

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