

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Darren Willis a prisoner at HMP Wymott on 14 April 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 Darren Willis died on 14 April 2016 of lung cancer while a prisoner at HMP Wymott. He was 47 years old. I offer my condolences to Mr Willis' family and friends.

The investigation found that Mr Willis received good care at HMP Wymott, with appropriate and timely referrals to secondary care, and close liaison with palliative specialists. Staff at the prison treated Mr Willis with compassion and dignity during his illness and I am satisfied that he received care equivalent to that he could have expected to receive in the community.

However I am concerned that the use of restraints when Mr Willis went to hospital was not always appropriately justified and that there was a delay in considering his application for compassionate release.

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

November 2016

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Summary

Events

1. On 2 April 2014, Mr Darren Willis was remanded to HMP Manchester for violent offences. He was sentenced to eight years in prison on 22 September. Mr Willis was moved to HMP Wymott on 13 April 2015.
2. On 15 October, a nurse saw Mr Willis as he complained of a cough lasting for approximately five weeks and had coughed up some specks of blood. The nurse referred Mr Willis to the prison GP. Five days later, the GP examined Mr Willis, gave him an inhaler and referred him for an urgent chest X-ray. The results showed patchy atelectasis (a condition where parts of the lungs do not inflate properly), which resolved naturally. A further X-ray, on 24 December, showed that the right hand hila (the lung roots that consist mainly of arteries and veins) was enlarged and dense.
3. On 25 December, Mr Willis had a massive haematemesis (vomiting blood); he suffered a cardiac arrest and was taken to hospital. While in hospital, doctors performed a bronchoscopy (a test to examine the windpipe and part of the lungs) and a CT scan, which revealed two tumours in Mr Willis' right lung. The hospital discharged him back to Wymott on 6 January 2016.
4. On 22 January, the hospital referred Mr Willis to a hospice for palliative care. Three days later, Mr Willis started radiotherapy treatment for his lung cancer.
5. On 29 March, 3 April and 7 April, Mr Willis was taken to hospital following further episodes of haematemesis.
6. On 13 April, Mr Willis suffered another episode of haematemesis and was admitted to hospital. The following morning, Mr Willis suffered a coughing fit, which resulted in a massive bleed, and he died at 5.20am.

Findings

7. We are satisfied that Mr Willis received a good standard of healthcare at the prison and staff treated him with compassion, dignity and respect. Mr Willis was appropriately involved in decisions about his care. There was a close working relationship with the hospital. We consider that Mr Willis' care was equivalent to that he could have expected to receive in the community.
8. We are concerned that the use of restraints when Mr Willis went to hospital was not always fully justified. We are also concerned that there was a delay in considering his application for compassionate release.

Recommendations

- The Governor and Head of Healthcare should ensure that staff undertaking risk assessments for prisoners taken to hospital understand the legal position, 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 applications for early release on compassionate grounds are completed and appropriately considered without delay and revisited as a prisoner's condition deteriorates.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Wymott 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 Willis' prison and medical records.
11. NHS England commissioned a clinical reviewer to review Mr Willis' clinical care at the prison.
12. We informed HM Coroner for Lancashire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
13. One of the Ombudsman's family liaison officers contacted Mr Willis' partner (his nominated next of kin) and his sister, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. His partner wanted the investigation to look at his medication management, whether he had made any formal complaints about this and if they were investigated. She also wanted the investigation to look at the management of any pastoral needs he had from the time of his diagnosis. His sister did not raise any specific issues.
14. The investigation has assessed the main issues involved in Mr Willis' 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.
15. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.
16. Mr Willis' partner and his sister received copies of the initial report. They did not make any comments.

Background Information

HMP Wymott

17. HMP Wymott is a medium secure prison holding over 1,100 adult men. Lancashire Care NHS Foundation Trust provides healthcare services at the prison. A private company provides GP services and out of hours medical cover. There are no inpatient beds, but there is 24-hour nursing cover.

HM Inspectorate of Prisons

18. The most recent inspection of Wymott was in July 2014. Inspectors reported that the quality of healthcare was reasonably good, but undermined by long delays and poor access to GPs. The range of clinics provided reflected the needs of the prison population and included clinics for chronic diseases. Pharmacy services needed improvement to ensure that prisoners received their medication on time. Inspectors reported that the wing for older prisoners and those with disabilities provided excellent care.

