Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Ratcliffe a prisoner at HMP Dartmoor on 7 November 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 Ratcliffe died on 7 November 2016, of a bacterial infection relating to liver cancer and liver disease while a prisoner at HMP Dartmoor. He was 68 years old. I offer my condolences to Mr Radcliffe's family and friends.

I am satisfied that generally Mr Ratcliffe received a reasonable standard of care at the prison, equivalent to that which he could have expected to receive in the community. However, I make a number of recommendations that are not related to Mr Ratcliffe's death, but which I refer for the attention of the Head of Healthcare.

It was unfortunate that the legal document, the do not resuscitate form, was incorrectly completed which may have affected decisions made by paramedics and healthcare staff on 3 September.

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. On 8 October 2015, Mr David Ratcliffe was sentenced to 12 years imprisonment for sexual offences and went to HMP Exeter. On 16 October, he transferred to HMP Dartmoor.

2. Mr Ratcliffe had a complex medical history and suffered poor health throughout his stay at Dartmoor. He attended numerous hospital appointments for diagnosis and treatment.

3. On 21 September, a prison GP saw Mr Ratcliffe in his cell. His abdomen was bloated and very painful. The doctor arranged for him to go to hospital, where an ultrasound scan identified end-stage liver cirrhosis with ascites (a build up of fluid in the abdominal cavity).

4. A consultant palliative care doctor at the hospital told Mr Ratcliffe that he had chronic liver disease and liver cancer. She told him that the cancer was in-operable and treatment restricted to pain relief.

5. On 9 October, Mr Ratcliffe went back to hospital. Healthcare staff telephoned the hospital for regular updates. On 7 November, Mr Ratcliffe died from of a bacterial infection relating to liver cancer and liver disease in hospital.

Findings

6. Overall the clinical reviewer was satisfied that the care Mr Ratcliffe received was equivalent to that he could have expected to receive in the community.

7. However we are concerned that the Do Not Attempt Resuscitation form, completed on 9 May, was incorrectly written and consequently invalid. This could have had an impact on his future care.

Recommendations

- **Doctors should take care when completing legal documents, such as Do Not Resuscitate forms, since incorrect details may invalidate the document.**

The Investigation Process

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

9. The investigator obtained copies of relevant extracts from Dartmoor's prison and medical records.

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

11. We informed HM Coroner for Torbay and South West Devon District of the investigation, who gave us the cause of death. We have sent the coroner a copy of this report.

12. The investigation has assessed the main issues involved in Mr Ratcliffe'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.

13. We shared the initial report with the Prison Service. There were no factual inaccuracies.

Background Information

HMP Dartmoor

14. HMP Dartmoor holds up to 640 adult male prisoners. The prison comprises six residential wings. Dorset Healthcare Unit Foundation Trust provides the prison's healthcare. Healthcare staff are on duty between 8.00am and 6.00pm on weekdays and between 8.30am and 5.15pm at weekends.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Dartmoor was in December 2013. Inspectors found the delivery of health services had improved with a small but well qualified team of healthcare staff delivering a wide range of clinics. Seven GP clinics were delivered each week.

Independent Monitoring Board

16. 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 September 2015, the IMB reported that the healthcare provider at Dartmoor had changed, though the new provider still suffered with a shortage of nursing staff. This meant that doctors had to complete tasks that should be done by nurses. The IMB noted that the ageing prison population's more complex and often chronic health conditions resulted in an increased attendance at a range of outpatient appointments and increased age related checks.

Previous deaths at HMP Dartmoor

17. Mr Ratcliffe was the fourth prisoner to die of natural causes at Dartmoor since November 2015. There were no similarities between the circumstances of Mr Ratcliffe's death and previous deaths at the prison.

Key Events

18. On 8 October 2015, Mr David Ratcliffe was sentenced to 12 years in prison for sexual offences and sent to HMP Exeter. On 16 October, he transferred to HMP Dartmoor.

19. Mr Ratcliffe had asthma, type 2 diabetes, heart disease, hypertension, chronic obstructive pulmonary disease (a group of lung conditions) and anaemia. He was prescribed medication for his various medical conditions which he continued to take at Dartmoor. Mr Ratcliffe went to hospital on a number of occasions to monitor and treat these conditions.

20. On 5 November, Mr Ratcliffe told a locum GP that he was struggling to climb stairs to get his medication. From the results of a blood test taken three days earlier, the GP confirmed that Mr Ratcliffe had iron deficiency anaemia. Mr Ratcliffe also said he had problems with rectal bleeding and had been coughing up blood. The GP planned to review Mr Ratcliffe in two weeks.

