Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr William Devlin a prisoner at HMP Woodhill on 3 July 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*

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 William Devlin died of cancer in hospital on 3 July 2016, while a prisoner at HMP Woodhill. He was 76 years old. I offer my condolences to Mr Devlin's family and friends.

Mr Devlin struggled with deteriorating physical health and a decreasing ability to swallow while in prison, but healthcare staff did not manage his health in line with national medical guidelines. Although it would not have changed the outcome for Mr Devlin, healthcare staff failed to adequately address his symptoms, and did not appropriately follow up an urgent referral for suspected cancer. Overall, I do not consider that Mr Devlin's clinical care at Woodhill was of the standard he could have expected to receive in the community.

Mr Devlin was not restrained when he died, but I am concerned that prison staff used handcuffs for almost a week after his hospital admission without a fully considered risk assessment, which took into account how his health and mobility affected his risk of escape or harm to others.

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 **December 2016**

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Summary

Events

1. On 13 April 2016, Mr William Devlin received a 13 years prison sentence for sexual offences. He had been in prison before. Mr Devlin suffered from a dysfunctional heart rhythm, high blood pressure and chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases including chronic bronchitis and emphysema). He was also underweight and had mobility difficulties. Mr Devlin lived on the healthcare unit during his time at Woodhill.

2. Prior to his arrival at Woodhill, Mr Devlin suffered with problems swallowing so his community GP referred him to hospital with suspected upper gastrointestinal cancer. However, once in prison, Mr Devlin missed his hospital appointment.

3. Healthcare staff reviewed Mr Devlin frequently, and put care plans in place to help him complete his daily activities. He struggled physically and suffered increasing difficulty with swallowing. As a result, Mr Devlin often refused his medication and meals.

4. On 22 April, a prison GP made a re-referral to the ear, nose and throat department in a local hospital. On 13 May, an administrator found out that the hospital had no record of the referral. The hospital made an appointment for 9 June.

5. On 8 June, a prison GP assessed Mr Devlin after he reported feeling unwell. The prison GP requested urgent blood tests and thought the results indicated a possible infection. Prison staff escorted Mr Devlin to hospital for further assessment and treatment. His condition continued to deteriorate in hospital and doctors discovered potentially cancerous cells in his throat.

6. Following throat surgery, doctors planned to return Mr Devlin to Woodhill for palliative care. However, his condition deteriorated and he died in hospital on 3 July.

Findings

7. We are not satisfied that Mr Devlin's care in prison was equivalent to that he could have expected to receive in the community. The clinical reviewer found that healthcare staff did not appropriately follow up an urgent referral for suspected cancer, did not provide medical care in line with national guidelines, and failed to involve specialist services with Mr Devlin's care in light of his symptoms. Provision of specialist equipment to support Mr Devlin's physical needs was also delayed.

8. We are also concerned that staff restrained Mr Devlin when he went to hospital without completing a fully considered risk assessment which took into account how his health and mobility affected his risk of escape or harm to others.

Recommendations

- The Head of Healthcare should ensure that prison GPs follow relevant National Institute for Health and Clinical Excellence (NICE) guidelines for suspected cancer and refer patients appropriately.
- The Head of Healthcare should ensure that if a patient has difficulty swallowing, healthcare staff examine the patient's neck and throat and consider the services of a dietician.
- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints 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

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

10. The investigator obtained copies of relevant extracts from Mr Devlin's prison and medical records.

11. NHS England commissioned a clinical reviewer to review Mr Devlin's clinical care at the prison. In her clinical review, she made some recommendations not included in this report, which the Head of Healthcare should address.

12. We informed HM Coroner for Milton Keynes of the investigation who gave us the cause of death. We have sent the Coroner a copy of this investigation report.

13. One of the Ombudsman's managers wrote to Mr Devlin's son to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not respond to our letter.

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

Background Information

HMP Woodhill

15. HMP Woodhill has a dual role of a local prison and a high security prison and can hold 727 men. Central and North West London NHS Foundation Trust provides health services at the prison. Nursing staff are on site 24 hours a day, and GP's provide daily clinics, including weekends and out-of-hours cover. There is an inpatient unit with 12 beds, which provides physical and mental healthcare for prisoners. End of life palliative care is also provided.

HM Inspectorate of Prisons

16. The most recent inspection of Woodhill was in September 2015. Inspectors reported that primary health services were good, although a high non-attendance rate meant prisoners waited too long for some services. The inpatient unit continued to provide good care, but the regime still needed to be more recovery focussed. Clinical records were of a high standard and included effective care planning for those with complex health needs.

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 2016, the IMB reported that healthcare and mental health services continued to improve during the last year, as did the relationship between the provider and the prison. The healthcare provider had worked to keep medical and dental waiting times to a minimum, which were comparable to the community. This was achieved despite a number of vacancies and problems recruiting healthcare staff.

Previous deaths at HMP Woodhill

18. Mr Devlin was the second prisoner to die from natural causes at Woodhill since January 2015. Two other prisoners have died since. There were no similarities between the circumstances of Mr Devlin's death and previous deaths at the prison.

