Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Arthur Denton a prisoner at HMP Humber on 11 November 2015

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141

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*

© Crown copyright 2015

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

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 Arthur Denton died on 11 November 2015, of a pulmonary embolism, while a prisoner at HMP Humber. He was 48 years old. I offer my condolences to Mr Denton's family and friends.

Mr Denton was in hospital recovering from an operation to treat mouth cancer, when he suffered a pulmonary embolism and died. Mr Denton was not an easy patient, but I am satisfied that he received effective care at Humber, including for deep vein thrombosis cause by intravenous drug use. After the prison dentist appropriately referred Mr Denton for suspected cancer, he missed one specialist appointment because of miscommunication between prison staff. However, this did not affect his ongoing treatment and I am satisfied that healthcare staff at the prison could not have predicted or prevented Mr Denton's sudden death.

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 **June 2016**

Contents

Summary 1
The Investigation Process 2
Background Information 3
Key Events 4
Findings 7

Summary

Events

1. On 22 August 2015, Mr Arthur Denton was recalled to prison for breaching the conditions of his licence. He had been at HMP Humber since 28 August.

2. Throughout his time at Humber, prison healthcare treated Mr Denton for a deep vein thrombosis in his left leg, caused by years of intravenous drug use.

3. On 18 September, Mr Denton told the prison dentist that he had an ulcer in his mouth, which had been there for three or four months. The dentist examined Mr Denton and immediately made an urgent referral under the NHS pathway that requires patients with suspected cancer to be seen by a specialist within two weeks.

4. Mr Denton refused to attend the first appointment booked for 1 October and was unable to attend a rebooked appointment on 8 October because healthcare staff had not informed the security department who therefore had no staff allocated to escort him. He eventually saw a specialist on 13 October.

5. On 27 October, Mr Denton had CT and MRI scans. On 4 November, after further investigations, a hospital doctor diagnosed mouth cancer. On 10 November, Mr Denton had surgery to remove the cancerous tissue.

6. On 11 November, while recovering from his operation in hospital, Mr Denton collapsed as a result of a pulmonary embolism. Hospital staff carried out cardiopulmonary resuscitation but Mr Denton did not recover. Doctors recorded his death at 9.45pm.

Findings

7. We are satisfied that Mr Denton received an appropriate standard of care at Humber, equivalent to that he could have expected to receive in the community. Mr Denton was not always a cooperative patient but prison healthcare staff treated his long-standing leg thrombosis appropriately, when he allowed them. The prison dentist referred him to hospital immediately when she suspected cancer. Mr Denton missed an appointment with a specialist because of miscommunication within the prison, which delayed his diagnosis by a week. This should not have happened, but there is no evidence this would have affected his treatment. Mr Denton's death was a sudden post-operative complication and there was nothing healthcare staff at Humber could have done to prevent it.

Recommendation

- The Governor and Head of Healthcare should ensure that prisoners do not miss hospital appointments for suspected cancer and other urgent matters, unless there are properly justified, exceptional and fully recorded reasons.

The Investigation Process

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

9. The investigator visited Humber on 23 November 2015. She obtained copies of relevant extracts from Mr Denton's prison and medical records and spoke with four members of staff and two prisoners.

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

11. We informed HM Coroner for Hull of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

12. One of the Ombudsman's family liaison officers contacted Mr Denton's sister to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She asked whether Mr Dalton had been in a fight or had any injuries when he went to hospital, and what medications he was prescribed. We found no evidence that Mr Denton had been involved in a fight or had any injuries when he went to hospital.

13. The initial report was shared with the Prison Service. There were no factual inaccuracies. Mr Denton's sister received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.

Background Information

HMP Humber

14. HMP Humber is made up of two former prisons, HMP The Wolds and HMP Everthorpe and holds up to 1,062 prisoners. The two prisons formally merged in April 2014.

15. City Health Care Partnership provides healthcare services. There are healthcare staff are on duty at all times.

HM Inspectorate of Prisons

16. The most recent inspection of Humber was in July 2015. Inspectors reported that a new health provider had begun to make positive changes and services were generally safe and responsive. There was good prioritisation of urgent cases. Care for prisoners with long-term conditions needed further development to match community standards.

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. The IMB has not yet issued an annual report for HMP Humber.

Previous deaths at HMP Humber

18. Mr Denton was the first prisoner to die from natural causes at Humber since the prison was formed in 2014.

Key Events

19. On 25 November 2011, Mr Denton was sentenced to three and a half years in prison for burglary. Mr Denton was conditionally released from prison several times, but recalled for breaching his licence conditions each time.

20. On 7 August 2015, Mr Denton was released from Humber on licence. Just three weeks later, on 22 August, he was recalled to HMP Hull for breaching his licence conditions and was returned to Humber on 28 August.

21. Mr Denton smoked and had a history of long-term intravenous drug use. He had long-standing deep vein thrombosis (DVT) and hepatitis C, as a result of intravenous drug use. Mr Denton consistently refused help to give up smoking and would not accept treatment for hepatitis C. He was on a methadone maintenance programme to treat opiate dependency. Healthcare staff monitored his DVT and prescribed paracetamol as pain relief. Mr Denton had an ulcerated leg and nurses changed his dressing regularly, although he sometimes refused to let them.

22. On 29 August, the day after he returned to Humber, Mr Denton asked healthcare staff for some tape, so that he could dress his leg ulcer himself. A clinical support worker dressed the wound and referred him to a GP to assess his leg. On 4 September, she chased this up after Mr Denton complained his leg was sore.

