Prisons & Probation Ombudsman
Independent Investigations

Investigation into the death of Mr Terrance Dinham, a prisoner at HMP Whatton on 14 September 2015

A report by the Prisons and Probation Ombudsman
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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*

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 Terrance Dinham died of lung cancer in HMP Whatton, on 14 September. Mr Dinham was 76 years old. I offer my condolences to Mr Dinham's family and friends.

The investigation found that the care Mr Dinham received was at least equivalent to that he could have expected to receive in the community. There were no obvious symptoms indicating that he had cancer, so there was no opportunity for an earlier diagnosis and he declined exploratory or active treatment. The prison appropriately monitored and treated him with pain relief.

However, I am concerned that the decision to restrain Mr Dinham in hospital did not fully take into account how his health, at that time, affected his risk of escape.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **March 2016**

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Summary

Events

1. Mr Terrance Dinham was sentenced to life imprisonment in 1982 and had been in a number of prisons since. He moved to HMP Whatton on 22 July 2013. He had an enlarged prostate, chronic obstructive pulmonary disease (COPD) and deep vein thrombosis (DVT), which was treated in prison.

2. On 26 August, Mr Dinham had blood tests to monitor his DVT treatment. The results showed abnormalities and a prison GP sent him to hospital for urgent treatment. While there, hospital doctors diagnosed that he had widespread lung cancer. However, he declined any further tests or interventions and returned to the prison for palliative care on 1 September.

3. Over the next two weeks, Mr Dinham's health deteriorated. He received pain relief and died in the palliative care suite of the prison on 14 September.

Findings

4. Before he went into hospital, Mr Dinham did not show or report any of the symptoms usually associated with lung cancer. Therefore, we are satisfied that it could not have been diagnosed sooner. He declined active treatment, but staff involved him in the decisions about his pain relief and location. The investigation found that the treatment Mr Dinham received was equivalent to that he could have expected to receive in the community.

5. In the days leading up to his admission to hospital, Mr Dinham was very unwell and had limited mobility. No healthcare staff were available to complete the section of the security risk assessment on how his health at that time affected his risk of escape and to the public. Despite prison managers assessing him as low risk, and noting his limited mobility in daily management checks, Mr Dinham was restrained throughout his six days in hospital, from 26 August to 1 September 2015. We are not satisfied that this decision fully took into account his health and how it affected his risk at that time.

Recommendation

- 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 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 Dinham's prison and medical records.

8. NHS England commissioned a clinical reviewer to review Mr Dinham's care at the prison.

9. We informed HM Coroner for Nottinghamshire and Nottingham City 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 Dinham's brother to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He raised no concerns.

11. The investigation has assessed the main issues involved in Mr Dinham'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.

12. Mr Dinham's family were informed the initial report was available, but did not wish to receive a copy or make any comment.

13. The prison found one factual inaccuracy which has been amended in this report. The prison has also submitted an action plan detailing what they have done to address the issues we raised and this is annexed to the end 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 from 7.30am to 6.30pm on weekdays and 8.30am to 1.30pm at weekends. There is an out-of-hours service for 24 hour healthcare cover. There are specialist clinics for older prisoners and those with chronic conditions. There are no inpatient beds, but there is a palliative care suite 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 that 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 Dinham was the eighth prisoner to die of natural causes at HMP Whatton since September 2014. We have made previous recommendations about the use of restraints without comprehensive risk assessments to justify their use.

Findings

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

19. Mr Terrance Dinham was sentenced to life imprisonment for serious offences and had been in prison since 1982. He spent time in a number of prisons, and transferred to HMP Whatton on 22 July 2013.

20. At his initial health screen at Whatton, a nurse noted that Mr Dinham was generally unwell, and had misused drugs and alcohol in the past. He was a smoker, and his attempts to stop had been unsuccessful. He had several medical conditions, including chronic obstructive pulmonary disease (COPD – the name for a collection of long-term progressive lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease) and high blood pressure. Dr A prescribed Mr Dinham omeprazole and sodium alginate (both for excess stomach acid), and tamsulosin (to treat symptoms of an enlarged prostate).

21. Dr B assessed Mr Dinham on 1 August, and noted that he suffered from deep vein thrombosis (DVT). Healthcare staff monitored this and his other conditions.

22. On 19 February 2015, Mr Dinham complained of pain and difficulty walking. Dr B sent him to hospital, where doctors diagnosed a life-threatening blood clot in his leg and advised that he needed an operation to remove it. Mr Dinham declined, and discharged himself against medical advice. Nurses and doctors in prison discussed this decision with him, and Nurse A concluded that he had the capacity to make decisions and decline treatment. Prison healthcare staff continued to monitor him and the blood clot was managed with a daily injection of clexane (to thin the blood).

23. On 20 August, Officer A took Mr Dinham to the healthcare centre because he was unsteady on his feet and delirious. Dr B diagnosed a chest infection and exacerbation of COPD, and prescribed antibiotics. The officer noted that Mr Dinham appeared a lot better the next day.

24. Mr Dinham went to the healthcare centre for blood tests to monitor his blood-thinning medication, on 26 August. He used a wheelchair as he could not walk. He told Nurse B that he had paralysis across the middle of his body, found it difficult to get out of bed, and needed help to go to the toilet. The nurse booked a GP appointment and an occupational therapy assessment. The blood test results, received later that day, showed Mr Dinham was at risk of bleeding. A prison GP sent him to hospital and he was admitted for emergency treatment.

