Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ernest Divall a prisoner at HMP Altcourse on 3 February 2016

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*

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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 Ernest Divall died on 3 February 2016 of myeloma (cancer of the white blood cells) at HMP Altcourse. He was 62 years old. I offer my condolences to Mr Divall's family and friends.

Despite not always being easy to manage, prison and healthcare staff made considerable efforts to include Mr Divall in discussions about his end of life care. I am satisfied that Mr Divall received a good standard of care at Altcourse, equivalent to that he could have expected to receive in the community.

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. On 16 June 2011, Mr Ernest Divall was sentenced to four years in prison for arson. In August 2012, at HMP Shrewsbury, he was diagnosed with myeloma (cancer of the white blood cells) and had chemotherapy. In December 2012, he was released on licence and the cancer was regarded as in remission. In June 2013, Mr Divall was recalled to prison and sent to HMP Altcourse after breaching his licence conditions.

2. When he first arrived at Altcourse, Mr Divall would not engage with healthcare staff but later agreed to blood tests to check the cancer had not returned. Mr Divall was admitted to a psychiatric hospital between October 2013 and January 2014, and was diagnosed with schizoaffective disorder.

3. In June 2015, Mr Divall lost weight and had back pain. In July, blood tests showed abnormalities and he was admitted to hospital for tests, which showed the cancer had returned. He began another course of chemotherapy.

4. In December, Mr Divall was admitted to hospital but his condition declined. Doctors decided that further treatment would not help and his prognosis was poor. On 5 January 2016, the hospital discharged Mr Divall back to Altcourse for palliative care. Healthcare staff consulted Mr Divall and began an end of life care plan.

5. Mr Divall's condition continued to deteriorate. He died at the prison on 3 February.

Findings

6. Mr Divall's mental health problems sometimes made it difficult for staff to manage his care, but the clinical reviewer found several areas of good practice. Healthcare staff worked in partnership with Mr Divall and held regular multidisciplinary reviews, which ensured consistent quality of care.

7. When his health declined, healthcare staff implemented a comprehensive end of life care plan, which covered all aspects of Mr Divall's care and was updated as his condition changed. The clinical reviewer identified a need for some improvement in medical record keeping and handling of samples, which the Head of Healthcare will need to address, but these did not affect Mr Divall's care. We are satisfied that Mr Divall received a good standard of care at Altcourse, equivalent to that he could have expected to receive in the community.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Altcourse 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 Divall's prison and medical records.

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

11. We informed HM Coroner for Merseyside of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.

12. One of the Ombudsman's family liaison officers contacted Mr Divall's sister to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Divall's sister said she was happy with the care Mr Divall had received at Altcourse.

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

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

15. The investigation has assessed the main issues involved in Mr Divall'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.

Background Information

HMP Altcourse

16. HMP Altcourse is a local prison in Liverpool, which takes prisoners from the courts in Merseyside, Cheshire and North Wales. It holds up to 1,324 sentenced and remanded adult and young adult men. G4S manage the prison and provide primary healthcare services.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Altcourse was in June 2014. Inspectors reported that prisoners had satisfactory access to most health services. There was a good range of clinical and screening services. Prisoners were generally positive about the care provided, especially in the inpatient unit. There were good arrangements for palliative and end of life procedures.

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 June 2015, the IMB reported that the 12 bed inpatient unit continued to manage and care for a diverse range of men. The healthcare management structure had been reformed and a new triage system had been introduced to reduce the length of waiting lists. Following the introduction of the Care Act 2014, the prison's links with the Local Authority had improved, although prison staff recognised that better links with Macmillan Nursing was required to enhance palliative care.

Previous deaths at HMP Altcourse

19. Mr Divall was the sixth prisoner to die of natural causes at Altcourse since May 2014. There were no significant similarities with the circumstances of the previous deaths.