23. On 7 September, a prison GP examined Mr Denton's leg ulcer and referred him for an X-ray to check for osteomyelitis (inflammation of the bone due to infection). He declined to have his leg redressed. Mr Denton often dressed his leg himself using toilet paper and J-cloths. Nurses advised him against this.

24. On 10 September, a nurse examined Mr Denton's leg ulcer and advised him to have an inadine dressing (a medicated non-adhesive dressing). Mr Denton refused and said it made his leg worse. On 12 and 14 September, Mr Denton refused further nursing intervention.

25. On 16 September, Mr Denton allowed a nurse to dress his leg and they discussed the importance of circulation, and keeping his leg raised whenever possible. Mr Denton agreed to have a Doppler scan (an ultrasound to measure blood flow through the arteries and veins), which the prison scheduled for 25 October.

26. On 18 September, Mr Denton told a prison dentist that he had an ulcer on the floor of his mouth, which had been there for three or four months. She examined Mr Denton and referred him urgently to a maxillofacial clinic under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks.

27. On 24 September, Mr Denton had a leg X-ray which showed no evidence of osteomyelitis. Mr Denton began to dress his leg ulcer himself again, despite advice from nurses.

28. The maxillofacial clinic at the hospital offered Mr Denton an appointment on 1 October, which he refused to attend and signed a disclaimer. The next day, the dentist explained to Mr Denton the importance of the appointment. The maxillofacial clinic offered another appointment for 8 October, which Mr Denton agreed to attend. However, healthcare staff did not notify the security department and there were no escorts available on the day to take Mr Denton to the appointment. Another appointment was made for 13 October.

29. On 13 October, Mr Denton went to the hospital and had a biopsy of the mouth ulcer. On 22 October, a member of the mental health team saw Mr Denton as he was anxious about the results of the biopsy. He spoke about his feelings at length. On 25 October, Mr Denton refused to attend the Doppler scan

30. On 27 October, Mr Denton was taken to hospital for CT and MRI scans. A hospital consultant reviewed the results and, on 4 November, told Mr Denton that he had mouth cancer, which would require an operation. The prison's mental health team continued to support Mr Denton and he was prescribed antidepressant medication.

31. On 10 November, Mr Denton had surgery at the hospital. The operation was successful and Mr Denton was taken to the hospital's Intensive Therapy Unit to begin his recovery.

32. At 8.20pm on 11 November, a nurse took Mr Denton's routine clinical observations and was concerned about his condition. She called the medical emergency team. Mr Denton stopped breathing and hospital staff began cardiopulmonary resuscitation. Mr Denton did not respond and a doctor recorded his death at 9.45pm.

Contact with Mr Denton's family

33. Mr Denton's sister had visited him in the afternoon and early evening of 11 November. When Mr Denton stopped breathing, the hospital telephoned his sister who came back to the hospital and was with him when he died.

34. On 12 November, the prison's family liaison officer telephoned Mr Denton's sister to offer condolences and support. He visited her on 14 November.

35. Mr Denton's funeral was held on 27 November. The prison contributed to the costs, in line with national policy.

Support for prisoners and staff

36. After Mr Denton's death a senior manager debriefed the escort officers who were at the hospital with Mr Denton and offered her support. The staff care team also spoke to both officers and offered them support.

37. Staff on Mr Denton's wing broke the news of his death to his close friends. The prison posted notices informing staff and prisoners of Mr Denton's death and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Denton's death.

Post-mortem report

38. A post-mortem examination found that Mr Denton had died of a pulmonary embolism caused by a deep vein thrombosis (DVT).

Findings

Clinical care

39. Mr Denton had a long history of intravenous drug use, which had caused a long standing deep vein thrombosis (DVT), an ulcer in his leg and hepatitis C. He had declined any treatment for hepatitis C. The clinical reviewer noted that prison healthcare monitored and treated Mr Denton's DVT and ulcer appropriately. Nurses engaged with him at every opportunity, even when he refused treatment.

40. The clinical reviewer considered that Mr Denton's care for oral cancer was well handled and that the prison dentist referred him quickly and appropriately when she identified a concern. (We discuss a missed hospital appointment below.) The prison treated his physical and emotional care needs appropriately once a diagnosis had been confirmed.

41. The clinical reviewer considered that Mr Denton's care was equivalent to that he could have expected to receive in the community. We are satisfied that the prison's healthcare team had a well-coordinated and holistic approach to Mr Denton's care. Mr Denton's death was sudden and unexpected and there was nothing that healthcare staff at Humber could have done to prevent it.

Missed hospital appointment

42. On 18 September, the dentist appropriately referred Mr Denton under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks. He received an appointment for 1 October, but refused to attend. The dentist persuaded Mr Denton of the urgency of the appointment and he agreed to attend a rearranged appointment on 8 October. However, he was unable to attend this appointment, apparently because of a miscommunication between the healthcare department and the security department and pressure on escort staff on the day.

43. Mr Denton eventually attended an appointment with a specialist on 13 October. While the missed appointment on 8 October only slightly delayed the diagnosis, and there is no evidence that this affected Mr Denton's cancer treatment, it is important that where possible, urgent appointments for suspected cancer are not cancelled. Early diagnosis of cancer can affect survival rates in some cases. We make the following recommendation:

The Governor and Head of Healthcare should ensure that prisoners do not miss hospital appointments for suspected cancer and other urgent matters, unless there are properly justified, exceptional and fully recorded reasons.

Prisons &
Probation
Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141