Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stefan Williams a prisoner at HMP Belmarsh on 9 January 2017

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 Stefan Williams died at HMP Belmarsh on 9 January of bowel cancer. He was 45 years old. I offer my condolences to Mr Williams' family and friends.

I consider that Mr Williams received a good standard of care at Belmarsh once his cancer diagnosis was confirmed. However, there was a potential delay in his diagnosis, which was attributable in part to healthcare staff at the prison, and this aspect of his clinical care was not equivalent to that which he could have expected to receive in the community.

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 **August 2017**

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Summary

Events

1. On 23 February 2016, Mr Stefan Williams was remanded in custody to HMP Belmarsh awaiting trial. He was epileptic but often failed to comply with taking his anticonvulsant medication.

2. Following a collapse in his cell on 24 October, Mr Williams was taken to hospital. He returned to prison the following day. His discharge report noted that he had been refusing to take his anticonvulsant medication. It also contained details of investigations that revealed suspicious lesions on a chest x-ray and an abnormal liver function test. The hospital planned to refer him to the chest clinic urgently under the NHS two-week rule but recommended that prison healthcare arrange a liver ultrasound scan and some other tests.

3. Prison healthcare staff noted that Mr Williams returned to prison with a hospital discharge report but did not record that the hospital had identified suspicious lung lesions. The prison GP arranged a repeat liver function test but not a liver ultrasound scan, contrary to the hospital's recommendation.

4. On 12 December, Mr Williams was admitted to hospital from court with chest pain. On 18 December, following extensive tests, doctors told him he had cancer and on 22 December, a gastroenterologist confirmed that Mr Williams had advanced cancer of the bowel, which had spread to his lungs and liver. Surgery was not an option and he was discharged back to the in-patient unit at Belmarsh.

5. Over the next five days, Mr Williams' physical condition deteriorated and, on 28 December, he was re-admitted to hospital as an emergency.

6. Mr Williams returned to Belmarsh for end of life care on the afternoon of 6 January. Mr Williams died at around 8.20pm on 9 January and the doctor certified his death at 9.05pm.

Findings

7. Healthcare staff at Belmarsh provided Mr Williams with comprehensive palliative and end of life care. Once Mr Williams had been diagnosed with terminal cancer, the clinical care he received at the prison was equivalent to that which he could have expected to receive in the community.

8. However, there was a delay in the diagnosis of Mr Williams' cancer which was attributable in part to actions not taken by healthcare staff at Belmarsh. Prison healthcare staff did not arrange a liver ultrasound scan as recommended by the hospital in October. It is likely that Mr Williams' cancer would have been diagnosed earlier had a liver scan been carried out at that stage. Staff also failed to note in Mr Williams' medical record that hospital investigations had identified suspicious lung lesions, and had they been aware, this information might have altered their assessment and clinical management of Mr Williams.

9. This aspect of Mr Williams' clinical care was not equivalent to that which he could have expected to receive in the community. Although the delay in diagnosis did

not affect the final outcome, an earlier diagnosis might have allowed palliative care to have been implemented earlier.

Recommendations

- The Head of Healthcare should ensure that all relevant information contained in hospital discharge reports are recorded in the prisoner's SystmOne record.
- The Head of Healthcare should ensure that actions recommended in hospital discharge reports are implemented. If they are considered inappropriate and not implemented the reasons should be recorded in SystmOne.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Belmarsh informing them of the investigation and asking anyone with relevant information to contact him. A prisoner at Belmarsh contacted the Ombudsman's office and the investigator had a telephone conversation with him.

11. The investigator obtained copies of relevant extracts from Mr Williams' prison and medical records.

12. NHS England commissioned a clinical reviewer to review Mr Williams' clinical care at the prison. A Prisons and Probation Ombudsman's investigator and the clinical reviewer interviewed one of the prison GPs at Belmarsh on 13 February 2017.

