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**Independent investigation report by the  
Prisons and Probation Ombudsman  
Nigel Newcomen CBE  
into the death of a man,  
a prisoner at HMP Dovegate,  
on 6 March 2015**

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## ***Our Vision***

*To carry out independent investigations to make custody and community supervision safer and fairer.*

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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

The man died of sepsis, caused by bowel cancer, on 6 March 2015, while a prisoner at HMP Dovegate. He was 41 years old. I offer my condolences to his family and friends.

I am concerned that there was a significant delay in diagnosing the man's cancer, as two GPs did not follow national clinical guidelines for referring patients to specialists and the man missed a number of investigative blood tests, which healthcare staff did not follow up.

After his diagnosis, the man refused to accept chemotherapy treatment, which significantly affected his chances of survival. I am satisfied that the man had the capacity to take this decision. I also consider that, overall, the man's clinical care following diagnosis was equivalent to that he could have expected to receive in the community. He was well supported by a lead nurse, a GP and other staff at the prison. In contrast, I am concerned that he was restrained for hospital admissions towards the end of life, without appropriate risk assessments which fully took into account his state of health and poor mobility.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

**August 2015**

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## SUMMARY

### Events

1. The man had been in prison since October 2009, serving an indeterminate sentence. He had been at HMP Dovegate Therapeutic Community since 8 July 2010.
2. In January and May 2013, the man saw two different GPs and told them he had abdominal pain, a change in bowel habits, had lost weight and that there was a family history of bowel cancer. His symptoms should have prompted an urgent referral to a specialist; instead, the doctors referred him for blood tests. The man did not attend a number of appointments for tests but healthcare staff did not establish the reasons. In August, another GP referred the man urgently to a gastroenterologist, seven months after he initially reported the symptoms. In September, he was diagnosed with bowel cancer.
3. The man had surgery to remove cancerous tumours in December 2013. The surgeon advised that chemotherapy treatment was the best chance of eradicating the cancer, but the man refused. In October 2014, an oncologist told the man that the cancer had returned and later advised that his condition was terminal. Again, the man decided not to have active treatment, but accepted palliative care. His condition quickly declined and he died in hospital on 6 March 2015.

### Findings

4. We are concerned that there were two missed opportunities to refer the man urgently for tests for suspected cancer in January and May 2013. This was compounded by the man not attending investigative blood tests. No one followed up the reason why he did not attend and we note that an inspection of the prison in 2013, found that many prisoners missed healthcare appointments because of a lack of officers to escort them. After the delay in diagnosing the man's bowel cancer, doctors considered that his refusal to accept chemotherapy treatment greatly affected his chances of survival. After his diagnosis, we are satisfied that his clinical care was equivalent to that he could have expected to receive in the community and a lead nurse and GP supported him well.
5. Managers authorised the use of an escort chain to restrain the man in hospital in December 2014 and 2015. We are not satisfied that these decisions were based on a full consideration of the man's health and mobility at the time and how this affected his risk of escape.

### Recommendations

- The Head of Healthcare should ensure that all GPs follow National Institute for Health and Clinical Excellence (NICE) guidelines for suspected cancer and refer patients with symptoms indicative of cancer urgently to specialists.

- The Director and Head of Healthcare should ensure that there are sufficient staff to escort prisoners to healthcare appointments and that any missed appointments are followed up, with the reasons recorded.
- The Director and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

## THE INVESTIGATION PROCESS

6. The investigator issued notices to staff and prisoners at HMP Dovegate informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
7. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.
8. The investigator obtained copies of relevant extracts from the man's prison and medical records. She and the clinical reviewer interviewed two members of staff at Dovegate on 29 April 2015. The investigator interviewed another member of staff by telephone.
9. We informed HM Coroner for South Staffordshire District of the investigation, who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
10. One of the Ombudsman's family liaison officers spoke to the man's mother to explain the investigation and to ask if she had any matters for the investigation to take into account. The man's mother did not have any specific issues for the investigation. She was positive about communication from the prison and the support she had received after the man's death.
11. The man's mother received a copy of the draft report. She shared our concerns about the restraints and about the delay in diagnosis.
12. The draft report was shared with the Prison Service. They raised issues that do not impact on the factual accuracy of the report. The action plan has been added to the end of the report.
13. The investigation has assessed the main issues involved in the man's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.

