Prisons & Probation
Ombudsman
Independent Investigations

# Independent investigation into the death of Mr David Stafford a prisoner at HMP Exeter on 30 September 2015

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

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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*

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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 David Stafford died on 30 September 2015 of bronchopneumonia and widespread cancer while a prisoner at HMP Exeter.  He was 62 years old.  I offer my condolences to Mr Stafford's family and friends.

Mr Stafford had a number of chronic health conditions related to alcoholism before he arrived in prison.  I am satisfied that prison healthcare staff managed these well and referred Mr Stafford to hospital when necessary.  After he was diagnosed with cancer, healthcare staff at Exeter made him as comfortable as possible.  As in previous investigations, I commend the staff at the prison for their caring and respectful approach to end of life care.

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

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

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# Summary

## Events

1. On 21 August 2012, Mr David Stafford was sentenced to seven years in prison for sexual offences and was sent to HMP Exeter. Mr Stafford was a chronic alcoholic and had a number of related health problems including pancreatitis and type 2 diabetes. His gallbladder and part of his liver had been removed. He completed an alcohol detoxification programme when he arrived in prison and transferred to HMP Dartmoor in November 2012. Healthcare and hospital staff frequently reviewed and managed his conditions.

2. In July 2015, Mr Stafford had a stroke and in August he was transferred to HMP Exeter, which has 24 hour health facilities. On 27 August 2015, Mr Stafford was admitted to hospital for tests and a CT scan showed he had cancer, which had spread to a number of his organs. No active treatment was possible. Doctors estimated he had just weeks to live. On 17 September, the hospital discharged Mr Stafford and he went back to a specially adapted palliative care cell at Exeter. Nurses implemented care plans and checked him frequently each day

3. Mr Stafford died at the prison on the morning of 30 September.

## Findings

4. We consider that Mr Stafford received a good standard of care at Exeter, at least equivalent to that he could have expected to receive in the community. When he reported symptoms, healthcare staff assessed him promptly and appropriately referred him to hospital specialists. After his discharge from hospital, healthcare staff supported and cared for Mr Stafford using comprehensive care plans. When he was admitted to hospital on 27 August, Mr Stafford managers appropriately considered his risk and decided that he did not need to be restrained. We make no recommendations.

# The Investigation Process

5. The investigator issued notices to staff and prisoners at HMP Exeter informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

6. The investigator obtained copies of relevant extracts from Mr Stafford's prison and medical records. He interviewed three members of staff at Exeter on 8 December 2015.

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

8. We informed HM Coroner for Exeter and Greater Devon of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.

9. One of the Ombudsman's family liaison officers contacted Mr Stafford's sister-in-law to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She asked why hospital staff had informed Mr Stafford's family that he was seriously ill in hospital rather than prison staff and asked for information about a fall Mr Stafford had in prison.

10. The investigation has assessed the main issues involved in Mr Stafford'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.

11. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

12. Mr Stafford's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

# Background Information

## HMP Exeter

13. HMP Exeter is a local prison holding 565 men. Dorset Healthcare University NHS Foundation Trust provides health services. There are 10 cells on F Wing for prisoners who need social care and one cell for end of life palliative care. The wing has facilities for visiting relatives.

## HM Inspectorate of Prisons

14. The most recent inspection of Exeter was in August 2013. Inspectors reported that care for prisoners on F Wing with complex social care needs and disabilities was impressive. There were 24-hour health services and a wide range of clinics, including for chronic diseases. Two nurses led the care of older prisoners. Palliative care was supported through an excellent new suite, which had been created for the care of terminally ill prisoners

## Independent Monitoring Board

15. 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 most recently published annual report for the year to December 2014, the IMB said the health services at Exeter were generally good and they noted the effectiveness of the palliative care suite. Healthcare assistants and prison officers worked together in teams to deliver palliative care and the prison kitchen was able to meet special dietary requirements

## Previous deaths at HMP Exeter

16. Mr Stafford was the third person to die from natural causes at Exeter since January 2014. We have found that Exeter has consistently provided good end of life care. There were no significant similarities with the circumstances of the other deaths.

## Findings

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

17. On 21 August 2012, Mr David Stafford was sentenced to seven years in prison for sexual offences and was sent to HMP Exeter. He had poor health with a history of chronic alcoholism and related conditions, including having his gallbladder and part of his liver removed. He had developed pancreatitis (inflammation of the pancreas) and had type 2 diabetes. Mr Stafford had alcohol detoxification treatment when he arrived.

18. In October 2012, a prison GP referred Mr Stafford to a specialist after a blood test showed high levels of PSA (prostrate specific antigen, which can be an early indicator of prostate cancer). In November, tests for prostate cancer were negative and arrangements were made to monitor Mr Stafford every three months.

19. On 30 November 2012, Mr Stafford was transferred to HMP Dartmoor and staff continued to monitor his PSA levels. Healthcare staff saw Mr Stafford frequently to monitor his chronic conditions. On 20 May 2014, routine PSA tests showed a slightly raised level and, after an urgent hospital referral, tests found nothing of concern. After another test which showed raised PSA levels on 8 July 2015, a prison GP referred Mr Stafford to hospital again.

20. On 27 July, Mr Stafford appeared to be uncoordinated and unsteady on his feet and a prison GP reviewed him the next day. He asked for blood tests, but Mr Stafford collapsed and complained of chest pains. The GP arranged for him to go to hospital by emergency ambulance. He was admitted to hospital and doctors diagnosed a stroke.

