

**Prisons &
Probation**

Ombudsman
Independent Investigations

Investigation into the death of Mr Benjamin Rodgers a prisoner at HMP Whatton on 29 July 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 Benjamin Rodgers died of widespread cancer at HMP Whatton on 29 July 2015. He was 77 years old. I offer my condolences to Mr Rodgers' family and friends.

Mr Rodgers had been diagnosed with cancer in 2010, two years before he was sentenced to prison. Healthcare staff at Whatton looked after him well. When Mr Rodgers' condition deteriorated, there were good care plans, including for end of life care and there was positive engagement with his family. I am satisfied that Mr Rodgers received a high standard of care at Whatton, at least equivalent to that he could have expected to receive in the community.

However, I am concerned that the risk assessments for the use of restraints when Mr Rodgers was taken to hospital, and for compassionate release, did not fully take into account Mr Rodgers' condition at the time.

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

February 2016

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Summary

Events

1. Mr Benjamin Rodgers had been diagnosed with kidney and lymph node cancer in 2010 while in the community. His left kidney and spleen were removed. A consultant monitored Mr Rodgers with six monthly CT scans. In July 2012, Mr Rodgers was convicted of serious sexual offences, and was sent to HMP Lincoln. On 6 September, he was sentenced to 19 years in prison. He remained under hospital care and, in April 2013, a scan showed Mr Rodgers had cancer in his remaining kidney. Cancerous nodules in his lungs had grown.
2. Oncologists continued to monitor Mr Rodgers and in April 2014, a CT scan showed suspected liver cancer. Mr Rodgers took oral chemotherapy to try to slow the growth of his the cancer. In July, an oncologist told him his condition was terminal and estimated his life expectancy was 12 to 24 months. On 31 July, Mr Rodgers moved to HMP Whatton for palliative care. Healthcare staff began care plans to ensure his needs were met and his pain was managed.
3. In January 2015, Mr Rodgers' cancer had spread to his bladder and in March, he had bladder and prostate surgery. His condition deteriorated and in June, his oncologist said his life expectancy was just weeks. The prison employed agency carers to look after Mr Rodgers during the night.
4. In July, healthcare staff began an end of life care plan. His door was left open at all times to facilitate his nursing care. He died in the prison on 29 July.

Findings

5. We are satisfied that Mr Rodgers received a good standard of care in prison, at least equivalent to that he could have expected to receive in the community. However, we are concerned that prison managers approved the use of restraints when Mr Rodgers went to hospital, without enough information about his condition at the time. We are also concerned that an application for compassionate release did not proceed on grounds of risk, when Mr Rodgers was virtually immobile at the time.

Recommendations

- The Governor 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 Governor should ensure that when assessing risk for the purposes of compassionate release, a distinction is made between the risks posed by the prisoner when fit and those posed by the same prisoner when suffering from a terminal condition.

The Investigation Process

6. The investigator issued notices to staff and prisoners at HMP Whatton informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
7. The investigator obtained copies of relevant extracts from Mr Rodgers' prison and medical records.
8. NHS England commissioned a clinical reviewer to review Mr Rodgers' clinical care at the prison.
9. We informed HM Coroner for Nottinghamshire and Nottingham District of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.
10. One of the Ombudsman's family liaison officers contacted Mr Rodgers' partner to explain the investigation. Mr Rodgers' partner had no specific issues for the investigation to consider and told us that the prison treated her and her partner well.
11. The investigation has assessed the main issues involved in Mr Rodgers' 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.
12. The initial report was shared with the Prison Service. There were two factual inaccuracies and the report has been amended accordingly. The action plan has been annexed to the report.
13. Mr Rodgers' partner received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.

