

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Trevor Huston, a prisoner at HMP Forest Bank, on 4 June 2022

A report by the Prisons and Probation Ombudsman

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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 Trevor Huston died in Bolton Hospice on 4 June 2022 of widespread kidney cancer while a prisoner at HMP Forest Bank. He was 71 years old. We offer our condolences to Mr Huston's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Huston received at Forest Bank was variable. There were examples of good practice and opportunities for improvement. She made some recommendations about using the NEWS2 tool and ensuring care plans were created to manage cancer conditions, which we repeat below. She also made other recommendations about ulcer care, welfare checks and recording hypertension readings, which are not repeated in this report but which the Head of healthcare will need to address.
5. We found two non-clinical issues of concern.
6. We are pleased to note that prison managers agreed, as an exception, to pay a contribution towards Mr Huston's funeral directly to the next of kin.
7. Mr Huston and his family raised concerns with the prison about the conduct of some of the night bedwatch staff. It was alleged that they treated Mr Huston inhumanely. Although prison managers were aware of these concerns, they said that the names of the officers involved were not provided to them, and said that as a result, they were unable to investigate these allegations. We consider that the prison managers response was unacceptable and wholly inadequate, and not in line with national guidance.

Recommendations

- The Head of Healthcare should remind healthcare staff of the use of the NEWS2 assessment when responding to emergencies to ensure that prisoners who are deteriorating, or at risk of deteriorating, will have a timely initial assessment by a competent clinical decision maker.
- The Head of Healthcare should ensure that prisoners with a cancer diagnosis have an identified lead nurse who will oversee the implementation of a plan of care, including advance care planning discussions, DNACPR discussions and referral to a Palliative Care Clinical Nurse Specialist.
- The Head of Healthcare should ensure that a care plan is implemented for every prisoner with a cancer diagnosis, to ensure a consistent, individualised approach to care, treatment and support delivery.

- The Director should ensure that prisoner complaints are handled in line with the Prisoner Complaints Policy Framework and that any issues raised are addressed promptly.
- The Director should commission an investigation into allegations that prison bedwatch staff made inappropriate and insensitive comments, with a view to considering whether disciplinary action is appropriate.

The Investigation Process

8. NHS England commissioned an independent clinical reviewer to review Mr Huston's clinical care at Forest Bank.
9. The PPO investigator investigated the non-clinical issues relating to Mr Huston's care, including Mr Huston's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
10. The PPO family liaison officer wrote to Mr Huston's next of kin, his sister, to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Huston's sister had clinical questions about Mr Huston's medication and the level of support he received, which have been addressed in the clinical review report. Mr Huston's sister also raised concerns about the conduct of some of the officers who had been on bedwatch duty when she visited Mr Huston in hospital.
11. Mr Huston's sister had not received the prison's financial contribution toward the funeral cost. We have addressed this issue in this report.
12. Mr Huston's family received a copy of the initial report. They raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.
13. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP Forest Bank

14. Mr Huston was the eighth prisoner to die at Forest Bank since June 2020. Of the previous deaths, three were from natural causes, two were self-inflicted and two were drug related. There are no significant similarities with our findings in the investigation into Mr Huston's death and the findings of the previous deaths.

Key Events

15. On 23 April 2021, Mr Trevor Huston was sentenced to nine years in prison for sexual offences and was sent to HMP Forest Bank.
16. Mr Huston had several health conditions including osteoarthritis, spondylosis (age related wear and tear to bones and muscles), irritable bowel syndrome and high cholesterol. He had mobility issues and used a walking stick. Healthcare staff saw him regularly and gave him medication for his conditions.
17. In May 2021, Mr Huston told healthcare staff that he had a lump on his neck and an intermittent earache for the past two years. Healthcare staff referred him to ear nose and throat (ENT) specialists for an appointment. However, when the hospital allocated him an appointment which was several weeks away, the prison GP discussed the referral with ENT specialists who agreed that a re-referral should be completed for suspected cancer. Mr Huston underwent various tests at hospital, and he was diagnosed with throat/tonsil cancer.
18. On 15 July, hospital specialists told Mr Huston that the cancer was treatable with 20 sessions of radiotherapy. Mr Huston was admitted to hospital for his radiotherapy and symptom control. He completed his treatment on 13 September and remained in hospital to continue with his symptom control.
19. On 27 September, Mr Huston returned to Forest Bank. Healthcare staff suggested that he should transfer to the prison's healthcare department, but Mr Huston refused. He said that he preferred to live on the wing with his friends and that he felt supported by a good network of staff and peers.
20. On 16 November, prison staff asked healthcare staff to review Mr Huston in his cell because he appeared unwell. A nurse completed his observations and noted that his oxygen saturation levels were very low, his pulse was high, and his blood pressure was elevated. She asked prison staff to call an ambulance. Two officers escorted Mr Huston to hospital, and he was not restrained.
21. In hospital on 17 November, Mr Huston tested positive for COVID-19. He also underwent various scans and tests, which indicated there might be widespread cancer.
22. On 8 December, Mr Huston returned to Forest Bank without a hospital discharge summary. Eventually the prison received a copy, and it said that Mr Huston needed to have a pureed diet and morphine sulphate solution every three hours to ease his symptoms. Records show that the prison kitchen was tasked with providing pureed meals, and a prison GP prescribed morphine sulphate twice a day.