21. On 14 August, hospital staff found Mr Stafford had an enlarged prostrate. Subsequent tests showed a benign (not cancerous) tumour. On 19 August, the hospital discharged Mr Stafford to Dartmoor. Healthcare staff arranged a ground floor cell as his mobility was now poor. Another prisoner helped with daily tasks such as collecting meals.

22. Healthcare staff arranged for him to move to HMP Exeter, which could better provide the level of care he needed. On 21 August, Mr Stafford was moved to the social care wing at Exeter.

23. Healthcare staff monitored Mr Stafford after he arrived and noted he appeared very confused. He often forgot how to use a knife and fork and eat properly. He complained of vomiting after meals and of stomach pains.

24. On 27 August, a prison GP noted Mr Stafford appeared extremely confused and unable to undertake simple tasks or instructions. Blood tests indicated significant abnormalities in his liver function and a high white blood cell count (often an indicator of serious infection). The doctor sent Mr Stafford to hospital by emergency ambulance and Mr Stafford was admitted as in inpatient. Doctors diagnosed bronchopneumonia and carried out further investigations.

25. On 30 August, doctors diagnosed Mr Stafford with cancer in his liver, brain and kidney and said he only had a matter of weeks to live. Hospital doctors informed Mr Stafford of his condition and a prison chaplain went to see him to support him.

26. The clinical reviewer considered that healthcare staff referred Mr Stafford to relevant specialists promptly, when necessary. We are satisfied there was no delay in his diagnosis and that prison staff supported him well.

### Mr Stafford's clinical care

27. While Mr Stafford was in hospital he decided that he did not want anyone to try to resuscitate him if his heart or breathing stopped. Hospital staff tried to discuss this with his family but were unable to contact them. The hospital consultant decided that resuscitation would not be in Mr Stafford's best interests and informed prison healthcare staff.

28. On 3 September, the prison held a multidisciplinary team meeting with representatives from all areas of the prison that would be involved in Mr Stafford's care. Healthcare staff created a care plan to ensure that Mr Stafford's pain management, fluid intake and referrals to palliative care teams would be managed effectively. A prison GP remained in contact with hospital staff until Mr Stafford was discharged back to Exeter on 17 September.

29. When Mr Stafford got back, the GP noted he was very confused and disorientated. However she discussed his illness and prognosis with him. Healthcare staff, supported by palliative care nurses, monitored him frequently and he had pain relief at all times. There were regular multidisciplinary meetings, to which Mr Stafford's family were invited but were unable to attend. Mr Stafford's condition declined rapidly.

30. At 5.00am on 30 September, an officer checked Mr Stafford, noted he was not breathing and radioed a medical emergency. The night manager arrived quickly. In line with Mr Stafford's wishes, they did not attempt resuscitation. At 5.25am, a paramedic confirmed Mr Stafford's death.

31. We are satisfied that Mr Stafford received a good standard of care at the prison. Healthcare staff monitored him every day and he received medication, including pain relief, as required. Records show he had comprehensive care plans and a well-considered, balanced diet. Regular multidisciplinary team meetings ensured that a wide range of services were well coordinated to meet Mr Stafford's needs.

### Mr Stafford's location

32. After the hospital discharged Mr Stafford in August, healthcare staff at Dartmoor arranged to move Mr Stafford to Exeter, which was better able to deliver the level of care he needed.

33. When he arrived at Exeter on 21 August, Mr Stafford's condition had deteriorated to the extent that he moved straight to the prison's palliative care suite. It had a hospital bed and all the medical equipment required to deliver palliative care. The door was left open at all times to allow healthcare staff unrestricted access. We are satisfied Mr Stafford was appropriately located throughout his illness, and that Exeter made commendable efforts to ensure his comfort and welfare.

### Restraints, security and escorts

34. When prisoners have to travel outside prison a risk assessment determines the nature and level of any security arrangements, including any restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. The level of restraints should be necessary in the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and factors such as the prisoner's health and mobility.

35. When Mr Stafford was taken to hospital as an emergency on 27 August, two prison officers accompanied him and used handcuffs for the journey. However, as soon as they arrived at the hospital they removed the handcuffs and Mr Stafford was not restrained again.

36. We are satisfied that, although Mr Stafford was restrained when he was taken to hospital, officers removed these very quickly and did not reapply them. This was appropriate and humane.

### Liaison with Mr Stafford's family

37. The prison has an agreement with the local hospital that when a prisoner is admitted, prison staff will contact the prisoner's family and inform them of his condition. However, on 27 August, contrary to the arrangement, hospital staff phoned his family before the prison could do this.

38. On 3 September, the prison appointed an officer as the prison's family liaison officer and she rang Mr Stafford's mother, who he had named as his next of kin. His sister-in-law took the call and explained that Mr Stafford's mother was seriously ill in hospital. His sister in law said that she and her husband would act as a point of contact for the prison. The officer kept his family updated about his condition. They agreed that she would telephone when Mr Stafford died.

39. As agreed, the officer telephoned his sister-in-law later on 30 September, informed her of Mr Stafford's death and offered condolences and support. Mr Stafford's funeral was on 20 October. The prison contributed towards the cost, in line with national policy.

40. Mr Stafford's sister-in-law was very positive about the care Mr Stafford had received from the prison and the communication she had had from the officer. We are satisfied that there was good liaison with Mr Stafford's family.

### Compassionate release

41. 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.

42. During the multidisciplinary meeting held on 3 September, the team discussed the possibility of compassionate release. A prison GP noted that before they could proceed they would need information about Mr Stafford's illness and a definitive prognosis from the hospital.

43. The information was received from the hospital on 18 September, and the prison submitted an application that day. Sadly, Mr Stafford died before a decision was made. We consider that the prison appropriately considered compassionate release and did their best to progress this.

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