Background Information

HMP Whatton

14. HMP Whatton in Nottinghamshire is a medium security prison holding up to 841 men convicted of sex offences.
15. Nottinghamshire Healthcare Foundation Trust provides healthcare services at the prison. The healthcare centre is open seven days a week. GPs from a local practice provide specialist clinics for older prisoners and those with chronic conditions and there is an out-of-hours service. There are no inpatient beds, but there is a palliative care suite in the healthcare centre, for end of life care.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Whatton was in February 2012. Inspectors reported that the quality of healthcare was good, and relationships between healthcare and prison staff were effective. They noted that the prison's palliative services were impressive.

Independent Monitoring Board

17. 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 May 2015, the IMB reported that the number of daily escorts to hospital affected the operation of the prison. The Board noted an increasing demand for healthcare services, the result of a higher proportion of elderly prisoners.

Previous deaths at HMP Whatton

18. Mr Rodgers' death was the ninth from natural causes at Whatton since the July 2014. We have found in other similar cases that Whatton has provided a good standard of care including for end of life. We have previously raised the need for risk assessments for hospital escorts to take into account current healthcare information about how the prisoner's condition affects his risk.

Findings

The diagnosis of Mr Rodgers' terminal illness and informing him of his condition

19. On 19 July 2012, Mr Benjamin Rodgers was convicted of serious sexual offences, and sent to HMP Lincoln. On 6 September, he was sentenced to 19 years in prison. In 2010, Mr Rodgers had been diagnosed with kidney and lymph node cancer. His left kidney and spleen were removed later that year. In March 2012, he developed cancerous nodules in his lungs. An oncologist at outside hospital said his cancer was stable and he did not need chemotherapy. He had CT scans every six months to monitor his condition.
20. Mr Rodgers' cancer progressed slowly and he remained generally well. On 11 April 2013, a CT scan showed cancerous lymph nodes in his remaining kidney, and that the nodules in his lungs had increased in size. A urologist decided to continue to monitor him with six monthly scans.
21. On 15 April 2014, a consultant oncologist told Mr Rodgers that a scan on 5 March had found a mass at the tip of his liver, suspected to be cancer. His gallbladder, kidneys and pancreas remained unchanged. The oncologist prescribed oral chemotherapy treatment to try to slow the growth of the cancer. Healthcare staff at Lincoln oversaw Mr Rodgers' treatment regime.
22. On 14 July, the consultant oncologist told Mr Rodgers' that his condition was terminal and that he had between 12 to 24 months to live.
23. Mr Rodgers had been diagnosed with cancer before he was sent to prison in 2012. He received good care at the prison and was able to attend hospital appointments. We are satisfied that he was appropriately informed of his terminal diagnosis in July 2014 and understood it.

Mr Rodgers' medical treatment

24. After his terminal diagnosis, Mr Rodgers was transferred to HMP Whatton. At the time, he looked after himself, could walk with the help of a walking stick, but used a wheelchair for longer distances. A nurse created a palliative care plan.
25. On 5 August, Mr Rodgers told a prison GP that he was worried he would miss some of his hospital appointments because of moving prisons. The GP reassured him that this would not happen and his care had been transferred to a further outside hospital.
26. On 23 August, Mr Rodgers ran out of his prescribed oral chemotherapy and it took until 2 September, to get a new prescription, as the hospital consultant had not signed the prescription. The clinical reviewer noted that this delay was caused by the hospital factors and not within Whatton's control. It did not affect the outcome for Mr Rodgers.
27. A nurse reviewed Mr Rodgers regularly. In October, the nurse noted that his pain was well managed; he was sleeping well and had no problems with eating or drinking. He continued oral chemotherapy.

