Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Gerald Roose a prisoner at HMP Erlestoke on 12 October 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 Gerald Roose died on 12 October 2016 of lung cancer at hospital. He was 60 years old. I offer my condolences to Mr Roose's family and friends.

Healthcare staff at HMP Erlestoke completed thorough care plans and reviewed Mr Roose regularly. I am satisfied that the care Mr Roose received was at least equivalent to that which he could have expected to receive in the community.

However, I am disappointed that the prison failed to provide evidence that restraints were used appropriately when Mr Roose was taken to hospital. I remind the Governor of his responsibility to provide documents to support my investigations. I am also concerned that the prison did not keep a record of any support they offered Mr Roose's family, nor was an application for compassionate release revisited when Mr Roose's health deteriorated.

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 2017**

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Summary

Events

1. Mr Gerald Roose was sentenced to life imprisonment for attempted murder in December 1985. On 16 September 2013, he was transferred to HMP Guys Marsh.

2. On 22 October 2015, Mr Roose attended hospital for an MRI scan of his lower spine after he had complained of pain. A prison GP reviewed the scan results, noted a mass around Mr Roose's lung and made an urgent referral under the NHS pathway, which requires a specialist to see patients with suspected cancer within two weeks. The next day, a prison GP told Mr Roose that he had lung cancer that had spread to the bones in his back.

3. On 4 November, after a hospital consultant saw Mr Roose, a prison nurse noted that Mr Roose's cancer was incurable. He began chemotherapy later that month and moved to HMP Erlestoke on 9 December in order to be closer to the hospital, which was providing his treatment.

4. Mr Roose continued to attend chemotherapy from Erlestoke. Prison GPs conducted regular cancer reviews with Mr Roose and a family liaison officer regularly attended. As Mr Roose's health deteriorated the prison requested a wheelchair and an overlay mattress to support him and he was referred to the local hospice. His named nurse regularly reviewed his needs and access to medication.

5. In early October 2016, Mr Roose began to struggle with his breathing and healthcare staff helped him until his breathing improved. On 10 October, healthcare staff sent Mr Roose to hospital, as they were concerned about his breathing.

6. Mr Roose's condition continued to deteriorate and he died in hospital on 12 October.

Findings

7. We agree with the clinical reviewer that the care Mr Roose received at Erlestoke was at least equivalent to that he could have expected to receive in the community. We agree with the clinical reviewer that there was no obvious missed opportunity to make an earlier diagnosis.

8. Despite repeated requests, the prison failed to provide risk assessments for Mr Roose to provide evidence of decisions taken on the use of restraints during his hospital visits. The Safer Custody department provided a timeline, which noted that staff restrained Mr Roose after his health deteriorated. We therefore assume that escort staff restrained him during his chemotherapy treatment but we do not know on what basis the decision to do so was made and whether it was justified.

9. After Mr Roose's diagnosis, the prison appointed a family liaison officer to support Mr Roose and his family. They did not keep a record of interactions with

Mr Roose's next of kin and family after his diagnosis or in the days following his death. We are therefore unable to assess the quality of family liaison.

10. In July, Erlestoke completed an application for Mr Roose's compassionate release, which was rejected. As Mr Roose's health deteriorated, there was no record that another application was completed.

Recommendations

- 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 Governor should ensure that, in line with PSI 58/2010, the Prison and Probation Ombudsman is promptly provided with all requested documents following a death in custody.
- The Governor should ensure that the appointed family liaison officer keeps comprehensive records, which detail all interactions with the next of kin, from the date they are appointed.
- The Governor should ensure that applications for early release on compassionate grounds are submitted without delay, kept under review and reconsidered quickly when a terminally ill prisoner's condition deteriorates.

The Investigation Process

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

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

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

14. We informed HM Coroner for Wiltshire and Swindon of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.

15. One of the Ombudsman's family liaison officers contacted Mr Roose's friend, to explain the investigation and to ask if she had any matters they wanted the investigation to consider. Mr Roose's friend wanted to know why Mr Roose was not granted compassionate release, why it took nearly five hours for Mr Roose to arrive at hospital after the ambulance was called and whether this delay contributed to his death.

16. The investigation has assessed the main issues involved in Mr Roose'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.

17. Mr Roose's friend received a copy of the initial report. They pointed out an omssion. This report has been amended accordingly.

18. The initial report was shared with the Prison Service. The Prison Service provided further evidence after the investigation closed.

