Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anthony Mitchell, a prisoner at HMP Dartmoor, on 30 January 2023

A report by the Prisons and Probation Ombudsman

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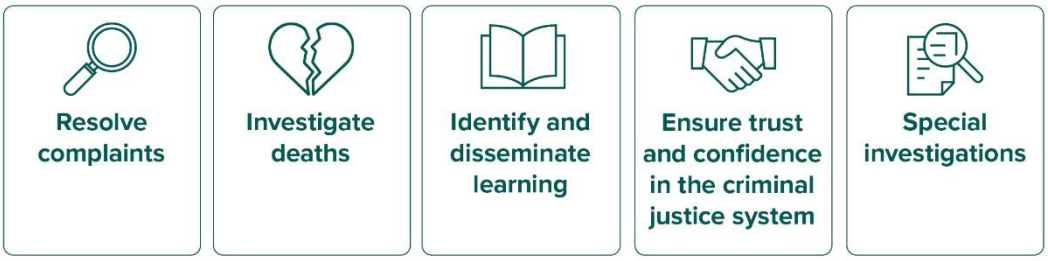
OUR VISION

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

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 Anthony Mitchell died from cancer of the oesophagus on 30 January 2023, while a prisoner at HMP Dartmoor. He was 86 years old. We offer our condolences to Mr Mitchell's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Mitchell received at Dartmoor was equivalent to that which he could have expected to receive in the community. However, he identified several issues which the Head of Healthcare will need to address.

5. When officers found Mr Mitchell unresponsive in his cell, one of them started CPR despite Mr Mitchell having a Do Not Attempt Resuscitation order in place. This meant that Mr Mitchell's wishes were not respected. The Governor and Head of Healthcare will want to consider how the existence of DNARs can be better communicated to wing staff.

Recommendations

- The Head of Healthcare should ensure that all staff are aware of the normal range for clinical observations, the relevance of finding an abnormal physical observation and action to take when this is noted.

- The Head of Healthcare should ensure that prisoners are involved in their end-of-life care where practicably possible and that patient involvement in these discussions is recorded in the clinical notes.

The Investigation Process

6. HMPPS notified us of Mr Mitchell's death on 30 January 2023.

7. NHS England commissioned an independent clinical reviewer to review Mr Mitchell's clinical care at Dartmoor.

8. The PPO investigator investigated the non-clinical issues relating to Mr Mitchell's care.

9. The PPO family liaison officer wrote to Mr Mitchell's next of kin, his friend, to explain the investigation and to ask if he had any matters he wanted us to consider. He 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 Dartmoor

11. Mr Mitchell was the tenth prisoner to die at Dartmoor since January 2021. Of the previous deaths, seven were from natural causes and two were self-inflicted. There are no similarities between our findings in the investigation into Mr Mitchell's death and our investigation findings for the previous deaths.

Key Events

12. On 26 February 2015, Mr Anthony Mitchell was sentenced to 21 years imprisonment for sexual offences. On 13 March, he was moved to HMP Dartmoor.

13. He had been diagnosed with follicular lymphoma (a type of blood cancer) in October 2013. Mr Mitchell's lymphoma was stable, and he received regular treatments of chemotherapy.

14. On 6 December 2022, Mr Mitchell's oncologist (cancer specialist) rang the prison's healthcare department and told them that Mr Mitchell's blood test results were abnormal and as a result, he was not able to have his chemotherapy treatment that week. The oncologist requested further blood tests.

15. On 7 December, the GP at Dartmoor received Mr Mitchell's blood test results, which were still abnormal. The healthcare team alerted the oncology ward, who requested a repeat blood test. Mr Mitchell's blood test results continued to be abnormal, so he was unable to receive his chemotherapy.

16. On 18 January 2023, Mr Mitchell told the GP at Dartmoor that he was having issues with poor appetite and constipation. The GP prescribed medication.

17. On 24 January, a healthcare assistant saw Mr Mitchell as he felt tired and had a poor appetite. She recorded that his clinical observations were all within normal range. However, his pulse was recorded as 114bpm, which was outside the normal range. No further review was arranged.

18. On 25 January, Mr Mitchell was admitted to hospital as he had been experiencing chest pains and a lack of energy. A member of the healthcare team at Dartmoor spoke to a nurse at the hospital and asked for an update on Mr Mitchell's condition (as officers attending the hospital had thought Mr Mitchell had been given a prognosis of two weeks). The nurse said that Mr Mitchell was no longer suitable for chemotherapy and would require fortnightly blood transfusions. She was unsure where the two-week prognosis had come from as this was not what the hospital had advised.

19. On 26 January, Mr Mitchell had a blood transfusion and then returned to Dartmoor. Staff moved Mr Mitchell to a ground floor cell to support him with his mobility.

20. While in hospital, Mr Mitchell said he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect.

21. On 27 January, the healthcare team at Dartmoor held a multidisciplinary team meeting (MDT) to discuss Mr Mitchell's condition. They noted the plan for fortnightly blood transfusions and that Mr Mitchell's prognosis was now short, but no timeframe was noted. It was noted that Mr Mitchell did not want to know the expected timeline. It was not clear from the medical records how much involvement Mr Mitchell had in these discussions about his care.

22. At 7.15am on 30 January, a prison officer found Mr Mitchell unresponsive in his cell. He called for support from another officer on the wing and they both entered the cell. One officer started CPR and the other radioed a code blue (a medical

emergency code used when a prisoner is unconscious or having breathing difficulties that alerts staff to attend and the control room to call an ambulance).

23. When a nurse arrived, she saw Mr Mitchell's DNAR on his cell wall and told the prison officer to stop CPR. At approximately 10.44am, a paramedic arrived and confirmed that Mr Mitchell had died.

Post-mortem report

24. The post-mortem report noted that Mr Mitchell had a secondary malignancy (cancer) of the oesophagus. It noted that Mr Mitchell had a history of lymphoma but recorded the cause of death as cancer of the oesophagus.

Findings

Governor to note

25. A prison officer started CPR on Mr Mitchell despite him having a Do Not Attempt Resuscitation (DNAR) order in place. This meant that Mr Mitchell's wishes about his end-of-life care were not respected.

26. The Head of Healthcare at Dartmoor told the PPO investigator that DNAR orders were recorded on the individual's Treatment Escalation Plan (TEP) form, which was kept on display in the prisoner's cell. She also said that healthcare staff verbally informed the wing officer in charge when an updated plan was placed in a prisoner's cell. This information should also be written into the wing observation book.

27. The officer who started CPR told the PPO investigator that he was unaware Mr Mitchell had a DNAR in place. He said that the healthcare dispensary room has a list of prisoners who have a DNAR in place, but officers do not have access to this room. He was aware that prisoners kept a copy in their cells but was not clear where. We know that Mr Mitchell's DNAR was on the board in his cell as that is how the nurse who responded knew he had one in place.

28. Wing staff need to be aware of prisoners with DNARs in place and respect their wishes. The Governor and Head of Healthcare will want to consider the learning from this investigation and review how the existence of DNARs can be better communicated to wing staff.

Adrian Usher
Prisons and Probation Ombudsman **September 2023**

Inquest

29. The inquest, held on 21 January 2025, concluded that Mr Mitchell died from natural causes.

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