## **BACKGROUND INFORMATION**

### **HMP DOVEGATE**

14. HMP Dovegate is privately run by Serco. The main prison holds around 933 remanded and sentenced men. Dovegate also has a therapeutic community (TC), separate to the main prison, which holds up to 200 men. The TC is a long term intervention for prisoners who have a range of risks and emotional and psychological needs. There are three TC houseblocks, each of which has specialist staff including therapists, trained specialist officers and offender supervisors.
15. Healthcare services are provided by Care UK (who took over from Serco Health in October 2014). There is an inpatient unit in the main prison for 12 prisoners, with 24-hour nursing cover. Two GPs are on duty Monday to Friday and Saturday mornings with an out of hours GP service at other times.

### **Her Majesty's Inspectorate of Prisons**

16. The most recent inspection of HMP Dovegate TC was in October 2013, though the main prison was inspected in January 2015. In 2013, inspectors reported that living conditions in the TC were very good and staff-prisoner relationships were strong. Unlike the main prison, the TC did not have health services provided on the wing. Prisoners reported it was difficult to access healthcare services and complained of delays.
17. There was a good range of triage and clinics available, but inspectors noted that the rate of non-attendance at appointments was too high. In August and September 2013, there had been 100% non-attendance at some clinics; 66% had occurred because of a lack of officers to escort prisoners to the health care centre. Inspectors noted that the consistently high failure-to-attend rate was the worst they had seen. At the 2015 inspection of the main prison, inspectors were also concerned about the high number of missed appointments, caused by insufficient staff to escort prisoners.

### **Independent Monitoring Board**

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to September 2014, the IMB reported that it had been a difficult year for healthcare staff, with a change in provider. Recruitment for staff was ongoing.

### **Previous deaths at HMP Dovegate**

19. The man was the third person to die from natural causes at the prison since the beginning of 2012. There were no significant similarities with the circumstances of these deaths, but we have previously made a recommendation about the use of restraints in hospital.

## FINDINGS

### The diagnosis of the man's terminal illness and informing him of his condition

20. The man had been in prison since 2009 and at HMP Dovegate Therapeutic Community since 8 July 2010. He suffered from diabetes and lung disease.
21. On 2 January 2013, the man told a locum GP, Dr A that he had abdominal pain and thought he had lost weight. He said he had blood in his stools, and his bowel habits had changed. He mentioned that his father had died from bowel cancer. The GP found no abnormality. He prescribed a muscle relaxant to relieve the abdominal pain and referred the man for blood tests. The man did not attend three appointments for blood tests. No reasons were recorded.
22. Four months later, on 14 May, the man reported these symptoms again to Dr B, another locum GP. He had lost 12kgs in six months. The GP examined him and again found no abnormality and prescribed a muscle relaxant. He referred the man for blood tests again and his medical records show that he did not attend three further appointments so he did not have the tests.
23. On 6 August, the man told another locum GP, Dr C, that he had had abdominal pain for the past six months and the other symptoms he had previously described. He had lost more weight (6kgs since May). The doctor examined him and noted that his abdomen was tender, but he could not feel a mass. He referred the man urgently to the gastroenterology clinic at Queen's Hospital, Burton-on-Trent, under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks.
24. On 22 August, at the gastroenterology clinic, Dr D found a tumour in the man's abdomen and referred him for additional tests, including a colonoscopy and a detailed scan. A blood test showed the man was anaemic, and the doctor prescribed an iron supplement. On 3 September, the man had a CT scan, but he did not have a colonoscopy planned for 6 September, as he had a panic attack.
25. On Friday 6 September, Dr D told the man that he had bowel cancer, with two malignant tumours and would need an operation. On Monday 9 September, Dr C discussed the diagnosis with the man and prescribed tramadol (an opiate-based painkiller).
26. The man's 'red flag' symptoms, in January and May 2013, should have prompted immediate fast track referrals for investigation, in line with clinical guidelines for suspected cancer. However, there was a delay of seven months before doctors referred him to a specialist. The clinical reviewer considered that there was a lack of continuity of care because of the number of locum GPs at the time. We are concerned that the GPs did not respond to the man's symptoms in line with national guidance.