Background Information

HMP Erlestoke

19. HMP Erlestoke is a medium security prison near Devizes in Wiltshire, which holds around 500 men. Since 1 April 2016, the InspireBetterHealth partnership has provided health services at the prison with Bristol Community Health providing the general nursing care. The Great Western Hospital Healthcare Trust and Avon and Wiltshire Mental Health Partnership provided healthcare prior to 1 April 2016.

20. Healthcare is available between 8.00am and 5.00pm on weekdays and 7.30am and 1.30pm on weekends. During each shift, a GP, three nurses and two healthcare assistants are available. No healthcare staff are available overnight, although Medvivo provides an out of hours GP service.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Erlestoke was in October 2013. Inspectors found that the health services at the prison were good and prisoners were satisfied with the care they received. Healthcare services were available each weekday with out of hours services provided for evenings and weekends. The prison assigned older prisoners with chronic diseases to a named nurse and clinical records were generally good.

Independent Monitoring Board

22. 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 31 March 2016, the IMB reported that The Great Western Hospital Healthcare Trust and Avon and Wiltshire Mental Health Partnership had provided inadequate healthcare cover during the reporting year.

Previous deaths at HMP Erlestoke

23. Mr Roose was the first prisoner to die of natural causes at HMP Erlestoke since January 2015.

Findings

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

24. On 23 December 1985, Mr Gerald Roose was sentenced to life imprisonment for attempted murder. He spent time at a number of prisons and had been at HMP Guys Marsh since 16 September 2013.

25. Mr Roose had a previous history of joint and bone pain and had complained to healthcare staff on numerous occasions of pain in his arm, right side, hip and lower back.

26. On 14 September 2015, Mr Roose attended an appointment at hospital, although there was no record in Mr Roose's medical record of when this referral was made. The healthcare practitioner did not see any signs of cancer and a pelvic x-ray taken at the appointment was unchanged from those previously taken. The practitioner arranged an MRI scan (magnetic resonance imaging uses radio waves and a magnetic field to create detailed images of organs and tissues within the body) six weeks later.

27. On 6 October 2015, a nurse saw Mr Roose after he complained of pain under his right arm and around his ribs. He told the nurse that the pain was a constant sharp pain that was worse when he moved. The nurse referred him to a prison GP but Mr Roose did not attend the appointment. The nurse saw Mr Roose again on 16 October, after he complained of chronic shoulder pain. He examined Mr Roose and noted that there was no visible bruising or swelling but movement was limited. He booked Mr Roose an appointment with a prison doctor.

28. On 22 October, Mr Roose attended hospital for the MRI scan on his lower spine. A prison GP noted that the scan showed a mass on Mr Roose's lung. She made an urgent referral under the NHS pathway, which requires patients with suspected cancer to be seen by a specialist within two weeks. A prison administrator sent the urgent referral.

29. The prison GP informed Mr Roose that he had a tumour in his lung that had spread to the bones in his back, on 23 October. She told Mr Roose that he would receive full support from prison healthcare and the respiratory team. She then prescribed him naproxen (an anti-inflammatory used to treat pain and inflammation) for pain relief.

30. On 26 October, Mr Roose told a nurse that he was worried about his recent cancer diagnosis. He reported pain in the right side of his chest but said that he did not want to take any pain relief that was stronger than the naproxen he had already been prescribed.

31. On 4 November, a nurse noted Mr Roose's cancer was incurable but there was symptomatic relief that would help with the pain he had in his side and back.

32. The clinical reviewer concluded that although the diagnosis was a chance finding, HMP Guys Marsh had not missed an opportunity to make a diagnosis earlier.

Clinical staff referred Mr Roose appropriately in order to manage his joint pain and he was informed of his diagnosis in a supportive and timely manner.

Mr Roose's clinical care

33. After his diagnosis Mr Roose was referred to the mental health team. A consultant psychiatrist saw him and offered to prescribe him antidepressants but he declined this. The psychiatrist noted Mr Roose had the capacity to make this decision.

34. Mr Roose began chemotherapy at hospital on 25 November. A nurse noted that he was aware of his options and consented to treatment.

35. On 9 December, Mr Roose was transferred to HMP Erlestoke in order to be in closer proximity to the hospital providing chemotherapy. A nurse referred him to the palliative care service at a hospice on 30 December. She requested input from a specialist nurse in order to support Mr Roose's palliative care.

36. On 7 April 2016, a prison GP conducted an in-depth cancer review with Mr Roose, which covered pain relief, mobility, spiritual care and family involvement. They also discussed resuscitation and Mr Roose said he did not with anyone to resuscitate him if his heart or breathing stopped. The GP requested he sign an order to that effect, although Mr Roose changed his mind. The GP again asked about resuscitation on 14 April, but Mr Roose remained undecided.