21. However, on 10 November, a prison GP examined Mr Ratcliffe, who continued to report passing blood. He immediately referred Mr Ratcliffe to gastroenterology under the two week fast track referral system (the NHS pathway that requires patients with suspected cancer to be seen by a specialist within two weeks).

22. On 17 November, as a result of the two week referral, a nurse examined Mr Ratcliffe at hospital. As a result of her examination she referred Mr Ratcliffe for a colonoscopy (a fibre optic examination of the large intestine) and a gastroscopy (a gastroscope is an instrument used to examine or view the interior of the stomach). He returned to Dartmoor with iron tablets.

23. On 4 December, Mr Ratcliffe attended hospital to have the colonoscopy and an endoscopy procedure (an endoscopy is a long flexible tube that looks inside the body). Unfortunately, as he had consumed a drink, the booked procedure was not completed.

24. On 9 December, a prison GP reviewed Mr Ratcliffe and noted that the iron deficiency anaemia was much improved but still present.

25. On 18 December, Mr Ratcliffe had the endoscopy procedure performed at hospital. A polyp was located on the intestine. A biopsy later confirmed that it was not cancerous.

26. On 22 February 2016, following blood, urine and liver function tests, a prison GP recorded that Mr Ratcliffe's iron deficient anaemia had been resolved.

27. On 4 May, a nurse examined Mr Ratcliffe after he had reported having chest pains for three days. Staff called an ambulance and Mr Ratcliffe went to hospital and was admitted. A doctor diagnosed Acute Coronary Syndrome (a range of heart problems caused by a sudden reduction of blood flow to part of the heart muscle). Mr Ratcliffe returned to Dartmoor on 9 May, with medication for angina and hypertension.

28. On 18 May, healthcare staff took a blood sample from Mr Ratcliffe and tested for urea and electrolytes (a kidney function measurement). A prison GP reviewed the results that indicated Mr Ratcliffe had a chronic kidney disease.

29. On 19 May, Mr Ratcliffe again, complained of chest pains and was admitted to hospital. A doctor diagnosed GORD (acid from the stomach leaking into the oesophagus) and he was discharged the next day.

30. On 23 May, Mr Ratcliffe again complained of chest pains, but refused to go to hospital against the advice of healthcare staff.

31. On 27 May 2016, Mr Ratcliffe told a prison GP he did not wish anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect

32. On 30 June, Mr Ratcliffe had an ultrasound scan (a device that creates an image of part of the inside of the body) on his kidneys. The scan showed that he had a shrunken possibly non functioning left kidney. A member of healthcare staff sent the results to his consultant at the hospital, who upon receipt later referred him to the nephrology team (kidney specialists).

33. On 3 July, a nurse went to the wing and spoke to Mr Ratcliffe. He was feeling uncomfortable and pointing to his liver area. His vital observations were within the normal range and she asked the wing officers to monitor him.

34. On 14 July, due to an administrative error by a member of staff, Mr Ratcliffe missed a hospital endoscopy appointment. After a discussion with him, healthcare staff made an appointment for the following day. The gastric biopsies resulting from the procedure did not show any abnormalities.

35. On 30 August, a prison GP examined Mr Ratcliffe. Liver function, urea, electrolytes and blood tests indicated abnormal liver function and worsened anaemia.

36. On 3 September, Mr Ratcliffe told a nurse that he was feeling unwell. The nurse arranged an ambulance crew to attend. The ambulance crew noticed that Mr Ratcliffe's name on the Do Not Resuscitate form (DNR) was incorrectly spelt and therefore invalid. After the paramedics examined Mr Ratcliffe they did not take him to hospital. On 14 September, with a prison GP, Mr Ratcliffe completed a new DNR form.

37. On 21 September, a prison GP saw Mr Ratcliffe in his cell. His abdomen was bloated and very painful. He was taken by ambulance to accident and emergency. An ultrasound scan at the hospital showed end-stage liver cirrhosis with ascites (a build up of fluid in the abdominal cavity). He remained in hospital for four days, received a blood transfusion and a doctor prescribed spironolatone and furosimide (drugs which control fluid build up).

38. On 24 September, Mr Ratcliffe returned to Dartmoor from hospital. He told a nurse that he was comfortable following the blood transfusion.

39. On 9 October, Mr Ratcliffe was feeling unwell with abdominal pain. He told a nurse that he had vomited twice and had loose stools. She found his abdomen

swollen and he was dehydrated. An ambulance took Mr Ratcliffe urgently to hospital, and a doctor admitted him.

40. A consultant palliative care doctor told Mr Ratcliffe that he had liver cancer. However, she was not sure that he had understood the diagnosis because he also had encephalopathy (a disease that affects brain function).