13. We informed HM Coroner for Inner South London District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

14. One of the Ombudsman's family liaison officers contacted Mr Williams' next of kin, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He indicated that the family would like to raise concerns at a later date. Mr Williams' family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

15. The initial report was shared with the Prison Service. The Prison Service did not identify any factual inaccuracies.

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

Background Information

HMP Belmarsh

17. HMP Belmarsh is a local and high security prison holding just over 900 male prisoners and serves the Central Criminal Court, Magistrates' Courts in South East London and parts of Essex. It also holds high security risk prisoners on remand and awaiting trial.

18. Healthcare is provided at Belmarsh by Oxleas NHS Foundation Trust. There is 24 hour healthcare cover by GPs and nurses and a 33 bed inpatient unit. There are also healthcare facilities on each house block, in reception and in the first night centre.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Belmarsh was in February 2015. Inspectors reported that Belmarsh had developed a strategy to support prisoners with palliative and end of life needs and two cells in the inpatient unit were being refurbished for this purpose. They also said that palliative care work was good and developing.

Independent Monitoring Board

20. 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 June 2016, the IMB reported that information sharing issues were highlighted in one of the death in custody inquests, where the jury found that failure to transfer information adequately from the treating hospital to the prison HCC was a "contributing factor" in the prisoner's death.

Previous deaths at HMP Belmarsh

21. There have been three previous deaths at Belmarsh since July 2015, two of which were self-inflicted and one due to natural causes. There are no significant similarities with Mr Williams' death. There has been another self-inflicted death at Belmarsh since, in February 2017.

Findings

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

22. On 23 February 2016, Mr Stefan Williams was remanded in custody to HMP Belmarsh awaiting trial for rape. On reception, staff noted Mr Williams was epileptic and that he had learning difficulties. Mr Williams often failed to comply with taking his anticonvulsant medication.

23. Following a collapse in his cell on 24 October 2016, Mr Williams was taken by emergency ambulance to hospital. He returned to prison early the following day with a discharge report. This noted that he had refused to take anticonvulsant medication prior to being taken to hospital. It also explained that hospital investigations had revealed suspicious lesions on a chest x-ray and an abnormal liver function blood test.

24. The hospital planned to refer him to the chest clinic urgently under the NHS two-week rule (the NHS pathway that requires patients with suspected cancer to be seen by a specialist within two weeks) but recommended that prison healthcare arrange a liver ultrasound scan.

25. Prison staff nurses both saw Mr Williams on the morning of his return and noted that he had a hospital discharge report but did not note its content in his SystmOne record (electronic medical record).

26. A prison GP saw Mr Williams later that day. He reviewed the discharge report and noted the issues about refusal of anticonvulsant medication in SystmOne but did not record the finding of the suspicious lung lesions.

27. Mr Williams was seen by prison healthcare staff on multiple occasions in the following weeks but they appear to have been unaware of his suspicious lung lesions. Had that information been readily available in SystmOne, their assessment and clinical management of Mr Williams might have been different.

The Head of Healthcare should ensure that all relevant information contained in hospital discharge reports is recorded in the prisoner's SystmOne record.

28. The prison GP arranged a repeat liver function test on 25 October but did not arrange a liver ultrasound scan, as recommended by the hospital. Mr Williams' results from the liver function test were recorded on 24 December.

29. At interview with the clinical reviewer on 13 February 2017, a prison GP confirmed that liver ultrasound scans are usually available within two weeks at Belmarsh. Mr Williams was subsequently found to have metastatic cancer (cancer which has spread from the site of the original cancer to other parts of the body) and it is likely that a liver ultrasound at this stage would have identified liver metastases.

30. The hospital discharge report contained recommendations for prison healthcare that were essentially all hospital investigations and actions. The clinical reviewer considered that, if staff at the hospital had concerns that Mr Williams' had metastatic liver cancer, they should have arranged the liver scan either at the

time of his admission or subsequently as an outpatient. This matter is outside the scope of this report. We do though make the following recommendation.