Key Events

19. On 13 April 2016, Mr William Devlin arrived at HMP Woodhill after receiving a 13 year sentence for historic sexual offences. He had been in prison before.

20. Prior to his arrival in prison, on 5 April, Mr Devlin suffered with problems swallowing, weight loss and a reduced appetite. His community GP had not found any throat or neck abnormalities but suspected that he had upper gastrointestinal cancer. The GP made an urgent referral to the hospital.

21. During an initial health screen at Woodhill, a nurse recorded that Mr Devlin had an appointment booked at the hospital on 16 April because he had experienced difficulty swallowing. She noted that he was a smoker and offered him smoking cessation advice, which he rejected. She also created a care plan to help Mr Devlin with his daily activities, and ordered specialist equipment to assist him, including a pressure mattress and a walking frame. Due to his poor physical health and mobility, healthcare staff admitted Mr Devlin to the prison's inpatient unit. He lived there for the rest of his time at Woodhill.

22. The following day, a prison GP recorded that Mr Devlin suffered from a dysfunctional heart rhythm, high blood pressure, an underactive thyroid and chronic obstructive pulmonary disease. The doctor also recorded that he was underweight and used a Zimmer frame to get around. The GP re-prescribed Mr Devlin's regular medication, which included atorvastatin (to treat cholesterol), diltiazem and ramipril (to treat high blood pressure), warfarin (to prevent blood clots) and a salbutamol inhaler (to improve his airflow). Healthcare staff regularly measured Mr Devlin's blood pressure and found that it was reasonable.

23. On 15 April, Mr Devlin's community medical practice contacted the prison to discuss the hospital appointment scheduled for the next day. A prison administrator told the practice that they would contact the hospital to try and keep the appointment. However, the administrator took no further action and Mr Devlin did not go to hospital.

24. Five days later, healthcare staff noted that Mr Devlin had refused food and medication due to his problems swallowing. He also said that he had missed his hospital appointment. They referred Mr Devlin to a prison GP, who saw him the following day, on 21 April. The GP requested a soft diet and medication that could be diluted for Mr Devlin. Kitchen staff began to provide a soft diet and healthcare staff supplied Mr Devlin with Ensure nutritional drinks and soluble medication.

25. The GP also asked administrative staff to arrange an urgent appointment for Mr Devlin. A prison administrator contacted the hospital to discuss Mr Devlin's missed appointment, but the hospital had no record of it. The administrator contacted the hospital to re-book the appointment, and hospital staff advised them to make a referral to the ear, nose and throat (ENT) department. On 22 April, the GP completed an ENT referral.

26. Later that day, Mr Devlin told a prison GP that he had agreed with his community GP that he did not want to be resuscitated if his heart or breathing stopped. The GP appropriately recorded Mr Devlin's decision.

27. On the same day, the prison reordered Mr Devlin's care equipment because it had not been delivered due to an external delay. It is not clear in Mr Devlin's medical record when he received this equipment though, on 1 June, a nurse recorded that he had a Zimmer frame and other care equipment in his cell.

28. On 2 May, the nurse recorded that Mr Devlin continued to struggle to swallow his medication and needed an urgent ENT referral. She sent a message to prison GPs about the referral. Two days later, a GP assessed Mr Devlin again. He recorded that Mr Devlin did not have any throat or neck abnormalities, and noted that staff had now made an ENT referral. The GP recommended a food chart to record and monitor Mr Devlin's diet, and asked nurses to weigh him each week. Healthcare staff completed a food chart between 5 May and 12 May, which noted that Mr Devlin continued to have trouble swallowing food and medication. However, Mr Devlin was only weighed once on 18 May.

29. On 13 May, a healthcare administrator contacted the hospital to follow up on Mr Devlin's ENT referral. Hospital staff confirmed that they had not received the referral because of a technical problem, and the administrator resent it. Nursing staff also referred Mr Devlin to Social Services for a carer's assessment, which did not happen before he was admitted to hospital in June.

30. Over the following weeks, Mr Devlin's health continued to deteriorate. As well as his problems with swallowing, he suffered from nausea and vomiting. Staff recorded that he appeared frail and was losing weight. They continued to encourage Mr Devlin to eat and take his medication, and updated his care plans to support him. On 28 May, a prison GP recorded that the hospital had booked Mr Devlin's ENT appointment for 9 June.

31. On the morning of 8 June, the GP assessed Mr Devlin after he reported feeling unwell. The GP noted that he was short of breath and had pain in the right side of his chest. The GP ordered urgent blood tests, which were abnormal and indicated a widespread infection. The GP decided to send Mr Devlin to hospital for treatment. A prison manager authorised two officers to accompany Mr Devlin and restrain him with handcuffs and an escort chain (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).

32. The hospital admitted Mr Devlin for further assessment and treatment. On 13 June, doctors informed the prison that Mr Devlin had a tumour in his throat and could not swallow. He was fed and medicated through a drip. The next day, when doctors advised that Mr Devlin's condition had deteriorated further, the prison manager agreed to remove the escort chain. Officers did not restrain him again.

