

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Malcolm Palmer a prisoner at HMP Gartree on 15 January 2016

**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 Malcolm Palmer died on 15 January 2016 of a stroke with underlying lung cancer, while a prisoner at HMP Gartree. He was 69 years old. I offer my condolences to Mr Palmer's family and friends.

Shortly before his death, Mr Palmer had been admitted to hospital and diagnosed with lung cancer. A prison GP referred Mr Palmer to a specialist promptly when he reported symptoms suggestive of cancer. I am satisfied that Mr Palmer received an appropriate standard of care at Gartree and there was nothing staff at the prison could have done to prevent his death.

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**

**July 2016**

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# Summary

## Events

1. Mr Malcolm Palmer was serving a life sentence and he had been at HMP Gartree since August 2009.
2. On 21 December 2015, Mr Palmer told a prison GP he was occasionally coughing up blood. The GP referred him for an urgent chest X-ray and the results were suggestive of lung cancer. On 30 December, a prison GP referred him urgently to a specialist for suspected cancer.
3. Before he had seen the specialist, Mr Palmer was admitted to hospital for review after an abnormal blood test. Officers used an escort chain to restrain him in hospital. Later that night, Mr Palmer was transferred to a specialist chest hospital.
4. Mr Palmer remained in hospital for tests. On 5 January, a hospital doctor told him he had lung cancer. On 11 January he learnt this was not curable and moved back to an oncology ward at hospital.
5. On 12 January, Mr Palmer complained of blurred vision and a CT scan showed he had suffered a stroke. His condition deteriorated quickly and restraints were removed later that day. Mr Palmer died in hospital in the early hours of 15 January.

## Findings

6. A prison GP promptly referred Mr Palmer for urgent investigative tests when he suspected cancer, which the hospital later diagnosed. His subsequent stroke in hospital on 12 January was unexpected. We are satisfied that Mr Palmer's clinical care in prison was equivalent to that he could have expected to receive in the community and there was nothing prison staff could have done to prevent his death.

## The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Gartree informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
8. The investigator obtained copies of relevant extracts from Mr Palmer's prison and medical records.
9. NHS England commissioned a clinical reviewer to review Mr Palmer's clinical care at the prison.
10. We informed HM Coroner for Leicester City and South District of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.
11. One of the Ombudsman's family liaison officers contacted one of Mr Palmer's daughters to explain the investigation. She had no specific matters for the investigation to consider.
12. The initial report was shared with the Prison Service. The Prison Service pointed out some factual inaccuracies and this report has been amended accordingly.
13. One of Mr Palmer's daughters received a copy of the initial report. She pointed out some factual inaccuracies and/or omissions. This report has been amended accordingly. Mr Palmer's daughter also raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

# Background Information

## HMP Gartree

14. HMP Gartree near Market Harborough in Leicestershire holds up to 708 men sentenced to life imprisonment and other indeterminate sentences. Leicestershire Partnership Trust is responsible for delivering primary physical and mental health services in the prison and Northamptonshire Healthcare NHS Foundation Trust runs secondary mental health in-reach services.

## HM Inspectorate of Prisons

15. The most recent inspection of Gartree was in March 2014. Inspectors were positive about the range and standard of health services. Prisoners' access to healthcare services was very good and waiting times for all clinics were short. Nurses held triage clinics daily with open access for prisoners with urgent needs. Prisoners were able to see a GP routinely within three days.

## Independent Monitoring Board

16. 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 November 2015, the IMB reported that a delay in renewing the healthcare contract had caused some uncertainty but it had been decided that the existing providers would continue until 2017. The IMB was concerned that the growing number of older prisoners and those suffering from terminal illness or in need of operations would create a major problem in providing staff for escorts. Leicestershire County Council was working closely with the healthcare provider and the prison to help meet the social care needs of a number of older prisoners.

## Previous deaths at HMP Gartree

17. Mr Palmer was the fourth prisoner to die of natural causes at Gartree since January 2014. There were no similarities with the circumstances of the previous deaths.