Independent Monitoring Board

19. 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 2015, the IMB reported ongoing problems with the supply of medication and a severe shortage of nurses. The IMB was also concerned about difficulties in prisoners getting GP appointments, unclear waiting times and that the process for notifying prisoners of their appointments was ineffective. The wings for elderly and disabled prisoners had access to a specialist regime.

Previous deaths at HMP Wymott

20. Mr Willis was the fourth prisoner to die of natural causes at Wymott since January 2015. There were no similarities between these deaths.

Findings

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

21. On 22 September 2014, Mr Willis was sentenced to eight years in prison for violent offences. He had been at HMP Wymott since 13 April 2015. Mr Willis' spleen had been removed in 1998, which put him at an increased risk of infections, though clinicians treated this with lifelong antibiotic treatment.
22. Mr Willis complained to the prison's pharmacy services, on 23 August, as he had not received his daily penicillin doses. The prison acknowledged that this mistake had been caused by staff miscommunication and they resolved it in early September by issuing a new, four weekly repeat prescription. Mr Willis did not submit any other formal complaints about his healthcare.
23. On 15 October, Mr Willis told a nurse that he had been coughing up blood and had a persistent cough for the last five weeks. She noted that Mr Willis did not have any shortness of breath but considered he might be suffering with a chest infection and referred him to a GP.
24. On 20 October, a locum GP reviewed Mr Willis, who said he had a chesty cough for six weeks. Mr Willis said that he had not suffered any weight loss and confirmed that he smoked ten cigarettes a day. The GP examined Mr Willis and noted that he had a few scattered wheezes on his chest. He prescribed him an inhaler to assist Mr Willis' breathing and referred him for an urgent blood test and chest X-ray. The X-ray, on 21 October, showed that he had patchy atelectasis (a condition where parts of the lungs do not inflate properly). The blood test results were normal. The hospital arranged a follow-up X-ray.
25. On 10 November, Mr Willis started on the prison's smoking cessation programme, as he wanted to stop smoking in light of his chest problems. A healthcare assistant gave him nicotine patches and an inhalator to hold a nicotine cartridge.
26. A follow up chest X-ray took place on 30 November, which showed that Mr Willis' lungs were clear and that the atelectasis was resolved. However the hospital arranged another follow-up X-ray for 24 December. This showed that the right hand hila (the lung roots that consist mainly of arteries and veins) were enlarged and dense. Hospital staff referred Mr Willis to a lung specialist.
27. At 5.02am on 25 December, a nurse attended Mr Willis' cell as he had vomited approximately one to two litres of blood. She found that he was unresponsive, pale, clammy, and she was unable to find a pulse. She and other staff started cardiopulmonary resuscitation (CPR). An automated external defibrillator (AED) advised no shock, so they continued CPR and requested an ambulance. At approximately 5.20am, Mr Willis started breathing and his pulse returned. Paramedics arrived at 5.40am and took him to hospital.
28. Mr Willis spent four days at hospital before moving to another hospital. On 4 January 2016, doctors performed a bronchoscopy and a CT scan, which found two tumours in his right lung. They took biopsies to see if they were cancerous.

29. Two days later, the hospital discharged Mr Willis back to Wymott and confirmed that they were planning to discuss his biopsy results at a lung cancer multidisciplinary meeting. The hospital also confirmed that if Mr Willis experienced any more bleeding then he should return to hospital immediately.
30. On the same day, a locum GP saw Mr Willis and discussed his potential diagnosis of lung cancer. The GP also prescribed tramadol (pain relief), co-amoxiclav (an antibiotic) and dexamethasone (a steroid).
31. At about 7.00am on 20 January, a nurse was called to Mr Willis' cell, as he had coughed up approximately one litre of blood. An ambulance was called and paramedics took Mr Willis to hospital at 7.12am.
32. While in hospital, on 22 January, doctors referred Mr Willis to a hospice for symptom control for pain in his lower left ribcage. Mr Willis was concerned about the pain because it caused him to cough and he was worried that it would cause him to vomit more blood and staff reassured him. Three days later, Mr Willis also started a course of palliative radiotherapy.
33. On 4 February, a consultant clinical oncologist reviewed Mr Willis and diagnosed him with squamous cell carcinoma (cancer) in his right lung. In a letter to the prison, the consultant said that 'on paper' his lung cancer was curable but that due to Mr Willis' poor condition and large bleeds, he was not a candidate for chemotherapy. The consultant said that palliative radiotherapy could stop the bleeding in his lung, although he made Mr Willis aware that there was a small risk that it could also cause a massive bleed. He told Mr Willis that his life expectancy was a matter of months not years. Hospital clinicians prescribed Mr Willis tranexamic acid medication (to help prevent haematemesis - coughing up blood) and oxynorm (pain relief).
34. The clinical reviewer was satisfied that prison clinicians appropriately referred Mr Willis for a chest X-ray in line with National Institute for Health and Care Excellence (NICE) guidelines and there was no delay in diagnosis. He was well informed and supported throughout the investigations by both prison and hospital staff.