Findings

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

20. On 16 June 2011, Mr Ernest Divall was sentenced to four years in prison for arson. In August 2012, when Mr Divall was at HMP Shrewsbury, he was diagnosed with myeloma and started a course of chemotherapy. On 13 December 2012, he was released on licence. The cancer was then in remission. On 25 June 2013, Mr Divall's was recalled to prison and sent to HMP Altcourse after breaching his licence conditions.

21. At an initial health screen at Altcourse, Mr Divall told a nurse that he had cancer but could not remember the details. He refused to see a GP or engage with healthcare staff, who contacted the hospital about his condition. The hospital said the cancer was in remission but he needed regular blood tests to check this. Mr Divall would not agree to a blood test at the time. In July, staff were concerned about Mr Divall's mental health and he was admitted to the prison's inpatient unit. A blood test at the end of July, confirmed the cancer was still in remission. Healthcare staff took blood tests every month when possible, but Mr Divall did not always comply.

22. On 15 October 2013, Mr Divall was admitted to a psychiatric hospital and diagnosed with schizoaffective disorder (a combination of schizophrenia and mood disorder symptoms). He returned to Altcourse on 24 January 2014, and continued to have monthly blood tests, which showed the myeloma remained in remission.

23. In June 2015, staff noticed Mr Divall had lost weight and he complained of back pain. On 17 July, blood tests showed some abnormalities but Mr Divall refused to go to hospital or be admitted to the inpatient unit for further observation. On 22 July, a prison GP examined him after a nurse was concerned that his condition had deteriorated. Mr Divall was admitted to hospital for tests, which found that the myeloma was no longer in remission. Hospital doctors informed him of the diagnosis.

24. We are satisfied that healthcare staff monitored Mr Divall appropriately and referred him quickly to hospital when he had concerning symptoms.

Mr Divall's clinical care

25. Mr Divall remained in hospital and began chemotherapy. On 19 August, the hospital discharged him and he was admitted to the prison's inpatient unit. Over the next two months nurses saw him every day and implemented appropriate care plans to monitor his treatment and symptoms.

26. Mr Divall's mental health deteriorated and he became increasingly difficult to manage. On 9 and 12 October, he refused chemotherapy and would not go to an appointment with his consultant. A nurse advised him of the risk of not continuing chemotherapy and the mental health team increased his medication. In mid-November, Mr Divall's mental health stabilised and he agreed to start chemotherapy again.

27. On 1 December a routine blood test was abnormal and he was admitted to hospital for further investigations and treatment. On 10 December, a prison GP visited Mr Divall in hospital and staff told him that Mr Divall's condition had worsened making him vulnerable to overwhelming infection. On 31 December, the hospital told the GP that Mr Divall was not responding to treatment and his prognosis was poor. He had pneumonia and further treatment would be of limited value.

28. The hospital decided they would not attempt further active treatment and, on 5 January 2016, Mr Divall was discharged for palliative care in the prison's inpatient unit. Nurses made Mr Divall comfortable and the hospital's palliative care team visited the prison to support him On 6 January, after discussion with other healthcare staff, a prison GP recorded that staff should not attempt to resuscitate Mr Divall if his heart or breathing stopped, as it would not be in his best interests. There was no record that anyone discussed this with Mr Divall. (The clinical reviewer has made a recommendation about this.)

29. Nurses monitored Mr Divall every day and helped him with eating and drinking and attended to his hygiene needs. Staff supported him to be as independent as possible. He attended hospital for blood transfusions as part of his palliative care.

30. On 26 January, Mr Divall had difficulty swallowing and a prison GP arranged a soft food diet and, where possible, that he should be given medication subcutaneously (under the skin). On 28 January, a hospital palliative care consultant prescribed additional medication to help relieve Mr Divall's increased agitation. Managers agreed that his cell door should be kept unlocked at all times to allow healthcare staff ready access to monitor and care for him.

31. Mr Divall's condition continued to deteriorate. At 6.00am on 3 February, a nurse checked Mr Divall and found him unresponsive with no signs of life. She considered that Mr Divall had died and, in line with the recorded order, she did not attempt to resuscitate him. A prison GP later recorded Mr Divall's death.