## Key Events

18. Mr Malcolm Palmer was serving a life sentence for murder and had been in prison since November 2008 and at Gartree since August 2009. He had ischaemic heart disease and heart failure. Prison GPs and a cardiac consultant at hospital reviewed him regularly.
19. On 21 December 2015, at a routine appointment, Mr Palmer told a prison GP that he occasionally coughed up blood. The doctor noted that a recent blood test showed slight anaemia and an increased white blood cell count, indicative of infection. She prescribed antibiotics and referred Mr Palmer for an urgent chest X-ray.
20. Mr Palmer had the chest X-ray on 24 December and the results were received on 29 December. On 30 December, a prison GP reviewed the results with Mr Palmer and explained that the X-ray showed a large mass and moderate fluid accumulation in his left lung, which were suggestive of lung cancer. She referred him urgently to a chest specialist under the NHS pathway, which requires patients with suspected cancer to be seen within two weeks.
21. On 2 January 2016, routine blood tests showed Mr Palmer's potassium and calcium levels were low. A nurse contacted the on-call GP, who advised that they should take Mr Palmer to hospital for review.
22. Officers used handcuffs for the journey to hospital but the prisons duty manager reduced this to an escort chain after the prison decided to admit him. (An escort chain is a long chain with a handcuff at each end, one attached to the prisoner and the other to an officer.) At 11.05pm, Mr Palmer was taken to a specialist chest hospital.
23. Mr Palmer had a number of tests and treatment in hospital. On 5 January, a hospital doctor told him he had lung cancer and would need more blood tests and a biopsy of the mass in his lung.
24. On 11 January, a hospital doctor told Mr Palmer that his lung cancer was not curable and he was moved to an oncology ward at the first hospital at 9.30pm that evening. Mr Palmer complained that his vision was blurred. An eye specialist examined him and referred him for a CT scan.
25. At 5.30am on 12 January, Mr Palmer had the CT scan, which showed he had suffered a stroke. At 7.40am, a doctor told an escort officer that Mr Palmer appeared to be blind, though they were waiting on test results. The escort officer updated the duty manager. Mr Palmer's condition deteriorated and, at 4.40pm, his breathing became laboured and a doctor considered he might have had another stroke. At 4.55pm, the duty manager told the officers that the deputy governor had authorised them to remove the escort chain. Doctors said that they did not expect Mr Palmer to live for more than 24 hours.
26. Mr Palmer remained comfortable in hospital but his condition continued to deteriorate. He stopped breathing at 1.45am on 15 January and a hospital doctor confirmed his death.

### **Contact with Mr Palmer's family**

27. Mr Palmer did not want anyone informed that he was in hospital. On 12 January, the duty manager asked the escort officers to check with Mr Palmer again and he indicated that he did not want anyone to contact his family until after his death.
28. Later that day, a hospital doctor decided that Mr Palmer no longer had the capacity to make decisions about contacting his family and that his next of kin should be informed. The escort officer informed the prison. However, the prison decided to respect Mr Palmer's wishes as he had confirmed that he did not want his family notified when he had had capacity.
29. On 13 January, the prison officially appointed an officer as their family liaison officer. At approximately 1.00pm, the officer received a telephone call from Mr Palmer's daughter, as she was concerned that she had not heard from him as planned on Saturday 9 January. He explained her father was in hospital and offered support. Mr Palmer's three daughters and one son visited him that day and the officer met them at the hospital. On 14 January, the officer arranged for Mr Palmer's grandchildren to visit him.
30. At 2.35am on 15 January, the officer telephoned Mr Palmer's daughters, as he had agreed he would do when he died. He offered his condolences and ongoing support. Mr Palmer's funeral was on 9 February. The prison contributed towards the costs, in line with national policy.

### **Support for prisoners and staff**

31. After Mr Palmer's death, a prison manager debriefed the escort staff who were with Mr Palmer when he died, to offer her support and that of the staff care team.
32. The prison posted notices informing staff and prisoners of Mr Palmer'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 Palmer's death.

### **Cause of death**

33. The coroner gave the cause of death as a stroke, with lung cancer as a contributory factor.

# Findings

## Clinical care

34. Mr Palmer suffered from ischaemic heart disease and heart failure. The clinical reviewer considered that these conditions were appropriately managed in prison. After Mr Palmer told a prison GP that he occasionally coughed up blood, the GP immediately referred him for an urgent chest X-ray. The results showed a large mass, indicative of lung cancer and the GP then appropriately referred Mr Palmer to a specialist under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks. Before he had this appointment, he was admitted to hospital after abnormal blood tests. Mr Palmer remained in hospital where he was diagnosed with incurable lung cancer.
35. After Mr Palmer suffered a stroke on 12 January, it was some hours before a manager reviewed his risk and decided that the escort chain should be removed. While an earlier review of the need for restraints might have been preferable, an appropriate decision was made to remove the restraints, which allowed Mr Palmer more dignity in the final days of his life. He died at the hospital three days later. The clinical reviewer was satisfied that prison GPs appropriately referred Mr Palmer for secondary care and the healthcare team maintained good contact with hospital staff after his admission. All his care and treatment after 2 January was in hospital. We are satisfied that Mr Palmer received a good standard of care in the prison, equivalent to that he could have expected to receive in the community.

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