

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Podmore, a prisoner at HMP Dovegate, on 28 May 2015

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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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.

Mr John Podmore died on 28 May 2015, of an upper gastrointestinal bleed, oesophageal varices and liver cirrhosis, while a prisoner at HMP Dovegate. Mr Podmore was 70 years old. I offer my condolences to Mr Podmore's family and friends.

The investigation found that there was a delay in diagnosing that a build-up of fluid in Mr Podmore's abdomen was due to liver disease and there was poor communication between prison healthcare staff and hospitals. While these issues did not alter the outcome for Mr Podmore, it meant that his end of life care was not as effectively planned and managed as it could have been. Mr Podmore was restrained for hospital appointments and admissions and I am not satisfied that the decisions to restrain him fully took into account how his health and condition affected his risk.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

December 2015

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Summary

Events

1. Mr John Podmore had been at HMP Dovegate since 17 December 2009, serving an 11-year sentence for sexual offences. He had a history of excessive alcohol consumption, poorly controlled diabetes and angina.
2. Mr Podmore was in hospital between 10 December 2014 and 9 March 2015 for the amputation of two toes, the result of a diabetic related infection. While he was in hospital, doctors noted ascites, a build up of fluid, in Mr Podmore's abdomen. The hospital did not investigate this further but his discharge letter noted that the fluid might be due to liver disease. On 26 March, a prison GP recorded that the fluid should be sent for analysis, but she did not do this until 16 April, three weeks later.
3. On 18 April, Mr Podmore reported shortness of breath and vomiting and was sent to hospital where doctors drained the fluid in his abdomen. They also found he had oesophageal varices (enlarged blood vessels in the oesophagus that are at risk of rupturing) often caused by liver disease.
4. After further episodes of vomiting on 12 and 17 May, hospital doctors closed a varix bleed in his oesophagus and also diagnosed liver cirrhosis (chronic irreversible damage to the liver). A prison GP and a hepatology consultant noted that Mr Podmore did not have any follow-up investigative tests and listed him as a priority for surgery to cut off the blood supply to the enlarged blood vessels.
5. In the early hours of 26 May, Mr Podmore was taken to hospital as he was vomiting blood. He had surgery to try to stop the bleeding, but his condition did not improve. He died in hospital on 28 May.

Findings

6. The delay, by both the hospital and the prison GP, in investigating the cause of the fluid in Mr Podmore's abdomen in March 2015, would not have altered the outcome for Mr Podmore but would have allowed more timely planning of palliative care. Mr Podmore's condition deteriorated unexpectedly quickly, but the clinical reviewer noted that poor communication between hospital services and prison healthcare services meant that his end of life care was not effectively planned and managed.
7. Managers authorised the use of restraints for Mr Podmore's hospital appointments and admissions throughout 2015. We are not satisfied that these decisions were based on a full consideration of Mr Podmore's health and mobility at the time and how this affected his risk of escape.

Recommendations

- The Head of Healthcare should ensure that when a medical need has been identified, tests are carried out and the results investigated promptly.

- The Head of Healthcare should agree protocols with local hospitals to ensure that necessary patient information is shared between the prison and hospitals to allow appropriate continuity of care.
- The Director 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

8. 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.
9. The investigator obtained copies of relevant extracts from Mr Podmore's prison and medical records.
10. NHS England commissioned a clinical reviewer to review Mr Podmore's clinical care at the prison.
11. We informed HM Coroner for South Staffordshire of the investigation and have sent him a copy of this report. The coroner did not order a post-mortem examination and accepted the cause of death provided by the hospital consultant, which was:
 - 1a. Upper gastrointestinal bleed
 - 1b. Oesophagal varices
 - 1c. Cirrhosis of the liver
12. One of the Ombudsman's family liaison officers contacted Mr Podmore's daughter to explain the investigation. Mr Podmore's daughter did not have any specific matters she wanted the investigation to take into account.
13. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies and an action plan has been annexed to this report.
14. Mr Podmore's daughter received a copy of the initial report. She did not make any comments.