32. The clinical reviewer considered that Mr Divall's care at Altcourse was equivalent to that he could have expected in the community. There were many areas of good practice, which included healthcare working in partnership with Mr Divall to plan his care, and regular multidisciplinary reviews to ensure continuity of quality care. We are satisfied that Mr Divall received a good standard of end of life care at Altcourse.

Mr Divall's location

33. Mr Divall had a single cell to help prevent infection during his cancer treatment. He told healthcare staff he wanted to stay on a normal wing for as long as possible. Nurses visited him every day so that he could remain on the wing.

34. On 19 August 2015, when Mr Divall's health deteriorated, he was admitted to the prison's inpatient unit. He remained in the inpatient unit for the rest of his life, apart from time spent in hospital. We are satisfied that Mr Divall was appropriately located throughout his illness.

Restraints, security and escorts

35. When prisoners have to travel outside prison, a risk assessment determines the nature and level of any security arrangements, including 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. Any restraints used should be necessary and decisions should be based on the security risk taking into account factors such as the prisoner's health and mobility.

36. For each of Mr Divall's hospital admissions a risk assessment was completed with contributions from security and healthcare staff. The risk assessments indicated that Mr Divall was a high risk to the public, aggressive towards staff and his condition did not affect his risk of escape. Prison managers usually decided that Mr Divall should be handcuffed on the way to hospital and restrained by an escort chain in hospital. (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.)

37. When Mr Divall was admitted to hospital, senior prison managers kept the need for restraints under review and authorised their removal for treatment, or when his health deteriorated.

38. When Mr Divall went to hospital on 1 December 2015, an emergency risk assessment was completed. The risk assessment did not contain a medical assessment but a prison manager decided officers should handcuff Mr Divall. The next day, a nurse noted that there were no medical objections to Mr Divall being restrained and his condition did not affect his ability to escape. The manager changed the restraints to an escort chain.

39. Prison managers kept the need for restraints under review each day. On 10 December, the prison manager noted that Mr Divall was very ill; he reduced the escort to one officer and decided that there was no further need for restraints. Mr Divall was not restrained again.

40. We are satisfied that the decisions to restrain Mr Divall were based on properly considered risk assessments with appropriate healthcare input. Prison managers frequently reviewed the decisions. When Mr Divall's health deteriorated, restraints were removed and not reapplied.

Liaison with Mr Divall's family

41. On 28 July 2015, the prison appointed an officer as their family liaison officer. Mr Divall's next of kin was his sister and the officer telephoned her to inform her he was in hospital and introduce herself. She kept in contact with Mr Divall's sister, and arranged for her to visit him in hospital and at the prison.

42. Mr Divall's sister had asked the officer to telephone her if Mr Divall died and on 3 February, she called her and offered condolences and support.

43. Mr Divall's funeral was on 18 February. The prison contributed towards the cost, in line with national policy.

Compassionate release

44. 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.

45. On 5 January 2016, the prison started an application for compassionate release. A doctor wrote to the Director indicating that no further hospital treatment was available and that Mr Divall's life expectancy was likely to be only weeks. The doctor was unclear about what community provision might be available. The prison requested a specialist's opinion on Mr Divall's life expectancy and for information about possible community care.

46. The prison did not receive the additional information but, on 28 January, a doctor wrote to the Director. He explained that he had spoken to the hospital specialists involved in Mr Divall's treatment and care, and they had agreed that, if released, the only option would be a hospice. The same day, a hospice doctor examined Mr Divall and wrote to the prison to say that his condition had worsened and he was in his final days of life. She said that Mr Divall had told her he preferred to stay at the prison and she did not consider he had any complex symptoms that needed specific hospice care.

47. On 2 February, a multidisciplinary meeting at the prison agreed that Mr Divall should remain in familiar surroundings with care provided from people he knew and trusted. They decided that a move to a hospice was not in his best interests and did not progress the application for compassionate release.

48. We are satisfied that the prison acted in line with Mr Divall's wishes and his best interests, and that it was reasonable for the prison not to proceed with an application for compassionate release.

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