The Head of Healthcare should ensure that actions recommended in hospital discharge reports are implemented. If they are considered inappropriate and not implemented the reasons should be recorded in SystmOne.

31. Mr Williams had an appointment in the chest clinic on 8 November at the hospital, which he refused to attend and for which he signed a disclaimer. It is possible that had he attended that appointment his cancer would have been identified earlier than it was.

32. On 12 December, during his trial, Mr Williams was taken to hospital from court complaining of chest pain and was admitted to hospital. On 14 December the trial judge, following telephone conversations with Mr Williams' consultant and a prison GP, ordered Mr Williams to attend court that afternoon. He was taken under escort from the hospital to the court and was returned to hospital after his appearance.

33. Following ultrasound and computerised tomography (CT) scans and a liver biopsy, on 18 December, Mr Williams was told by his doctors that he had bowel cancer.

34. On 22 December, a gastroenterologist at the hospital informed the nurse manager at Belmarsh that Mr Williams had advanced cancer of the bowel which had spread to his lungs and liver. The gastroenterologist confirmed that surgery was not an option. Mr Williams was discharged later that afternoon and was admitted to the prison inpatient department.

Mr Williams' clinical care

35. On his return to Belmarsh, a nurse noted that Mr Williams was in denial regarding his diagnosis and that his physical condition was deteriorating. She created a physical health care plan outlining the care that Mr Williams required.

36. A prison GP explained Mr Williams' diagnosis to him on 23 December and a multi-disciplinary meeting (MDT) was held later that day to decide on how he should be managed.

37. Over the next five days Mr Williams' physical condition deteriorated. On 28 December, because he was unsteady, confused and disorientated, prison GP referred him to the hospital as an emergency. A nurse accompanied him in the ambulance.

38. On 5 January, the in-patient manager created a detailed and comprehensive end of life care plan for Mr Williams that encompassed nursing and personal care. Daily spiritual support visits from the chaplaincy were also planned.

39. A palliative care nurse from a hospice planned to visit Mr Williams on 9 January and advised that a Do Not Attempt Resuscitation order (DNAR) (a document signed by a doctor containing an instruction not to attempt resuscitation should the patient's heart or breathing stop) should be completed as soon as possible to

ensure that clear instructions were in place in the event that Mr Williams' heart or breathing stopped.

40. Mr Williams remained in hospital until the early afternoon of 6 January when he was discharged back to Belmarsh for end of life care. On arrival, he was immobile and went directly into the palliative care suite where constant nursing support was provided. An open door policy to ensure nursing staff had unrestricted access to him was implemented.

41. A prison GP spoke to Mr Williams at around 2.15pm in the palliative care suite but he was semi-conscious and not able to have a meaningful discussion. The GP decided that Mr Williams did not have the capacity to make a decision about a DNAR order. The DNAR was discussed at a MDT meeting two hours later and the form completed and signed by the GP.

42. The GP met Mr Williams' next of kin on 7 January, when they visited the prison, and discussed the DNAR, the existence of which they agreed. Over the next two days Mr Williams remained bedbound but saw visiting family. He continued to take food and medication but deteriorated steadily.

43. The GP reviewed Mr Williams at around 6.00pm on 9 January and planned to review him again at around 9.00pm to determine whether his family should be asked to attend the prison.

44. Mr Williams died at around 8.20pm on 9 January. The GP certified his death at 9.05pm. A post-mortem result gave his cause of death as carcinomatosis (widespread cancer throughout the body) and carcinoma of the colo-rectal region.

45. Healthcare at Belmarsh provided Mr Williams with comprehensive palliative and end of life care. Once the diagnosis of terminal cancer was confirmed, the clinical care provided by healthcare was equivalent to that Mr Williams could have expected to receive in the community.