27. We are also concerned that the man missed a number of blood test appointments, after his GP appointments in January and May 2013, which were further missed opportunities to identify his cancer. There is no record that anyone followed up these missed appointments to establish the reasons. As there is no record, we cannot know whether the man decided not to attend the appointments or whether this was the prison's responsibility. However, we note that, at an inspection of the therapeutic community in 2013, HM Inspectorate of Prisons found a very high rate of non-attendance at healthcare appointments, most of which were caused by a lack of staff to take prisoners to their appointments.
28. We consider there was an unacceptable delay in the man's initial diagnosis of cancer compounded by a failure to ensure that requested blood tests were taken. We make the following recommendations:

**The Head of Healthcare should ensure that all GPs follow National Institute for Health and Clinical Excellence (NICE) guidelines for suspected cancer and refer patients with symptoms indicative of cancer urgently to specialists.**

**The Director and Head of Healthcare should ensure that there are sufficient staff to escort prisoners to healthcare appointments and that any missed appointments are followed up, with the reasons recorded.**

#### **To the man's medical treatment**

29. After doctors diagnosed the man's malignant cancer in September 2013, he initially refused surgery as he wanted to explore other options. He later agreed to treatment and, on 11 December, had surgery to remove the tumours in his bowel. A consultant colorectal surgeon told him he would also need chemotherapy to ensure the cancer did not return. The man was discharged back to Dovegate on 15 December. Hospital and prison healthcare staff monitored the man's condition and discussed his treatment options with him. To the man was in telephone contact with the specialist nurse at Queen's Hospital and the mental health in-reach team at Dovegate supported him.
30. The man decided not to have chemotherapy as he hoped to move to a medium secure unit in May 2014 and wanted to wait till then. (He did not transfer.) Nurses and mental health staff at Dovegate explained the risks of not having treatment, but were satisfied that the man had the capacity to make decisions about his treatment.
31. On 22 April 2014, at an oncology appointment with Dr E, the man said he had changed his mind and now wanted chemotherapy. The doctor explained that it should have been done with 12 weeks and, as it was now 18 weeks since his surgery, chemotherapy would not be effective. The man was upset and blamed healthcare staff for not being able to have the treatment. A nurse reminded him that he had decided not to have the treatment

32. The man refused to go to any hospital appointments between May and July. Staff did not cancel them and gave him the opportunity to attend on the day.
33. On 10 October, a multidisciplinary team meeting noted that to the man's bowel motions were abnormal. He had lower abdominal and pelvic pain, but had a good appetite. Four days later, a blood test showed he was anaemic. The man agreed to have additional tests and Dr F, a lead GP at Dovegate, prescribed tramadol. On 24 October, the clinical lead at Dovegate, discussed the man's pain relief with a community palliative care nurse and following her advice, his prescription was changed from tramadol to pain relief patches.
34. On 4 November, Dr E, a consultant clinical oncologist at Queen's hospital, told the man that his cancer was terminal. The doctor offered palliative chemotherapy to prolong his life expectancy. Dr F and the clinical lead at Dovegate, and officers continued to support the man. At first the man agreed to chemotherapy, but then changed his mind and said he wanted quality, rather than quantity of life. Dr F had increased his pain relief and prescribed anti-sickness medication. To the man moved to the prison's inpatient unit a few days later.
35. On 24 November, the clinical lead at Dovegate and a community palliative care nurse discussed the man's decision not to have chemotherapy with him. They talked about resuscitation and the man said he wanted staff to try to resuscitate him if his heart or breathing stopped. He said his appetite was better and his nausea was well managed.
36. On 10 December, a multidisciplinary team meeting noted that the man was receiving palliative treatment and his life expectancy was between two to six months. To the man declined any support from the mental health in-reach team. On 12 December, he agreed with Dr F that he now did not want to be resuscitated and signed an order to confirm his decision.
37. On 23 December, the man was unwell and admitted to Queen's Hospital, where he was treated for sepsis (widespread inflammation caused by an infection). The cancer had spread around his kidney and he needed a nephrostomy (an artificial opening between the kidney and the skin to allow urine to drain). Without this, his condition would rapidly decline. The man refused to have the procedure, so the hospital fitted a catheter and gave him long term antibiotics. He discharged himself on 29 December.
38. The multidisciplinary team met the next day to agree a care plan and ensure that all necessary equipment was available. The clinical lead at Dovegate and Dr F reviewed his palliative care plan and offered him mental health support and counselling from a local hospice. They increased his pain relief and anti-anxiety medication.
39. On 26 January 2015, the man refused to go to hospital for a blood transfusion when his red blood cell count was very low. Instead, doctors prescribed an iron supplement. He became physically weaker and, on 28 January, he started using a zimmer frame. He began to become confused and anxious