28. On 19 January 2015, a consultant oncologist stopped the oral chemotherapy as successive scans had shown the treatment had had little effect. The oncologist told Mr Rodgers that he suspected a cancerous nodule in his bladder. On 3 February, doctors found and removed a section of the nodule and also removed a section of his prostate gland. On 3 March, Mr Rodgers had surgery on his bladder and prostate gland. He returned to the prison the next day.
29. Nurses attended to Mr Rodgers daily, and a lead nurse continued to see him regularly for cancer reviews. He attended several hospital oncology appointments in March and April. By 2 June, Mr Rodgers was dependent on a wheelchair to get around. A prison GP discussed end of life care with him and Mr Rodgers said he did not want anyone to try to resuscitate him if his heart or breathing stopped.
30. On 7 June, the lead nurse noted that Mr Rodgers was having difficulty getting out of bed, because of pain in his back, abdomen and chest. After this, the prison employed agency healthcare assistants for overnight care from 7.00pm to 7.00am.
31. On 18 June, a prison GP noted Mr Rodgers was increasingly frail and not eating or drinking much. She prescribed nutritional drinks. Blood tests on 19 June showed Mr Rodgers was still anaemic with a rising platelet count, a sign of worsening kidney cancer. On 23 June, the prison GP prescribed fentanyl patches, for long-lasting pain relief. Mr Rodgers continued with oramorph (liquid morphine) for breakthrough pain.
32. On 25 June, a prison GP spoke to an oncology consultant who said that Mr Rodgers would not benefit from further treatment and his prognosis was probably weeks rather than months. The prison GP informed Mr Rodgers of this.
33. In early July, Mr Rodgers was given a pressure-relieving mattress to help prevent bedsores. He was now doubly incontinent and unable to get out of bed. From 17 July, Mr Rodgers' door was left open at all times, to allow nurses easy access. On 21 July, his lead nurse began an end of life care plan, and discussed this with Mr Rodgers and his partner.
34. Two healthcare assistants were looking after Mr Rodgers during the night of 28 July. They each sat with him throughout the night. In the morning, his breathing became laboured and at 7.17am, one of the healthcare assistants recorded that he had stopped breathing. In line with Mr Rodgers' wishes, she did not attempt to resuscitate him. At 7.51am, paramedics arrived and recorded that Mr Rodgers had died. The coroner gave the cause of death as carcinomatosis (widespread cancer) and renal cell carcinoma (kidney cancer).
35. During his time at the prison, Mr Rodgers remained under the care of oncologists and attended hospital. Prison healthcare staff implemented effective care plans, which were reviewed as necessary to ensure that they met Mr Rodgers' needs, including pain relief. An end of life care plan was agreed with Mr Rodgers and his partner. We are satisfied that Mr Rodgers received very good care at Whatton, at least equivalent to that he could have expected to receive in the community.

Mr Rodgers' location

36. At Lincoln, Mr Rodgers' cancer was stable and he lived on a standard wing. At the end of July 2014, once Mr Rodgers had a terminal diagnosis, he was moved to Whatton for palliative care, as the prison has a dedicated palliative care suite.
37. When Mr Rodgers' health deteriorated significantly in May 2015, another terminally ill prisoner was using the palliative care suite. Staff at Whatton moved Mr Rodgers to a suitably adapted cell with an ensuite shower. He had 24-hour care and the same standard of nursing he would have received in the palliative care suite. Although he was not able to use the palliative care suite, we are satisfied that Mr Rodgers was appropriately located at Whatton.

Restraints, security and escorts

38. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. However, it also has a responsibility to balance this by treating prisoners with humanity. The use of restraints 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 risk assessment and kept under review as circumstances change.
39. On 19 January 2015, when Mr Rodgers attended hospital for an oncology appointment, a prison manager assessed him as low risk to the public and of escape. The lead nurse noted that Mr Rodgers walked with a stick but needed a wheelchair for longer distances. The prison manager decided that Mr Rodgers should not be restrained.
40. Despite that decision, when Mr Rodgers went to hospital five times between the end of January and the end of March, prison managers decided that Mr Rodgers should be handcuffed on the way to and from hospital and restrained by an escort chain on arrival. (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.) They assessed Mr Rodgers as low risk in all areas. The healthcare section of the risk assessments indicated no objection to the use of restraints but gave no further detail of his condition or whether it impacted on his risk of escape.
41. Mr Rodgers had a hospital appointment on 20 May. By this time, his health had deteriorated significantly and he had moved to a specially adapted cell. The prison was unable to find the risk assessment for this hospital visit, but the escort record shows that Mr Rodgers was still restrained.
42. On 8 June, a prison manager completed a security review and decided, after discussion with healthcare staff, that officers should not restrain Mr Rodgers for any future hospital escorts. Mr Rodgers did not go to hospital again.
43. 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. It is difficult to see how restraints could be justified between the end of January and May, when they were not needed for an earlier hospital visit in January and after which, Mr Rodgers' condition steadily deteriorated. His mobility was poor and he needed a wheelchair. The healthcare contributions to the risk assessments were inadequate and we would have expected decisions about the need for restraints to be considered as part of effective care planning for a terminally ill prisoner. We repeat the following recommendation, which we have made to Whatton before:

