

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Christopher Newman, a prisoner at HMP The Mount, on 20 June 2022

A report by the Prisons and Probation Ombudsman

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE



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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 Christopher Newman, who was 79 years old, died of metastatic pancreatic cancer on 20 June 2022, while a prisoner at The Mount. We offer our condolences to Mr Newman's family and friends.
4. The clinical reviewer concluded that the care Mr Newman received at The Mount was of a standard equivalent to that which he could have expected to receive in the community. She made two recommendations about ensuring that healthcare staff adhere to NICE (National Institute for Clinical Excellence) guidance in relation to falls in older people and nutrition support for adults, which we do not repeat in this report, but which the Head of Healthcare will need to address.
5. We did not find any non-clinical issues of concern.

Investigation Process

6. NHS England commissioned an independent clinical reviewer, to review Mr Newman's clinical care at The Mount.
7. The PPO investigator has investigated non-clinical issues, including Mr Newman's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. The Ombudsman's family liaison officer wrote to Mr Newman's next of kin, his partner, to explain the investigation. She did not respond to our letter.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out a factual inaccuracy and this report has been amended accordingly.

Previous deaths at The Mount

10. Mr Newman was the fifth prisoner to die at The Mount since June 2020. Of the previous deaths, two were from natural causes and two were self-inflicted. There have been two further deaths since Mr Newman's death, both from non-natural causes. There are no similarities between our findings in the investigation into Mr Newman's death and our investigation findings for the previous deaths.

Key Events

11. On 27 May 2003, Mr Christopher Newman was remanded to HMP Belmarsh charged with murder. On 6 September 2005, he was sentenced to life imprisonment with a minimum term of fourteen years.
12. Mr Newman had several pre-existing medical conditions, including chronic obstructive pulmonary disease (COPD, the name given to a range of respiratory conditions) and sleep apnoea (breathing can stop during sleep). He also had mobility issues and used a walking stick to help him move around. He received appropriate medications to manage his conditions.

2015-2021

13. On 31 March 2015, Mr Newman transferred to HMP The Mount.
14. A nurse completed his initial health screen. She created care plans to manage his care and referred him to the prison's respiratory clinic. Healthcare staff reviewed Mr Newman regularly over the months that followed.
15. On 19 February 2016, a prison GP saw Mr Newman. He told the GP that for the past nine months he had a two-centimetre lump on the right side of his neck. The GP made a two week wait referral to the hospital (An individual suspected of having developed cancer will be reviewed by hospital staff within two weeks.)
16. The hospital confirmed that the growth on Mr Newman's neck was benign and advised him that he should undergo a surgical procedure to remove it, but Mr Newman refused. Over the years that followed, Mr Newman received annual reviews in the prison's respiratory clinic. He also received ongoing wound care for the growth on his neck.
17. On 8 January 2018, a prison GP saw Mr Newman and diagnosed him with high blood pressure. Healthcare staff created a care plan and monitored his blood pressure, and other care needs regularly.
18. On 5 June 2019, a prison GP saw Mr Newman after he complained of constipation and heartburn for the previous four months. The GP made an urgent two week wait referral to a gastroenterology specialist and carried out full blood tests. The blood test results indicated that Mr Newman had anaemia. The GP considered that Mr Newman should undergo a faecal immunochemical test (FIT test checks for signs of blood in faeces), but Mr Newman refused.
19. Hospital staff reviewed Mr Newman on 10 July. They considered that he should undergo a gastroscopy (a procedure in which a camera is passed down into the upper digestive system) the following day. However, despite the repeated best efforts of healthcare staff encouraging him to go ahead with the procedure, Mr Newman consistently refused.
20. On 19 February 2021, a healthcare assistant saw Mr Newman. As part of her review, she recorded his weight as 90kg. In October, his weight was recorded as 70kg. There is nothing in Mr Newman's medical records to indicate his weight loss was noted as a concern.

21. On 14 December, a prison GP saw Mr Newman after he collapsed twice within a 24-hour period. He told the GP that he was experiencing shortness of breath and that he felt unsteady on his feet. The GP checked Mr Newman's blood sugar level, which was low. He considered that he was displaying the symptoms of diabetes and sent him to hospital by emergency ambulance. Mr Newman was admitted to hospital as an inpatient.
22. Hospital staff carried out a series of tests. The results showed that Mr Newman had an inoperable cancerous mass on his pancreas. Hospital staff informed him that he had between three and six months to live. He told hospital staff that he did not wish to undergo a biopsy to ascertain how aggressive the cancer was, nor did he wish to undergo palliative chemotherapy.

2022

23. Mr Newman was discharged from hospital and returned to The Mount on 12 January 2022. Prison healthcare staff reviewed and updated his care plans and saw him daily. He also received support from the prison's Mental Health Inreach Team.
24. On 15 February, a nurse made a referral to a hospice on Mr Newman's behalf. Hospice staff informed her that they would review her referral as Mr Newman's condition deteriorated.
25. On 24 February, a nurse saw Mr Newman after he complained of chest pain. She sent him to hospital by emergency ambulance for further review. A CT scan (computerised tomography) showed that his cancer had spread within his abdomen. He was discharged from hospital and returned to The Mount the same day.
26. On 28 March, a nurse saw Mr Newman. She noted that his stomach was very swollen and that he was short of breath. He was taken to hospital by emergency ambulance for further review and was admitted to hospital as an inpatient. His condition stabilised and he was discharged back to the prison on 1 April.
27. On 19 April, a hospice nurse saw Mr Newman. She reviewed his prescribed medications and discussed his wishes in respect of his death. He told her that he wanted to die in a hospice. A few days later, she reviewed Mr Newman again. She noted that his condition had deteriorated rapidly since her last review. His stomach was hard and swollen. She considered that he needed an ascites drain (a procedure that drains excess fluid from the stomach cavity) and Mr Newman was taken to hospital by emergency ambulance. He was admitted to hospital as an inpatient. The hospital told prison healthcare staff that Mr Newman had declined any treatment and that his prognosis would be no more than four weeks.
28. Mr Newman's condition continued to deteriorate in hospital and, at 3.00pm on 20 June 2022, Mr Newman died. A hospital doctor confirmed his death at 3.12pm.

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 Newman's cause of death as metastatic pancreatic cancer. He also had diabetes mellitus, chronic obstructive

pulmonary disease and hypertension (raised blood pressure) which were also listed as contributory factors.

Lisa Burrell
Assistant Ombudsman

June 2023

Inquest

The inquest, held on 30 January 2023, concluded that Mr Newman died from natural causes.

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