and, for two weeks from 9 February, was supported under Prison Service suicide and self-harm prevention procedures, after he said he might kill himself. He was confused and had hallucinations, but the clinical lead at Dovegate noted it was not clear whether this was due to the cancer spreading to his brain or his opiate medication. On 19 February, Dr F prescribed the man a low dose anti-psychotic medication, as he was becoming more agitated.

40. The man's condition began to decline rapidly. On 28 February, he was admitted to Queen's Hospital when he was dehydrated and a locum doctor was concerned about possible sepsis and pneumonia. After receiving intravenous fluids, the man's condition improved slightly. On 4 March, healthcare and hospital staff discussed the possibility of him returning to the prison's inpatient unit but his condition suddenly deteriorated. He died on the afternoon of 6 March.
41. We are satisfied that the man's clinical care after his diagnosis was equivalent to that he could have expected to receive in the community. Although there had been a delay in diagnosis, the man's consultant believed that chemotherapy after the operation in December 2013 would have significantly reduced the chances of the cancer returning. The man was appropriately reviewed for mental capacity when he decided not to have treatment. Staff at the prison supported him and he built a good rapport with the clinical lead at Dovegate and Dr F.

### **The man's location**

42. The man chose to continue living in his houseblock for as long as he could and staff and other prisoners gave him good support. Nurses frequently offered him the opportunity to move to the inpatient unit, but he preferred not to. On 13 November 2014, after his condition worsened, he willingly moved to the inpatient unit.
43. On 29 December, after the man discharged himself from hospital, he was given a cell with a hospital bed in the inpatient unit. Healthcare staff took his medication to his cell, as he found it difficult to move around. On 14 January 2015, the security department agreed that the man's cell door should remain open at all times to allow staff ready access to care for him. The clinical lead at Dovegate arranged to have extra healthcare assistants on duty to allow someone to sit with him, and one of the man's friends from his houseblock visited him regularly.
44. After the man was admitted to hospital on 28 February, the clinical lead at Dovegate agreed with the man and the hospital that he should stay there and then move to a hospice for end of life care. He died before a move to a hospice could take place.
45. We are satisfied that the prison appropriately took into account the man's preferences about his location during his illness and that he had suitable accommodation to meet his needs.

## Restraints, security and escorts

46. 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 level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.
47. When the man went to hospital in December 2014 and February 2015, he had a terminal illness and was in a very poor condition, with little mobility. The healthcare section of the risk assessments did not include relevant information about his condition and how it would have affected his risk of escape as the High Court judgment requires. Two escort officers accompanied the man and applied an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). After his final admission to hospital on 28 February, the escort chain was not removed until 5.00pm on 1 March, nearly twenty four hours after his admission. It is difficult to see how managers reached the conclusion that the man was a risk of escape or a risk of re-offending, when he was in such a weak condition and escorted by two officers.
48. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances, which must be fully considered, taken into account and balanced against the security risks. We do not consider that staff appropriately assessed the man's risk, or took fully into account his condition at the time. We make the following recommendation:

**The Director and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.**

## Liaison with the man's family

49. The man telephoned his mother often and kept her up to date about his condition. On 11 November 2014, at the man's request, the clinical lead at Dovegate rang his mother to tell her about his prognosis. The man's mother

said she appreciated the call, and was happy for the prison's family liaison officer to visit her.