37. Mr Roose's health continued to deteriorate and on 6 May a prison GP opened a care plan and requested the involvement of a family liaison officer.

38. On 28 June, Mr Roose told a nurse that he wanted to be resuscitated. The nurse informed him that a doctor may decide that resuscitation would be unsuccessful but recorded his wishes. He also arranged for the prison to provide Mr Roose with a lock box, so he could access his medication when healthcare was closed.

39. On 4 August, a prison GP saw Mr Roose for a review. He increased Mr Roose's dose of nortriptyline (used to treat nerve pain) and prescribed oramorph (morphine based pain relief). The GP arranged for Mr Roose to have fortnightly reviews with a nurse.

40. Two days later, a nurse saw Mr Roose to discuss a recent loss of medication. Staff were concerned he may be vulnerable to being bullied so, on 12 August, Mr Roose was relocated to a cell on another wing. Staff planned to escort Mr Roose to his previous wing to collect his medication; however, on 16 August, he told the nurse that he did not want his oramorph medication.

41. A prison GP saw Mr Roose on 9 September to discuss resuscitation and explained the possibility of it causing distress. Mr Roose agreed not to be resuscitated and the form was completed. However, after Mr Roose was admitted to hospital with a chest infection on 18 September, he denied knowledge of agreeing to the form being completed and stated he wanted to be actively resuscitated.

42. On 7 October, the hospital discharged Mr Roose back to Erlestoke. A nurse saw him the same day and noted that he appeared unsteady on his feet. She asked

him if he would prefer to be located in a disabled wing but he declined. She also noted that Mr Roose wanted to be resuscitated and that staff needed to call for an ambulance in the event of an emergency.

43. The following day, a nurse examined Mr Roose as he was struggling to breathe. Mr Roose had already taken his medication and she noted that his symptoms were beginning to ease. She assisted Mr Roose until he was able to breathe without difficulty and requested that another nurse attend later that day to review Mr Roose's care and medications. This nurse reviewed Mr Roose several times during the day. She administered his medications and advised wing staff in relation to Mr Roose's palliative care.

44. On 10 October, a nurse saw Mr Roose after wing staff informed her he was having difficulty breathing. She decided to call an ambulance to take Mr Roose to hospital. Erlestoke called an ambulance at 2.33pm, although the ambulance service operator confirmed that the situation was not an emergency and that the ambulance would aim to arrive within an hour. After the ambulance did not arrive, the prison contacted the Ambulance Service again at 3.57pm, although the ambulance operator reiterated that the situation was still not an emergency and that they were very busy. At 5.42pm, the prison called again after the ambulance failed to arrive. The prison requested a "blue light ambulance" signalling an emergency, and said that Mr Roose was a cancer patient who was very ill and needed to be taken to hospital. The ambulance arrived at 6.05pm and left Erlestoke at 6.45pm. He was admitted to hospital. While waiting for the ambulance, healthcare staff supported Mr Roose to ensure that he was as comfortable as possible.

45. Mr Roose's condition did not improve and Mr Roose died at 7.51am on 12 October.

46. The clinical reviewer concluded Mr Roose received a good standard of care while at Erlestoke. His clinical needs were met and there was sufficient planning for his care as he deteriorated.

47. Although there was a significant passage of time before an ambulance arrived to take Mr Roose to hospital on 10 October, responsibility for this lies with the South West Ambulance Service so the matter falls outside the remit of our investigation. We are satisfied that prison healthcare staff appropriately supported Mr Roose during this delay and that they made regular attempts to obtain an ambulance.

Mr Roose's location

48. Guys Marsh transferred Mr Roose to Erlestoke on 9 December 2015, in order to be closer to the hospital which provided his treatment.

49. On 17 June 2016, a prison GP asked Mr Roose if he would like to be transferred to a palliative care unit at HMP Exeter. Mr Roose declined and said he wanted to be closer to his next of kin.

50. On 9 September, Mr Roose told the GP that he wanted to move to HMP Leyhill for palliative care, after the GP became concerned about his deteriorating health. A decision was not made about this transfer before Mr Roose's death although, on 5 October, the Head of Healthcare at Leyhill requested further details about

Mr Roose and told a nurse he would need to be assessed prior to being transferred to Leyhill. Mr Roose's condition deteriorated and he went to hospital before being assessed.

51. We are satisfied that Mr Roose was appropriately accommodated while at Erlestoke and that appropriate efforts were made to transfer him to an establishment able to provide palliative care.