The Governor 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 Mr Rodgers' family

44. A prison manager acted as the prison's family liaison officer from 7 August 2014. He went to see Mr Rodgers the same day to explain his role. With Mr Rodgers' consent, the family liaison officer telephoned Mr Rodgers' partner on 11 August, to introduce himself. He arranged visits for Mr Rodgers' partner and his son and kept in contact with Mr Rodgers and his family, throughout his illness.
45. On 21 July 2015, when Mr Rodgers' health deteriorated significantly, the family liaison officer telephoned his partner and son and arranged for them to visit. During the visit, they agreed that, when Mr Rodgers died, the family liaison officer would telephone his son first, and he would arrange to be with his father's partner when prison staff broke the news.
46. After Mr Rodgers died, the family liaison officer telephoned his son as they had previously arranged. His son was unable to go to Mr Rodgers' partner's home as planned, so he asked the family liaison officer to telephone her. A prison manager agreed that they should do what his son had asked. At 9.15am, the family liaison officer telephoned Mr Rodgers' partner and informed her that he had died. He visited her at 10.30am the same morning to offer condolences and further support.
47. The prison held a memorial service on 12 August. Mr Rodgers' funeral was on 20 August and the prison contributed to the costs in line with Prison Service Instructions.
48. We are satisfied that there was good liaison with Mr Rodgers' family. Mr Rodgers' partner told us that she was well supported by the prison both before and after his death.

Compassionate release

49. Release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months can be permanently released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. The criteria for early release for determinate sentenced prisoners are set out in Prison Service Order (PSO) 6000.

Among the criteria is that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of the National Offender Management Service (NOMS).

50. On 2 February 2015, the family liaison officer spoke to Mr Rodgers about compassionate release. Mr Rodgers said that he was appealing against his conviction and wanted to see this process through before considering applying for release.
51. On 25 June, after a prison GP told Mr Rodgers that his life expectancy was now likely to be weeks, Mr Rodgers told the family liaison officer that he wanted to apply for early release. The prison started an application for compassionate release on 1 July. On 14 July, the Governor acknowledged Mr Rodgers' rapidly deteriorating health but considered that he still presented a high risk of harm to children and therefore did not support Mr Rodgers' application.
52. On 15 July, the prison contacted the Public Protection Casework Section and explained that the Governor did not support Mr Rodgers' application for early release. A casework manager from PPCS said that, as the Governor did not support the application, it could not progress.
53. Mr Rodgers was in prison for offences committed between 1973 and 2002, some years before he had been diagnosed with cancer. Given his physical condition, it is difficult to understand how Mr Rodgers was considered a high risk on 14 July. By this time he was seriously ill, unable to get out of bed, and doubly incontinent. Three weeks before, his consultant had said he had just weeks to live. Mr Rodgers died two weeks later.
54. We do not know whether an application for early release would have succeeded; there could have been a number of reasons why he was not suitable. However, we are not satisfied that the Governor's assessment of risk, which prevented the application going forward, was based on an objective assessment of his condition at the time and how this affected his risk. The fact that he was bedridden, with no hope of recovery, suggests that the risk of re-offending was past. We make the following recommendation:

The Governor should ensure that when assessing risk for the purposes of compassionate release, a distinction is made between the risks posed by the prisoner when fit and those posed by the same prisoner when suffering from a terminal condition.

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