50. On 5 December, the prison family liaison officer and the clinical lead at Dovegate visited the man's mother and his brother. They explained his medical condition and that he was terminally ill. They discussed what would happen when he died. The man's mother asked to be told of his death by telephone and said she would like to visit him. His mother visited him at the prison on 22 December.
51. The prison family liaison officer telephoned the man's mother after he was admitted to hospital on 23 December and 28 February 2015, and kept her updated on his condition. As agreed, the prison family liaison officer telephoned the man's mother to inform her when he died and offered condolences and ongoing support. In line with national policy, the prison contributed to the costs of the man's funeral. We are satisfied that family liaison was appropriate.

### **Compassionate release**

52. Exceptionally, prisoners can be released before their sentence has expired, on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months and fulfil other criteria.
53. The man wanted to apply for compassionate release and on 26 November, Dr F completed the medical section, indicating that the man's life expectancy was two to six months, and that his condition had deteriorated rapidly over the previous few weeks.
54. On 28 November, an officer completed the offender manager section of the application form. She noted that the man did not need hospice care at the time and the only alternative release accommodation would be Probation Service approved premises, which were not suitable. The Director of Dovegate did not support the man's release as he had no suitable release accommodation but submitted the application to the Public Protection Casework Section of the National Offender Management Service on 3 December.
55. On 11 December, the man's application was refused as he did not fully meet the criteria and had no suitable accommodation. On 5 March, a manager revised the application but the man died before the second application could be considered. We are satisfied that the prison appropriately considered the possibility of compassionate release.

## Action Plan: The man at HMP Dovegate on 6 March 2015

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and Function Responsible	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that all GPs follow National Institute for Health and Clinical Excellence (NICE) guidelines for suspected cancer and refer patients with symptoms indicative of cancer urgently to specialists.	Accepted	Measures are in place to ensure GPs follow NICE guidelines for suspected cancer and refer patients with symptoms indicative of cancer urgently to specialists. Clear referral pathways are also in place and escorts for any urgent referrals are prioritised, including national healthcare screening appointments. All these pathways have been communicated through clinical governance and to GP's through the national communication channels of Care UK. All cancer referral appointments are measured through a review of SystmOne (electronic patient records) which ensures that an appointment is made with the acute hospital and that the patient gets seen.	Head of Healthcare Completed	Review January 2016
2	The Director and Head of Healthcare should ensure that there are sufficient staff to escort prisoners to healthcare appointments and that any missed appointments are followed up, with the reasons recorded.	Accepted	Measures have been put into place to ensure that staff are in place to escort prisoners to both internal and external healthcare appointments. No external healthcare appointments are cancelled without the authority of the Director or Deputy Director in liaison with Healthcare. Any such cancellations are followed up by Healthcare and appointments rearranged. This is monitored daily by the Director/Deputy Director at the operational meetings. Going forward, a review of the staffing resource in September will look to maximise staff availability for escorts. Cancellations and breeches of NHS waiting	Director and Head of Healthcare  Target date for completion: 30 September 2015	Review January 2016

			times are measured monthly and the circumstances reviewed. Work with community specialists to engage with in-reach services continue and x-ray, ultrasound and telemedicine facilities are now in place in Dovegate to ensure that those prisoners needing priority escorts are put in place.		
3	The Director and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time	Accepted	<p>All staff undertaking risk assessments for prisoners taken to hospital were reminded during a verbal briefing in July of the legal position when undertaking risk assessments, and that they need to take into account the health of a prisoner and the security risk the prisoner poses at the time.</p> <p>The local risk assessment document at HMP Dovegate will take into account the requirements contained in the standard risk assessment form within the National Security Framework. We accept the recommendation and will carry out individual risk assessments based on the medical advice and assessed risk to the public. All risk assessments carried out will be monitored via external and internal audits processes</p>	Director and Head of Healthcare Completed	Review January 2016