Restraints, security and escorts

52. 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.

53. Despite repeated requests during the investigation, Erlestoke failed to provide us with the risk assessments to cover attendance at hospital for chemotherapy treatment. Instead, the prison provided a timeline that recorded Mr Roose as being restrained in hospital after his health deteriorated on 17 September, though restraints were reviewed and removed on 19 September. Erlesoke then provided the risk assessments after the investigation concluded. The risk assessments for 15 hospital visits from 16 December 2015 to 17 September 2016 show Mr Roose was restrained during chemotherapy treatment, despite his wheelchair use and declining health.

54. Mr Roose was taken to hospital on 10 October and the bed watch records confirm that he was not restrained at any point up to his death.

55. Security measures must be proportionate to a prisoner's circumstances, and must be fully considered, and balanced against the actual risk they pose. After reviewing the risk assessments provided, we are concerned that Mr Roose was restrained during his chemotherapy treatment. In line with the 2007 High Court judgment so 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.

56. Prison Service Instruction (PSI) 58/2010 contains a mandatory instruction that "when the PPO is carrying out investigations or enquiries that staff comply with requests for information and assistance". Throughout our investigation, the investigator asked various members of staff, including the Governing Governor,

for copies of the risk assessment documents. However, these were not supplied until the investigation concluded. We make the following recommendation:

The Governor should ensure that, in line with PSI 58/2010, the Prison and Probation Ombudsman is promptly provided with all requested documents following a death in custody.

Liaison with Mr Roose's family

57. PSI 64/2011 states prisons must ensure that arrangements are in place for an appropriate member of staff to engage with the next of kin or a nominated person of prisoners who are either terminally or seriously ill. The PSI also states that a log book must be opened that records all interactions with a family.

58. Erlestoke appointed an officer as the family liaison officer on 3 June, after he attended a meeting with Mr Roose and healthcare in relation to his palliative care. During the meeting, Mr Roose told staff that his family were aware of his diagnosis. He was assigned to liaise between Mr Roose and his daughter. However, he did not keep a record of his involvement or his interactions with Mr Roose's family.

59. As the officer was on leave when Mr Roose died, we would have expected the prison to have appointed an interim family liaison officer and recorded interactions with Mr Roose's family and next of kin. Erlestoke said they appointed a prison chaplain to act as the family liaison officer in the officer's absence and that he had contact with the family. However, there is no evidence to support this. After he returned on 17 October, he recorded that he had collected Mr Roose's Will and passed it on to the chaplaincy to discuss with Mr Roose's family. Although Erlestoke appointed a family liaison officer in his absence, records do not show what support they offered the family.

60. Mr Roose's funeral was held on 17 November. Staff at HMP The Verne arranged the funeral, as Mr Roose had requested before his death, and Erlestoke contributed to the cost, in line with national instructions.

61. In light of the lack of documentation, we cannot be satisfied that appropriate family liaison has taken place. For that reason, we make the following recommendation:

The Governor should ensure that the appointed family liaison officer keeps comprehensive records, which detail all interactions with the next of kin, from the date they are appointed.

Compassionate release

62. Release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months can be permanently released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. The criteria for early release for determinate sentenced prisoners are set out in Prison Service Order (PSO) 6000. Among the criteria is that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release

would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of the National Offender Management Service (NOMS).

63. Erlestoke submitted an application for Mr Roose's compassionate release on 4 July. On 9 August, an offender supervisor informed Mr Roose his application had been rejected. PPCS rejected the application because Mr Roose's prognosis was more than three months, there was still a risk of reoffending, his offender manager did not support the application and his medical treatment could continue while in custody. Mr Roose did not provide a release address and Erlestoke also did not provide a risk management plan for Mr Roose.

64. In September, Mr Roose told prison staff that he wanted his compassionate release to be reconsidered. On 16 September 2016, PPCS stated that an appropriate address needed to be supplied for Mr Roose's release, before they considered his application. Erlestoke decided to concentrate their efforts on moving Mr Roose to another prison with 24 hour healthcare instead. PPCS confirmed that they did not receive another application when Mr Roose's health deteriorated.

65. There is no evidence that Erlestoke did try to find another alternative address after 16 September. We would expect them to do this for the purposes of early release on compassionate grounds, while at the same time arranging the move to Leyhill for palliative care, in case an address could not be found. We make the following recommendation:

The Governor should ensure that applications for early release on compassionate grounds are submitted without delay, kept under review and reconsidered quickly when a terminally ill prisoner's condition deteriorates.

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