

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Alan Dutton a prisoner at HMP Stafford on 1 March 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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he 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 Alan Dutton, a prisoner at HMP Stafford, died in hospital on 1 March 2016 of lung cancer, which had spread to his liver and bones. He was 85 years old. I offer my condolences to Mr Dutton's family and friends.

I am satisfied that Mr Dutton received a generally good standard of care at Stafford, equivalent to that he could have expected in the community. However, there was a short delay in referring Mr Dutton to a specialist, as healthcare staff did not respond quickly when Mr Dutton lost a significant amount of weight. While this did not affect the outcome for Mr Dutton, it is important that symptoms indicative of a potential critical illness are investigated promptly.

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

September 2016

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Summary

Events

1. On 11 February 2011, Mr Alan Dutton was sentenced to 12 years in prison. He was 84, when he was transferred to HMP Stafford in October 2014. Mr Dutton had high blood pressure and osteoarthritis of the hip. He was prone to coughs and chest infections, but chest X-rays between 2012 and 2015 showed no evidence of cancer.
2. On 11 January 2016, after concerns that Mr Dutton was not eating well, a nurse weighed him and noted that he had lost three stones since April 2015. The nurse planned to refer him to the prison GP but this did not happen. On 25 January, a nurse examined Mr Dutton in his cell, as wing staff were concerned about his weight loss, incontinence and general deterioration. A GP reviewed Mr Dutton the next day and referred him urgently to a specialist. An administrator faxed the referral two days later. The prison received an appointment for 3 February, but the hospital later changed this to 8 February.
3. In the meantime, Mr Dutton's condition continued to deteriorate. On 4 February, a prison GP sent him to hospital, where he was admitted and initially treated for a chest infection. Scans and X-rays over the next few days revealed that Mr Dutton had advanced, inoperable lung cancer, which had spread to his liver, pelvis and bones. Mr Dutton remained in hospital, where he died on 1 March.

Findings

4. The clinical reviewer considered that, overall, Mr Dutton's care was equivalent to that he could have expected in the community. However, the nurse who weighed him on 11 January did not refer him to the prison GP, as planned, to investigate his significant weight loss. A GP did not examine him until two weeks later, after concerns about his deteriorating health. Although the GP decided to refer him urgently to a specialist for suspected cancer, two days elapsed before the referral was faxed to the hospital. While it does not appear that these delays affected the outcome for Mr Dutton, as the cancer was already at an advanced stage, it is important to respond quickly to symptoms, which might indicate a serious illness.

Recommendation

- The Head of Healthcare should ensure that staff refer prisoners with concerning symptoms, such as significant weight loss, to a GP promptly and that urgent referrals for suspected cancer are clearly indicated and actioned quickly.

The Investigation Process

5. The investigator issued notices to staff and prisoners at HMP Stafford informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
6. The investigator obtained and reviewed copies of relevant extracts from Mr Dutton's prison and medical records.
7. NHS England commissioned a clinical reviewer to review Mr Dutton's clinical care at the prison.
8. We informed HM Coroner for South Staffordshire of the investigation, who notified us of the cause of Mr Dutton's death. We have sent the coroner a copy of this report.
9. One of the Ombudsman's family liaison officers contacted Mr Dutton's daughter to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Dutton's daughter was content with the care her father had received at the prison and the support the prison gave her after his death.
10. The investigation has assessed the main issues involved in Mr Dutton'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 Prison Service considered our initial report and found no factual inaccuracies.
12. Mr Dutton's daughter received a copy of the initial report. She made no specific comments.

Background Information

HM Prison

13. HMP Stafford is a medium security prison, which holds more than 700 prisoners convicted of sexual offences. Staffordshire and Stoke-on-Trent Partnership NHS Trust provides healthcare services. There are no inpatient facilities. Nurses are on duty daily between 7.45am and 5.30pm and there is a weekday GP service, with an on-call service outside these hours.

HM Inspectorate of Prisons

14. The most recent inspection of HMP Stafford was in February 2016. The report has yet to be published, but inspectors told us that the standard of health services was reasonably good.

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 latest annual report, for the year to April 2015, the IMB reported that there had been an increase in the number of older prisoners with health problems and long-term conditions. Additional funding had been used to buy equipment and recruit healthcare assistants, but the GP waiting list had increased significantly and it was not always possible to see everyone on the list within a week. The prison was considering adapting part of a wing, to facilitate end of life care.

Previous deaths at HMP Stafford

16. There have been five deaths from natural causes, at Stafford, since the beginning of 2015. Three of the other deaths are still under investigation. There were no significant similarities with the circumstances of the death we have already investigated.