46. A potential delay in the diagnosis of cancer was attributable in part to actions not taken by healthcare staff at Belmarsh. This aspect of Mr Williams' clinical care was not equivalent to that which he could have expected in the community

47. The potential delay can also be attributed to Mr Williams' reluctance to accept medical advice.

48. The potential delay in diagnosis did not affect the final outcome for Mr Williams but might have allowed palliative care to begin earlier. We refer to our recommendation above, which highlights that prison healthcare staff must implement actions specified in hospital discharge reports.

Mr Williams' location

49. On 22 December, following his cancer diagnosis and discharge from hospital, Mr Williams was located in the prison's inpatient unit.

50. Following a further hospital admission on 28 December, Mr Williams was discharged back to Belmarsh on 6 January for end of life care. He went directly to the palliative care suite where he remained until his death on 9 January.

51. We are satisfied that Mr Williams was located appropriately during his illness.

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. Mr Williams collapsed at court and was admitted to hospital on 12 December. A note in the medical record on that day advises that a nurse had completed a medical risk assessment for his continued stay under bedwatch.

54. It is evident from the records made by staff undertaking the bedwatch that a risk assessment authorised the use of an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer) existed. However, because a copy of the risk assessment has not been made available to the investigator it is not known what factors went into that assessment or who authorised it. It is evident that prison managers regularly visited the ward between 12 and 22 December and approved the continued use of an escort chain.

55. During his final admission to hospital on 28 December, Mr Williams was not restrained. The risk assessment, authorised by a security governor, records that Mr Williams was, owing to the nature of his offence, a medium risk to the public and hospital staff but because of his deteriorating medical condition restraints were judged unnecessary.

56. Mr Williams' admission to hospital evolved into a bedwatch escort and he remained in hospital under supervision of two prison officers until 6 January when he returned to prison. During the time he was in hospital prison managers visited the ward regularly and reassessed and approved the continuation of the no restraint decision. The initial and ongoing assessments resulting in Mr Williams not being subject to restraints were appropriate.

Liaison with Mr Williams' family

57. Mr Williams' nominated next of kin was his stepfather. It is not clear when the prison first contacted Mr Williams' stepfather, but a note made in the medical record by the in-patient manager, timed and dated 10.35am on 28 December, indicates that a member of staff from the Safer Custody/Security team had informed the family. It has not been possible to identify that person. Mr Williams received frequent visits from his family while in hospital.

58. On 28 December, the deputy governor authorised a protocol for Mr William's next of kin and other family members to visit him in the palliative care unit should he return to Belmarsh. He returned to prison on 6 January.

59. On 7 January, the prison's Family Liaison Officer (FLO) arranged with Mr Williams' sister for the family to visit in line with the protocol. He met them when they visited Mr Williams. The family also spoke with the prison GP and discussed Mr Williams' deterioration and the DNAR with them, the existence of which they agreed. The GP told them he would ask for them to be called into the prison if he considered that Mr Williams' life was ending.

60. The GP saw Mr Williams at around 6.00pm on 9 January and had not seen any significant deterioration. Mr Williams declined a drink from a healthcare support worker at around 8.15pm. About five minutes later Mr Williams died.

61. The FLO was informed of Mr Williams' death around 8.35pm and he immediately informed Mr Williams' stepfather by telephone. It is unclear whether she had made a prior arrangement to use this method to inform Mr Williams' next of kin of his death rather than deliver the message in person in line with Prison Service protocols. She offered an immediate visit to the prison for family members which they declined.

62. The FLO continued to support Mr Williams' family during the preparations for the funeral and returned his property to them on 22 January. On 25 January she conducted Mr Williams' funeral service, the cost of which the prison contributed to in line with national policy.

63. We consider that Belmarsh appropriately supported Mr Williams' family and kept them informed about his condition.

Compassionate Release

64. Prisoners can be released early on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.

65. Mr Williams had not been sentenced when he received his terminal diagnosis and therefore, a compassionate release application or release on temporary licence could not be considered. However, the Offender Management Unit at Belmarsh was in touch with his solicitor and supported a bail hearing. A bail application was made but refused.

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