Mr Willis' clinical care

35. On 8 February, Mr Willis returned to Wymott and a doctor from the hospice met with him to discuss his pain relief and pastoral needs.
36. On 13 February, a member of healthcare staff arranged a soft diet for Mr Willis, as he was struggling to take food and drink. On the same day, Mr Willis also made a request for oxynorm as he had run out. Staff made special arrangements with hospital oncologists for an emergency prescription.
37. On 18 February, a meeting took place between healthcare staff and the chaplaincy team to discuss how best the prison could provide pastoral and mental health support to Mr Willis. Mr Willis was referred to a psychotherapist and was supported to continue to engage with the mental health team. It was noted that Mr Willis was already engaging with the chaplaincy team.

38. Throughout February, March and April, regular meetings took place between prison healthcare staff and hospice staff. This included reviewing Mr Willis' medication, to ensure effective management of his pain relief and symptom control.
39. On 8 March, a nurse asked Mr Willis about his resuscitation wishes and he said that he did not want anyone to resuscitate him if his heart or breathing stopped. Two days later, Mr Willis repeated this and agreed to an order to that effect. However, on 12 March, he changed his mind and this was noted in his medical records.
40. On 15 March, following a brief meeting with a mental health nurse, Mr Willis decided he did not want any further support from mental health services.
41. On 17 March, a doctor from the hospice saw Mr Willis, who complained about lower back pain. This was a new pain and the doctor referred him for an urgent MRI scan, as she was concerned that the pain could be due to malignant spinal cord compression (when cancer spreads to the spine and presses on the spinal cord and nerves). The next day, Mr Willis went to hospital for the scan but discharged himself before it took place as he did not want to wait. As Mr Willis had an appointment with his consultant oncologist on 22 March, healthcare staff decided not to reschedule the MRI scan.
42. Mr Willis saw the oncologist on 22 March, but there is no record of whether the MRI scan was rescheduled.
43. On 29 March, 3 April and 7 April, Mr Willis coughed up blood. Each time, he received immediate care from the nursing team and went to hospital.
44. On 4 April, Mr Willis told a doctor from the hospice that he was not receiving his tranexamic acid medication. Staff noted that this was something Mr Willis held in his possession. They checked his cell and found three boxes of the medication. The doctor considered Mr Willis was confused about when to take it and discussed ways to ensure he took the medication. Mr Willis agreed that nurses would give him this medication in future.
45. On 7 April, a psychotherapist saw Mr Willis. He was concerned about the impact his illness was having on his partner, his loss of appetite and difficulty in sleeping. A doctor prescribed zispin (a mild anti-depressant).
46. On 11 April, a nurse reviewed Mr Willis' pain relief regime and suggested a transfer to HMP Preston, which has an inpatient unit, where he could be monitored 24 hours. Mr Willis said he did not want to move and he was receiving his pain relief regularly.
47. At approximately 12.00am on 13 April, a nurse attended Mr Willis' cell, as he had coughed up blood. She assessed this was about approximately 700ml, gave him oxygen and asked for an ambulance. Paramedics arrived and took him to hospital.
48. The hospital admitted him, and he continued to cough up blood. Mr Willis' condition did not improve and, after a massive bleed following a coughing fit, he died at 5.20am on 14 April.

49. We agree with the clinical reviewer that Mr Willis received a high standard of healthcare following his diagnosis, with appropriate and timely referrals to hospital when needed and close liaison with palliative specialists. Mr Willis was appropriately involved in decisions about his care and there was a close working relationship with the hospital. Staff at the prison treated Mr Willis with compassion and dignity during his illness. We are satisfied that the care Mr Willis received was equivalent to that he could have expected to receive in the community.