33. On 16 June, doctors found potentially cancerous nodules (abnormal cells) in Mr Devlin's throat. He went to another hospital on 24 June for throat surgery, and returned to the other hospital three days later.

34. Doctors planned to return Mr Devlin to Woodhill for palliative care. However, on 3 July his condition deteriorated further and he became unresponsive. Mr Devlin died at 7.05pm, with his family present.

Contact with Mr Devlin's family

35. On 14 June, the prison appointed an officer as a family liaison officer. In May, Mr Devlin's family had asked the prison to stop any further contact from Mr Devlin due to his offences but she decided to make contact with Mr Devlin's son due to the seriousness of his condition. She offered Mr Devlin's son support and, two days later, provided the same support to Mr Devlin's sister and ex-wife. He also arranged for Mr Devlin's family to visit him in hospital.

36. When Mr Devlin became unresponsive on 3 July, an officer contacted Mr Devlin's family who went to the hospital to see him (the family liaison officer was not available that day). They were with Mr Devlin when he died.

37. The officer visited the hospital to offer his condolences and support to Mr Devlin's family.

38. In line with national guidance, the prison contributed to Mr Devlin's funeral costs.

Support for prisoners and staff

39. After Mr Devlin's death, a senior prisoner manager informally debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

40. The prison posted notices informing other prisoners of Mr Devlin's death, and offering support.

Cause of death

41. The Coroner confirmed that Mr Devlin died of metastatic cancer of unknown primary (where the origin of the cancer is unknown), with atrial fibrillation (abnormal heart rhythm), ischaemic heart disease (reduced blood supply to the heart) and chronic obstructive pulmonary disease (lung disease) as contributing factors.

Findings

Clinical care

42. The clinical reviewer considered that the care Mr Devlin received was not equivalent to that he could have expected to receive in the community. They noted that Mr Devlin did not receive a two-week urgent appointment for suspected cancer because of multiple system failures.

43. While prison healthcare staff were aware that Mr Devlin's community GP made an urgent referral for suspected cancer and that he thought he had an appointment booked for 16 April, they failed to actively follow up the appointment until 22 April. Healthcare staff did not chase up this appointment until 13 May, when the hospital confirmed that they had not received the original request.

44. Although technical problems played a part in the referral of 22 April not reaching the hospital, given the seriousness of the concerns about Mr Devlin's health, we would have expected healthcare staff to have been more proactive in following up on his missed appointment. There was a delay of around two months between the initial referral and Mr Devlin's hospital appointment, which is unacceptable in a case of suspected cancer. The clinical reviewer believed that the delay did not change the outcome for Mr Devlin, but that it probably prevented him from receiving appropriate palliative care and symptom treatment sooner.

45. The clinical reviewer also found that prison GPs did not provide medical care in line with national guidelines for good practice. The clinical reviewer found no evidence that the GPs thoroughly examined Mr Devlin's throat and neck, but instead relied on reports from other staff about his difficulty swallowing.

46. The clinical reviewer also found that GPs did not manage Mr Devlin's weight loss symptoms appropriately. Despite his difficulty swallowing and frequent refusal of food and medication, clinicians did not record his weight often enough. Apart from one request for a soft diet, there was no record that they considered the involvement of specialist intervention for this symptom.

47. The clinical reviewer also felt that there were unnecessary delays in obtaining care equipment to manage his physical needs. In light of these concerns, we make the following recommendations:

    The Head of Healthcare should ensure that prison GPs follow relevant National Institute for Health and Clinical Excellence (NICE) guidelines for suspected cancer and refer patients appropriately.

    The Head of Healthcare should ensure that if a patient has difficulty swallowing, healthcare staff examine the patient's neck and throat and consider the services of a dietician.

Restraints, security and escorts

48. 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 judgment 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 judgment 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.

49. When Mr Devlin went to hospital on 8 June, a nurse signed the healthcare section of the risk assessment and recorded no objection to officers using handcuffs. The nurse did not include any information about Mr Devlin's medical or physical condition. Security staff noted that Mr Devlin was a medium risk to females but was a low risk to the public and of escape. A prison manager decided that two officers should escort Mr Devlin to hospital using handcuffs and an escort chain.

50. As his condition deteriorated, the prison manager reviewed the decision and authorised the removal of restraints on 14 June. While we welcome this decision, we do not believe that the use of restraints was justified when he first went to hospital, when his heath and mobility were extremely poor.

51. Although the Prison Service has responsibility to protect the public, security must be balanced with humanity. We are not satisfied that the use of restraints was justified by risk assessments that fully considered his diminished health and mobility. Therefore, we are not satisfied that the prison had appropriately distinguished his risk of escape in light of his significant medical conditions. We are also not satisfied that the prison reviewed the appropriateness of the restraints quickly enough because they were not removed for six days. 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 on the use of restraints 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.

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