Background Information

HMP Dovegate

15. HMP Dovegate is privately run by Serco. The main prison holds around 933 remanded and sentenced adult men. There is also a therapeutic community, separate to the main prison, which holds up to 200 men.
16. Healthcare services are provided by Care UK, which took over from Serco Health in October 2014. There is an inpatient unit for 12 prisoners and 24-hour nursing cover. Two GPs provide cover Monday to Friday and Saturday mornings. There is an out of hours GP service at other times.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Dovegate was in January 2015. Inspectors reported that the standard of healthcare was improving, but the facilities were too small for the number of prisoners, the waiting times for routine GP appointments were excessive and too many hospital appointments were rescheduled. An appropriate range of primary care services was provided. Prisoners with life-long conditions and complex needs were properly identified and relevant clinics, including a weekly GP led session, were provided. Independent Monitoring Board

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 the change in provider. Additional nurses had been employed and recruitment was ongoing. The Board also noted that work had started to upgrade the healthcare facilities.

Previous deaths at HMP Dovegate

19. Mr Podmore was the second prisoner to die from natural causes at Dovegate since the beginning of 2014. We have previously raised the issue of the inadequate risk assessments for the use of restraints.

Key Events

20. Mr John Podmore was convicted of sexual offences in March 2009, and sentenced to 11 years in prison. He had been at HMP Dovegate since 17 December 2009.
21. Mr Podmore had a history of excessive alcohol consumption, poorly controlled type two diabetes and angina. Nurses and prison GPs monitored and reviewed his diabetes. Two blood tests in April 2014 showed Mr Podmore's liver function was abnormal, but a further test on 30 October showed an improvement. There were no other significant entries in his medical records between March 2009 and December 2014.
20. Due to his poorly controlled diabetes, two of Mr Podmore's toes became infected and were amputated at outside hospital on 10 December 2014. While he was in hospital, a consultant diagnosed kidney impairment, anaemia and ascites (a build up of fluid in the abdomen). The hospital did not investigate the ascites further. Mr Podmore stayed in hospital for three months and went back to Dovegate on 9 March 2015. At the prison, he was admitted to the inpatient unit in the healthcare centre and prison nurses implemented a post-operative care plan. After the amputation, Mr Podmore used a wheelchair and nurses encouraged him to walk as much as he could. He refused to use walking aids.
21. On 25 March, Mr Podmore had a blood test, which showed his liver function had deteriorated. The next day, the prison's lead GP read his hospital discharge letter, which suggested that liver disease was the cause of the ascites. The hospital had taken no action about this while Mr Podmore was an inpatient and had made no plans to review him. The GP noted that the fluid should be drained to determine the cause and he should be referred to a hepatology clinic. (Hepatology is the branch of medicine which covers diseases affecting the liver, gallbladder, biliary tree and pancreas.) No immediate action was taken. On 18 April, the lead GP assessed Mr Podmore in his cell, when he said he felt sick and uncomfortable. She noted that his abdomen was swollen and took a sample of the fluid for analysis.
22. On 18 April, Mr Podmore complained of shortness of breath and vomiting. The prison's lead GP again reviewed him in his cell. She suspected that he might have heart failure, as well as a possible heart attack, and sent him to outside hospital for investigative tests.
23. The hospital drained Mr Podmore's abdominal fluid and discharged him on 22 April. His discharge letter noted that he had oesophageal varices (abnormal, enlarged veins in the lower part of the foodpipe) and was waiting for the results of a full liver screen. They had prescribed drugs to reduce the pressure in the blood vessels, and for acid reflux and water retention. The hospital had arranged a follow up appointment at the hepatology clinic in six weeks. Mr Podmore was aware he had liver disease, which was likely to have been caused by previous excess alcohol consumption.
24. On 12 May, a prison GP examined Mr Podmore, who had been vomiting for about 24 hours and looked unwell. A recent blood test had shown he had acute