Mr Willis' location

50. When Mr Willis first moved to Wymott, he moved to a normal prison wing. As his condition deteriorated, healthcare staff offered him a transfer to the elderly and disabled unit, but he declined this as he had formed friendships on his existing wing.
51. Healthcare staff also offered him the opportunity to move to the inpatient unit at HMP Preston, where he would have the opportunity to access 24-hour inpatient healthcare. Mr Willis refused this because of the friendships that he had formed at Wymott.
52. We are satisfied that staff appropriately considered Mr Willis' location throughout his illness and took account of his wishes.

Restraints, security and escorts

53. 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.
54. We note that there is no clear level of risk shown on Wymott's escort risk assessments in relation to risk to the public, to staff and of escape. When Mr Willis was admitted to hospital on 20 January, a senior prison manager authorised officers to restrain Mr Willis with 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.) This was despite the healthcare section of the risk assessment indicating that Mr Willis was incapacitated as a result of his condition, had a life threatening condition and there were medical objections to the use of restraints. Later the same day, another prison manager (it is unclear who) authorised the restraints to be removed.
55. Mr Willis remained in hospital and, on 5 February, the senior prison manager reviewed the restraints and authorised officers to restrain Mr Willis with an escort chain again. The records are incomplete and there was no healthcare input, but

this was the day after Mr Willis had received his terminal diagnosis and it is clear from health records that he was very unwell.

56. Throughout the rest of February, March and early April, Mr Willis attended hospital either for appointments or because he was unwell a further eight times (three of these were with further bleeds). Each time there was healthcare input into the risk assessment and no objection to the use of restraints. Prison managers approved the use of handcuffs en route and an escort chain in hospital that was removed for treatment.
57. The last time Mr Willis went to hospital was on 13 April, when he suffered another bleed. There was healthcare input into the risk assessment and no objection to the use of restraints. A prison manager approved the use of handcuffs en route and an escort chain at the hospital. Later the same day, a senior prison manager authorised officers not to restrain Mr Willis because he was on the palliative care register and his mobility was limited. He was not restrained again.
58. Public protection is critical, but security measures must be proportionate to a prisoner's individual circumstances, which must be fully considered, taken into account and balanced against the security risks. We are satisfied that there was healthcare input into almost all risk assessments but unclear on the extent to which the criteria set out in the court judgement were applied. There was only one occasion on 20 January, when clinicians objected to the use of restraints and considered his condition impacted on his risk of escape. Every other time, the risk assessments show healthcare staff considered his condition did not impact on his risk of escape (by ticking a box). We understand that on some occasions restraints may have been justified. However we do not understand why the prison did not consider that Mr Willis' risk of escape had diminished when he went to hospital several times having coughed up significant volumes of blood and therefore think it unlikely that restraints were justified every time he went to hospital.
59. Ultimately, it is the Governor's responsibility to ensure that the process is managed properly, but the Head of Healthcare also needs to ensure that healthcare staff understand their responsibilities and have appropriate and considered input into the risk assessment process. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff undertaking risk assessments for prisoners taken to hospital understand the legal position, 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.

Liaison with Mr Willis' family

60. Mr Willis had named his partner as his next of kin. On 20 January 2016, the prison appointed the prison chaplain to act as their family liaison officer. He contacted Mr Willis's partner that day and explained his role and offered support. He kept in contact with Mr Willis' partner and updated her on his condition.

61. After Mr Willis died, the prison chaplain and a prison manager visited Mr Willis' partner at home to inform her and to offer their condolences and support.
62. Mr Willis' funeral was on 17 May. The prison contributed towards the costs in line with national Prison Service policy.
63. We are satisfied that there was appropriate contact with Mr Willis' next of kin, who was well informed and supported by prison staff.

Compassionate release

64. 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).
65. On 26 January, the prison started an application for compassionate release and a prison GP provided information on Mr Willis' current health. Three days later, a probation officer provided information on his level of risk. However, a Governor did not consider the application until 11 March. He decided not to recommend release or progress the application at that time based on the nature of Mr Willis' offending history.
66. We note that offending history is not among the eligibility criteria governing release on compassionate grounds and we are concerned about the length of time it took for the Governor to consider the application. We are also concerned that the application was not revisited as Mr Willis deteriorated. We make the following recommendation:

The Governor should ensure that applications for early release on compassionate grounds are completed and appropriately considered without delay and revisited as a prisoner's condition deteriorates.

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