

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Brian Inch, a prisoner at HMP The Mount, on 17 November 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. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.
3. Mr Brian Inch died in hospital of lung cancer on 17 November 2022, while a prisoner at HMP The Mount. He was 71 years old. We offer our condolences to Mr Inch's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Inch received at The Mount was of a good standard and equivalent to that which he could have expected to receive in the community. She made no recommendations.
5. We found no non-clinical issues of concern. We make no recommendations.

The Investigation Process

6. HMPPS notified us of Mr Inch's death on 17 November 2022.
7. NHS England commissioned an independent clinical reviewer to review Mr Inch's clinical care at The Mount.
8. The PPO investigator investigated the non-clinical issues relating to Mr Inch's care.
9. The PPO family liaison officer wrote to Mr Inch's next of kin, his nephew, to explain the investigation and to ask if he had any matters he wanted us to consider. He had questions about the healthcare Mr Inch had received in the lead up to his death. We have answered these questions in this report and in the clinical review.
10. Mr Inch's nephew received a copy of the initial report. He did not make any comments.
11. The initial report was shared with HMPPS. There were no factual inaccuracies.

Previous deaths at HMP The Mount

12. Mr Inch was the tenth prisoner to die at The Mount since November 2019. Of the previous deaths, four were from natural causes, three were self-inflicted and two were drug related.

Key Events

13. On 15 July 2022, Mr Brian Inch was sentenced to seven years imprisonment for drug offences. On 12 August, he was moved to HMP The Mount.
14. On 19 September, Mr Inch told a nurse at The Mount that he had a chesty cough, headache and was feeling tired. The nurse recorded Mr Inch's clinical observations, which were normal, and listened to his chest. She arranged a for a GP to see him the next day.
15. On 20 September, a nurse spoke to Mr Inch by the in-cell telephone. (Mr Inch was not able to attend the healthcare centre in person as there were no officers available to take him.) During the call, Mr Inch said he had no difficulty breathing and that he did not have a temperature.
16. On 21 September, a nurse saw Mr Inch to check his temperature and listen to his chest. Mr Inch's temperature was normal, and his chest was clear.
17. On 3 October, Mr Inch told a healthcare assistant that he thought he had a chest infection and she told this to the nurse in charge.
18. On 4 October, a nurse saw Mr Inch. He told the nurse that he had been coughing and that he had lost weight. The nurse did a physical examination, which was normal, and took some blood for a full health screening. She also took a mucus sample to check for tuberculosis (TB - a serious bacterial infection). That day, the nurse spoke to a GP about Mr Inch as she thought he may need antibiotics. The GP prescribed antibiotics and requested an urgent chest X-ray (under the urgent two-week referral route for suspected cancer).
19. On 6 October, the GP saw Mr Inch. He told Mr Inch his blood test results were abnormal and showed signs of infection. The GP asked for further blood tests to be done in two weeks' time.
20. On 17 October, Mr Inch attended a hospital appointment for a chest X-ray.
21. On 20 October, the GP saw Mr Inch. Mr Inch's blood pressure was normal, and he said he was feeling much better following the antibiotics. The GP listened to his chest and found Mr Inch had some basal crackles (abnormal breath sounds that can indicate inflammation, fluid, or infection in the lung). The GP prescribed another course of antibiotics and asked for further blood tests.
22. Later that day, the GP spoke to Mr Inch on the phone as he had received the results of his chest X-ray, which were abnormal. He made an urgent referral for a neck ultrasound scan and told Mr Inch that he may need further tests.
23. On 26 October, Mr Inch saw the GP following his second course of antibiotics and had further blood tests done.
24. On 27 October, the GP reviewed Mr Inch's blood test results. The results showed he had rising sepsis markers (signs of sepsis, a life-threatening reaction to an infection). The GP arranged for Mr Inch to be seen urgently at the hospital. Mr Inch was admitted to hospital for investigation and a scan of his chest.

25. On 1 November, a hospital consultant said that the results of Mr Inch's scan showed possible cancer in his lung or oesophagus (food pipe), and that he needed a biopsy. The same day, Mr Inch returned to The Mount and awaited a follow up appointment.
26. On 9 November, the GP prescribed an inhaler to Mr Inch to help with his cough.
27. On 12 November, a nurse saw Mr Inch in his cell as he said he was feeling unwell. Mr Inch said he had no appetite and no energy. The nurse took his clinical observations, which showed a high temperature. She gave Mr Inch paracetamol and arranged for healthcare staff to check on him every 30 minutes for the rest of the afternoon. The next day, the healthcare team recorded Mr Inch's temperature was normal.
28. On 15 November, Mr Inch attended a hospital appointment for a bronchoscopy (a procedure that lets doctors look inside the lungs). Following the procedure, Mr Inch's health deteriorated, and he became unresponsive. He was put on oxygen and end-of-life care.
29. Mr Inch died at 5.43am on 17 November.

Cause of death

30. The coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Inch's cause of death as advanced pulmonary carcinoma (lung cancer).

Adrian Usher
Prisons and Probation Ombudsman

September 2023

Inquest

The inquest, held on 19 January 2024, concluded that Mr Inch died from natural causes.

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