- kidney failure, which can be a side effect of poorly controlled diabetes. The GP sent Mr Podmore to a further outside hospital, for further assessment.
25. Hospital doctors performed an endoscopy (where a thin, flexible tube with a camera on the end is passed down the oesophagus), which showed bleeding in Mr Podmore's oesophagus. They closed the wound and discharged Mr Podmore on 16 May, with a diagnosis of liver cirrhosis (chronic irreversible damage and scarring of the liver). He returned to the inpatient unit at the prison.
 26. The next day, 17 May, Mr Podmore vomited a brown substance with blood and healthcare staff sent him back to outside hospital by ambulance. The hospital discharged him the next day, and advised that he should be taken to the accident and emergency department if he had a significant oesophageal bleed. Mr Podmore's condition improved and he stopped vomiting.
 27. On 20 May, the prison's palliative care lead assessed Mr Podmore and discussed all aspects of his care with him.
 28. On 22 May, the prison's lead GP spoke to Mr Podmore's hepatology consultant at outside hospital. The hepatology consultant explained that Mr Podmore's liver disease and kidney function were worsening. He considered that Mr Podmore had a life expectancy of six to twelve months and should be referred for end of life care. He was surprised that the original outside hospital had not carried out an endoscopy when he was admitted there. He listed him as a priority for banding of the varices (where a small rubber band is put round the enlarged blood vessel to cut off the blood supply) to help prevent fatal and distressing acute oesophageal bleeding.
 29. The prison's lead GP and a nurse discussed the prognosis with Mr Podmore later that day. The nurse noted that he was anxious and upset. He said that he wanted to go back to a residential wing to be with his friends, as he had to remain in his cell on his own in the inpatient unit for most of the day. However, due to his condition a move back to a wing was not possible. The nurse asked staff to monitor his mood and give him extra support.
 30. On the evening of 24 May, Mr Podmore said he had chest pains and was breathless. An ambulance service first responder went to the prison and took an electrocardiogram (ECG – a diagnostic tool that measures the electrical activity and rhythm of the heart). The result was normal. Mr Podmore said he did not want to go to hospital for further assessment and signed an ambulance service disclaimer form to confirm this.
 31. On 25 May, the prison's palliative care lead examined Mr Podmore and found a lump in his chest. He looked pale and lethargic. She thought the lump might be a bleed or a hernia and sent him to outside hospital. (Mr Podmore said he had misunderstood the disclaimer he had signed the previous day and did not realise that the first responder had wanted to take him to hospital.) The hospital found no cause for the chest pain and discharged him later that evening.
 32. At about 1.15am on 26 May, wing staff asked a nurse to assess Mr Podmore as he had vomited blood. The nurse took his clinical observations, such as blood pressure and oxygen saturations, which were all within the normal range. She

asked officers to request an ambulance, which they did immediately. While she was waiting, she checked Mr Podmore's observations twice more and he was stable. An ambulance arrived at 2.05am and took him to hospital. Mr Podmore was restrained by an escort chain. The ambulance crew noted that Mr Podmore had vomited approximately a pint of blood.

33. Hospital staff drained some of the fluid from Mr Podmore's stomach. At 6.45pm, after he vomited a lot of blood, a nurse called the hospital resuscitation team and asked the escort officers to remove the escort chain. Surgeons carried out emergency surgery and a blood transfusion.
22. On 27 May, doctors performed a procedure in which new connections are made between the blood vessels in the liver, allowing a better flow of blood and reducing the pressure in the varices. However, Mr Podmore's condition suddenly deteriorated and he was placed on life support. He died at 11.35pm on 28 May, with his daughters at his bedside.

Contact with Mr Podmore's family.

23. The prison's family liaison officer spoke to Mr Podmore on 18 May. He said that he wanted his daughter to know that he was unwell in hospital, but had not contacted her recently and did not know her telephone number. The family liaison officer agreed to try get in touch with his daughter on his behalf.
24. The family liaison officer tried, unsuccessfully, to contact Mr Podmore's daughter using telephone numbers listed in his prison record. On 22 May, she decided that she would go to see Mr Podmore's daughter at her home, with a nurse to help explain his condition. Before she was able to arrange this, she went on leave.
25. On 26 May, after Mr Podmore had been admitted to hospital, a member of staff at the prison took over as the prison's family liaison officer, as the current family liaison officer was on leave. The family liaison officer managed to obtain a current telephone number and called Mr Podmore's daughter to let her know that he was seriously ill in hospital. He arranged a taxi to take both his daughters to and from the hospital on 27 May, to visit Mr Podmore and met them there. He met Mr Podmore's daughters at the hospital again on 28 May, to offer support.
26. In line with Prison Service policy, the prison contributed to the costs of the funeral, which was held on 12 June.