25. Escort officers recorded that Mr Dinham found it difficult to move around and needed help to walk. He declined treatment and sometimes displayed difficult behaviour, although they commented he was never hard to manage.

26. On 1 September, a hospital doctor discussed the results of a chest X-ray with Mr Dinham, which showed he had advanced and incurable lung cancer that had spread to other parts of his body. Hospital doctors planned to carry out further investigations to identify possible treatment and symptom management, but Mr Dinham declined. He returned to prison the same day.

27. The clinical reviewer concluded that Mr Dinham had not shown any obvious signs of underlying cancer, such as recurrent chest infections, weight loss or coughing up blood. We are satisfied that there were no missed opportunities to diagnose his cancer.

Mr Dinham's medical treatment

28. Nurse C reviewed Mr Dinham on 3 September. He understood that his condition was terminal and said he did not want to be resuscitated if his heart or breathing stopped. Healthcare staff completed an order to this effect on 4 September. Nurse B noted he had a poor prognosis and short life expectancy of up to two weeks. Staff created care plans, including palliative care needs and nurses took Mr Dinham's medication to his cell, as he was too unwell to collect it. Dr B prescribed medications for pain relief (hyoscine butylbromide, levomepromazine and morphine) and to help him sleep (midazolam).

29. Mr Dinham quickly became bedbound and unable to eat. Staff made welfare checks every two hours. On 10 September, Mr Dinham moved to the palliative care suite and, the next day, nurses began administering continuous pain relief through a syringe driver. A care assistant provided 24-hour comfort care, and nurses and doctors assessed him frequently. His health deteriorated further and Dr C pronounced him dead at 1.25pm on 14 September.

30. The clinical reviewer concluded that the timing of his diagnosis and the clinical care Mr Dinham received was equivalent to that he could have expected to have received in the community. Prison healthcare staff reviewed and assessed him frequently. There was also good communication between the hospital and prison, and the care plans and medication were appropriate.

Mr Dinham's location

31. On 2 September, Mr Dinham agreed to move to a cell more suitable for his needs. At his review with Nurse C the next day, Mr Dinham said that he would prefer to stay in prison rather than go to hospital, if his condition deteriorated. He moved to the palliative care suite on 10 September

32. The clinical reviewer concluded that the timing of Mr Dinham's transfer to the palliative care suite was appropriate, and that due to his rapid decline and his intensive health needs, it would not have been practical to release him on temporary licence. There is evidence that prison staff discussed with Mr Dinham where he would be best placed, as well as where he wanted to be. We are satisfied that Mr Dinham's location was appropriate and staff took account of his wishes.

Restraints, security and escorts

33. 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 judgement 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 judgement 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.

34. The risk assessment for Mr Dinham's journey to hospital on 26 August, noted that healthcare staff were not on duty at the time, so the medical section was not completed. Prison managers assessed him as a low risk of harm to the public and escape, but authorised officers to use 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). They did not record the reasons for the use of restraints, which remained in place until he returned to the prison on 1 September.

35. In daily management checks, each prison manager noted that Mr Dinham's mobility was poor and he was very unwell. His behaviour varied, but escort staff recorded that this did not affect their ability to keep him under control. Prison healthcare staff obtained updates on Mr Dinham's condition. However, neither hospital nor prison medical staff were asked for input on how Mr Dinham's health affected his risk at that time.

36. 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 acknowledge that staff were unable to obtain immediate medical input to the risk assessment, but this should have been updated as soon as healthcare staff were available. In the absence of a healthcare contribution to the risk assessment, it seems there was little or no consideration of how Mr Dinham's condition impacted on his risk of escape, as the 2007 High Court judgement requires. He was an elderly man in poor health who needed a wheelchair or assistance to walk and was escorted by two prison officers. Managers making decisions about the use of restraints need to consider all the evidence about a prisoner's health and mobility at the time. Ultimately, it is the Governor's responsibility to ensure that the process is managed properly, but the Head of Healthcare also needs to ensure that healthcare staff understand their responsibilities and have appropriate and considered input into the risk assessment process. We make the following recommendation:

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 Dinham's family

37. On 4 September, the prison appointed Officer B as Mr Dinham's family liaison officer. The officer was unable to contact Mr Dinham's brother, his nominated next of kin, until 6 September, as his contact details were not up to date. Mr Dinham's brother said he was happy to be contacted when Mr Dinham died, but would not visit him and they agreed that the prison would organise the funeral.

The Head of Security telephoned Mr Dinham's brother on the day Mr Dinham died, as Officer B was on leave.

38. Mr Dinham's funeral was held on 24 September. The prison arranged and paid for the funeral, in line with national guidance.

39. We are satisfied that the prison's contact with Mr Dinham's family was appropriate.

Compassionate release

40. Prisoners can be released from custody 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.

41. The prison manager spoke to Mr Dinham on 9 September, about compassionate release. Mr Dinham said that, although he wanted to be released, if he could not live with his family he would prefer to stay in prison where he knew people. Officer B spoke to Mr Dinham's family, who wanted limited involvement. The prison did not apply for compassionate release. We believe this was appropriate in the circumstances, and in line with Mr Dinham's wishes.

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