41. Whilst at hospital, staff at the prison kept a keen interest in Mr Ratcliffe's condition and regularly rang the hospital for updates. They recorded key aspects of his condition. They discussed care plans around his possible discharge. However, his condition deteriorated and on 7 November he died.

Contact with Mr Radcliffe's family

42. On 19 October, Dartmoor appointed an officer as the family liaison officer. Mr Ratcliffe had no nominated next of kin and when the officer spoke to him on 27 October, he would not give any family details.

43. The officer obtained details of Mr Ratcliffe's ex wife from his prison records and on 1 November he attempted to contact her. The phone number was no longer valid. He then obtained details of a friend of Mr Ratcliffe's, also listed in his records, and spoke to him on the telephone. Mr Ratcliffe's friend said he would contact Mr Ratcliffe's daughter and inform her of her father's condition.

44. The officer did not hear back from Mr Ratcliffe's daughter and, on 8 November, he rang Mr Ratcliffe's friend and told him that Mr Ratcliffe had died. Mr Ratcliffe's friend said that his daughter did not want contact with the Prison Service.

45. On 11 January 2017, Mr Ratcliffe's funeral took place. The prison arranged and conducted the funeral and paid for the costs in line with national policy.

Support for prisoners and staff

46. After Mr Ratcliffe's death, a governor informed staff at the prison that he had died. She reminded staff of the support mechanisms available should they feel particularly distressed by the news.

47. The prison posted notices informing other prisoners of Mr Ratcliffe's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Ratcliffe's death.

Cause of death

48. There was no post mortem examination after Mr Ratcliffe's death. However, the hospital gave the cause of death as Streptococcal Spontaneous Bacterial Peritonitis (a bacterial infection) relating to Hepatocellular Cancer (liver cancer) and Cirrhosis Secondary to Alcoholic Liver Disease (chronic liver disease). He also had Diabetes Mellitus Type 2.

Findings

Clinical care

49. The clinical reviewer is satisfied that overall the care Mr Ratcliffe received at Dartmoor was equivalent to that which could have expected in the community. However, he makes a number of recommendations that are not related to Mr Ratcliffe's death but which we refer for the attention of the Head of Healthcare.

50. On 5 November, a prison GP examined Mr Ratcliffe after he reported rectal bleeding and coughing up blood. He agreed to review him in two weeks. However, another GP saw Mr Ratcliffe five days later when he reported similar symptoms and immediately referred him under the two week cancer referral rule. The clinical reviewer considered that Mr Ratcliffe could have been referred five days earlier by the first GP. However, the fact that there was a minor delay did not change the outcome for Mr Ratcliffe.

51. After his diagnosis in hospital, prison healthcare staff contacted the hospital on a regular basis to get updates about his condition. They planned for his possible discharge and return to prison. A bed at a local nursing home was obtained for Mr Ratcliffe, but unfortunately he died before staff could arrange his move.

52. The clinical reviewer stated that the care and concern shown to Mr Ratcliffe by the prison staff during terminal illness was equivalent to that which he could reasonably have expected in the community.

53. However we are concerned that when Mr Ratcliffe told a prison GP on 9 May he did not wish anyone to resuscitate him if his heart or breathing stopped and signed an Order to that effect, the form was incorrectly completed and his name was spelt incorrectly.

54. It is important that the DNR forms are completed accurately to ensure that patients' wishes are properly considered. We make the following recommendation:

    Doctors should take care when completing legal documents, such as a Do Not Resuscitate forms, since incorrect details may invalidate the document.

55. The clinical reviewer noted that Mr Ratcliffe's medical records were satisfactory completed. Pain relief was appropriate and he received satisfactory explanations following referrals about treatment and medication. Staff gave him appropriate support in every aspect of his care.

Restraints, security and escorts

56. When prisoners have to travel outside of the prison to a hospital, a risk assessment determines the nature and level of any security arrangements, including any 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 take into account factors such as the prisoner's health and mobility.

57. Prison officers escorted Mr Ratcliffe to hospital nine times between May 2016 and October 2016. Five of these escorts were to the accident and emergency department by ambulance.

58. Risk assessments were completed, though on occasions they did not contain healthcare input. A senior prison manager told the investigator that on these occasions healthcare were not available as they fell outside of the hours that they were on duty.

59. On 9 October, officers escorted Mr Ratcliffe to hospital. The officers did not use restraints. He remained in hospital until 7 November and he was not restrained.

60. We are pleased that prison managers at Dartmoor did not restrain Mr Ratcliffe during his transfer to hospital on 9 October and after his admission, and took account of how his health affected his risk to the public and of escape.

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