Support for prisoners and staff

34. The prison's palliative care lead held a debrief to offer support to the staff involved in Mr Podmore's care. The staff care team attended the meeting.
27. The prison posted notices informing other prisoners of Mr Podmore's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm in case they had been adversely affected by Mr Podmore's death.

Findings

Clinical care

43. Mr Podmore had a history of diabetes and angina when he was sentenced to prison. In early 2015, while in hospital as an inpatient, the hospital identified that he had excess abdominal fluid, thought to be related to liver disease caused by alcohol abuse. The hospital did not investigate this further but referred to the possibility of liver disease in a discharge letter. On 26 March, the lead GP at Dovegate identified the need for further tests, but these were not done until 16 April, three weeks later. The lead GP accepted that there was a delay and said that this had been due to resource issues at the time. She acknowledged that earlier diagnosis, either by the hospital or the prison healthcare team, would have allowed more time to plan and manage Mr Podmore's palliative care.
44. After Mr Podmore was diagnosed with varices and liver cirrhosis, his secondary care was inconsistent, partly because he was twice taken to outside hospital as an emergency and his hepatology consultant was at a different hospital. This caused some confusion and led to poor communication between the hospitals and Dovegate's healthcare team. The lead GP and the clinical lead accepted that communication between Dovegate and secondary services needed to improve to ensure effective continuity of care.
45. The clinical reviewer concluded that the delay in investigating the build-up of fluid in his abdomen did not change the outcome for Mr Podmore and the upper gastrointestinal bleed (from varices) was predictable, but not preventable until he had surgery. However, the delay in diagnosis and management of his condition, as well as the poor communication between prison healthcare staff and the secondary care services, meant that his end of life care was not effectively planned and managed. We make the following recommendations:

The Head of Healthcare should ensure that when a medical need has been identified, tests are carried out and the results investigated promptly.

The Head of Healthcare should agree protocols with local hospitals to ensure that necessary patient information is shared between the prison and hospitals to allow appropriate continuity of care.

Restraints

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. Mr Podmore had eight hospital appointments and admissions from December 2014 to May 2015. In some cases the medical section of the risk assessments noted that he was able to walk short distances and used a wheelchair. Others noted that he could not walk unaided and needed a wheelchair. One noted he could move unaided in that he could transfer to a wheelchair. Some had no healthcare input about his mobility. None commented on how his condition affected his risk of escape as the court judgment requires. Dovegate uses a standard pre-printed form which asks healthcare staff a number of questions about the prisoner's condition but does not ask this question. Despite his acknowledged poor mobility, in each case, managers decided that double handcuffs should be used and an escort chain when he was receiving treatment. (Double handcuffing is when the prisoner's hands are handcuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs . They are usually used for high risk prisoners in good health. An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.)
48. From the time his toes were amputated, Mr Podmore's mobility was poor. As his condition worsened and he became weaker, the risk assessments did not change and he was still regarded as a medium risk to the public, of hostage taking and of escape. Prison managers authorised two escort officers to accompany him, double handcuffs and an escort chain for treatment and when using the toilet/shower.
49. For Mr Podmore's last admission to hospital on 26 May, the risk assessment remained the same with a security assessment of medium risk for all factors including escape. The healthcare section noted that Mr Podmore could not move unaided and used a wheelchair. Despite this, the authorising manager decided that an escort chain should be used but noted he was, "terminally ill and had limited mobility". Officers removed the escort chain about 15 hours after Mr Podmore's admission to hospital when he needed emergency treatment and it was not reapplied.
50. It is difficult to see how managers reached the conclusion that Mr Podmore, an elderly man with limited mobility, was a risk of escape or of re-offending, when he was in such a weak condition and escorted by two officers. 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 Mr Podmore's risk, or fully took into account how his condition impacted on this risk, as the 2007 High Court judgement requires. We make the following recommendation:

The Director 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.

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