2022

23. On 25 January, hospital specialists told Mr Huston that he had a lesion on his kidney which appeared to be cancerous. Mr Huston was upset and shocked. Prison staff and his friends offered him support.
24. On 3 April, Mr Huston complained of feeling unwell with right sided weakness. Healthcare staff arranged for his transfer to Salford Royal Hospital for

investigations. Hospital specialists diagnosed him with a brain tumour and widespread metastatic tumours.

25. On 13 April, hospital staff discharged Mr Huston and he returned to Forest Bank. However, on his return, a nurse noted that he still appeared unwell. He was pale and lethargic, and still had a cannula in his hand. She observed an episode of uncontrollable shaking in Mr Huston's right leg and noted that he was very distressed. She noted that this was an unsafe discharge due to the level of care and support Mr Huston needed. She called an ambulance and Mr Huston returned to Salford Royal Hospital and was admitted as an inpatient.
26. In consultation with hospital staff on 4 May, Mr Huston said that he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect. The hospital consultant gave a prognosis of up to six months.
27. On 25 May, Mr Huston's condition began to deteriorate. He had a chest infection that had caused his lung to collapse, he was unable to speak, eat or drink. His prognosis was now between three to six weeks and plans began for his transfer to a hospice for end of life care. Care continued at Salford Royal Hospital until his transfer to Bolton Hospice for palliative care.
28. Release on temporary licence (ROTL) can be granted for precisely defined and specific activities which cannot be provided in the prison. A risk assessment is completed to ensure that the prisoner's temporary release does not present unacceptable risks. The Governor of the prison is able to grant the temporary licence and will decide on whether the prisoner is to be accompanied by staff.
29. On 1 June, Mr Huston's condition deteriorated further. He was released on temporary licence to Bolton Hospice. He was accompanied by one officer.
30. At 11.05am on 4 June, Mr Huston died in Bolton Hospice. His sister was present when he died.

Post-mortem report

31. The Coroner concluded that Mr Huston died of widespread metastatic renal cell carcinoma.

Non-Clinical Findings

Funeral expenses

32. 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.
33. The family liaison officer (FLO) told Mr Huston's family that the prison would provide financial support for funeral arrangements. However, Mr Huston's next of kin said she did not want the funeral director to know that her brother had been in prison, so she would settle the invoice herself. She asked if the payment could be sent directly to her. Prison staff explained that the policy advised that any funeral invoice payments should be made directly to the funeral director.
34. We appreciate that once we brought this to the attention of senior prison managers, they agreed, as an exception, that they would pay a contribution towards the funeral expenses once they received an invoice from the next of kin. We accept that this was an unusual situation, and we are pleased that they have reimbursed the family.

Bedwatch staff

35. 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 Prisoner Complaints Policy Framework says that staff must apply the 'balance of probabilities' as the standard of proof to investigate complaints. The Framework says that a problem-solving approach must be adopted when responding to complaints. The key to good problem solving is ensuring the real problem is dealt with.
36. Mr Huston's next of kin gave examples when Mr Huston had told her about his experience with some of the night bedwatch prison staff. He gave examples of caring treatment, confirming that staff had treated him with humanity. However, there were also allegations of poor treatment by the night bedwatch staff. This ranged from denying him access to contact his next of kin, to making inappropriate comments about him which left him feeling afraid to ask them for anything.
37. Clearly it is unacceptable and unprofessional for bedwatch officers to make inappropriate and insensitive comments. We would also have expected a more caring attitude towards a terminally ill prisoner from all bedwatch staff.
38. Enquiries with prison managers confirmed that they were aware of the allegations. They told us that Mr Huston had raised concerns through the family liaison officer. The concerns were passed to the Director, Deputy Director and the Security Manager. However, they said that they were unable to pursue any enquiries because Mr Huston and his family did not provide them with the names of the officers involved. We consider that this response is unacceptable and inadequate and consider that the prison could have, and should have, done more to assist Mr Huston with his complaint, particularly with identifying the night bedwatch staff concerned, as all the staff details are in the bedwatch logs.

39. We are very concerned that senior managers made no attempts to investigate or resolve this issue. We were not, therefore, able to confirm or form a view as to whether Mr Huston and his family's concerns were well founded or not. We make the following recommendations:

The Director should ensure that prisoner complaints are handled in line with the Prisoner Complaints Policy Framework and that any issues raised are addressed promptly.

The Director should commission an investigation into allegations that prison bedwatch staff made inappropriate and insensitive comments, with a view to considering whether disciplinary action is appropriate.

**Lisa Burrell
Assistant Ombudsman**

January 2024

Inquest

The inquest, held on 25 April 2024, concluded that Mr Huston died from natural causes.

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