Findings

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

17. On 11 February 2011, Mr Alan Dutton was sentenced to 12 years in prison for sexual offences (later reduced to nine years on appeal). He had several health problems, including high blood pressure and osteoarthritis of the hip. He used a walking stick and later a wheelchair, to get about. In 2013, Mr Dutton had a right hip replacement; his left hip had already been replaced. Mr Dutton had not smoked for about 40 years but had several episodes of coughing and chest infections. Between June 2012 and May 2015, he had four chest X-rays, which showed no signs of cancer.
18. On 10 October 2014, Mr Dutton transferred to HMP Stafford and weighed 13st 13 lbs at an initial health screen. He suffered continuing chronic hip pain and was under the care of an orthopaedic specialist. A prison GP prescribed increasing doses of painkillers.
19. On 11 January 2016, Mr Dutton's social worker reported that he was not eating well. Later that day, a nurse weighed him and recorded he was 11st 1lb, over three stones less than when he was last weighed on 15 April 2015. She noted she had placed him on the waiting list to be seen by a doctor, but there is no record of an appointment.
20. On 15 January, a nurse noted that Mr Dutton had ongoing diarrhoea. On 25 January, officers were concerned that Mr Dutton had lost control of his bowels and that he had lost weight. She examined Mr Dutton and arranged an urgent GP appointment.
21. The next day, 26 January, Mr Dutton told a prison GP that he had no appetite and was in constant pain, which he thought was due to severe osteoarthritis in his hip. The GP recorded that Mr Dutton looked ill and emaciated. He prescribed a food supplement and noted he intended to refer him to a colorectal specialist, but did not record the priority. On 28 January, a healthcare administrator faxed a hospital referral under the NHS pathway, which requires patients with suspected cancer to be seen by a specialist within two weeks. The prison could not explain the reason for the short delay in sending the referral. The hospital initially sent an appointment for 3 February, which they later changed to 8 February.
22. On 4 February, a prison GP reviewed Mr Dutton and was concerned about his condition. He arranged for Mr Dutton to be taken to hospital and he was admitted as an inpatient.
23. On 12 February, a hospital respiratory consultant wrote to the prison GP and explained that they had initially treated Mr Dutton for a chest infection, but a chest X-ray and CT scan had revealed cancer in his right lung, which had spread to his liver, spine and left hip. Additionally, an MRI scan had shown cerebrovascular disease. A doctor said he had discussed the diagnosis with Mr Dutton and told him that it was incurable.

24. The clinical reviewer noted that a more timely review by a GP after his weight loss was identified on 11 January might have led to a slightly earlier diagnosis and the GP's referral for suspected cancer should have been sent to the hospital the same day. Although this did not affect the outcome for Mr Dutton, as the cancer was well advanced, it is important that staff respond promptly to symptoms, which might indicate cancer. We make the following recommendation:

The Head of Healthcare should ensure that staff refer prisoners with concerning symptoms, such as significant weight loss, to a GP promptly and that urgent referrals for suspected cancer are clearly indicated and actioned quickly.

Mr Dutton's clinical care

25. Prison healthcare staff frequently telephoned the hospital for updates on his condition. They visited him and attended relevant meetings to discuss his care.
26. Mr Dutton remained in hospital after his diagnosis and died three weeks later, on 1 March. The coroner reported that the cause of death was lung carcinoma (lung cancer) with widespread metastasis. Cerebrovascular disease (limited blood supply to the brain) and hypertension (high blood pressure) had also contributed to his death.
27. All of Mr Dutton's treatment after his diagnosis was in hospital and prison healthcare staff kept in touch with the hospital about his condition after Mr Dutton was admitted. Although there was short delay in referring him to hospital, the clinical reviewer concluded that Mr Dutton's care was equivalent to that he could have expected to receive in the community and prison staff could not have prevented his death. We are satisfied that Mr Dutton received appropriate care.

Mr Dutton's location

28. Before he went to hospital, Mr Dutton lived in a standard single cell. He had disability aids and community carers visited twice a day, to help with his personal care.
29. After Mr Dutton's diagnosis, prison healthcare staff discussed his care needs with his hospital consultant and palliative care services, and made plans for his discharge from hospital, including the possibility of enhanced support at Stafford. A local hospice offered a bed. However, Mr Dutton's condition deteriorated significantly on 25 February, and hospital staff considered he was too unwell to transfer to the hospice and he remained in hospital.
30. We are satisfied that Mr Dutton was accommodated properly throughout his illness and that healthcare staff appropriately planned for his possible discharge.

Restraints, security and escorts

31. When prisoners have to travel outside prison, a risk assessment determines the nature and level of security arrangements, including restraints.

32. 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.
33. Two prison officers escorted Mr Dutton to hospital on 4 February. We are pleased to note that prison managers appropriately took into account Mr Dutton's age and poor health, and decided that he should not be restrained.

Liaison with Mr Dutton's family

34. Mr Dutton's offences were against members of his family. Mr Dutton's daughter, who he had named as his next of kin, initially said that his family did not want any direct contact with him, but wanted to be kept informed of his condition through a family liaison officer or prison healthcare staff. On 12 February, a nurse informed Mr Dutton's daughter that he had terminal cancer.
35. On 16 February, the prison assigned a prison manager as the family liaison officer. Before Mr Dutton became ill, another of his daughters who had been a victim of his offences had asked to meet him. Over the next few days, the family liaison officer and other prison managers held discussions with Mr Dutton's offender manager, and victim liaison and restorative justice representatives to arrange a supervised visit. This took place on 24 February. Other members of Mr Dutton's family visited him during his final days.
36. At 9.30pm on 1 March, escort staff informed the prison that Mr Dutton's death was imminent. The family liaison officer and the duty manager arrived at the hospital just after he died. They offered condolences and support to Mr Dutton's family. The family liaison officer telephoned Mr Dutton's daughter the next morning to check her wellbeing and discuss her wishes for the funeral arrangements.
37. In line with national guidance, the prison paid for Mr Dutton's funeral, which was held on 21 March. We are satisfied that the prison liaised appropriately with Mr Dutton's family.

Compassionate release

38. 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.
39. On 17 February, Mr Dutton's offender supervisor began an application for early release. Using the information from his consultant's letter of 12 February, a prison GP noted on the form that Mr Dutton had advanced inoperable lung cancer that had spread to his spine, pelvis and his life expectancy was less than six months. He added that Mr Dutton was unlikely to commit any further criminal acts given his medical condition. The application was completed on 1 March. However, Mr Dutton died that night, before staff were able to submit it for consideration.
40. We are satisfied that the prison appropriately considered the possibility of compassionate release.

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