Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Robert Chellingworth a prisoner at HMP Exeter on 4 June 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 Robert Chellingworth died of prostate cancer at HMP Exeter on 4 June 2016. Mr Chellingworth was 68 years old. I offer my condolences to Mr Chellingworth's family and friends.

I am satisfied that Mr Chellingworth received a standard of care equivalent to that he could have expected to receive in the community. However, prior to his diagnosis, I am concerned that an urgent two week referral was delayed because the pro-forma went missing. It is also disappointing that I need to repeat concern about the inappropriate use of restraints on a very sick man at HMP Exeter. I should not need to do so.

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 **December 2016**

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Summary

Events

1. Mr Robert Chellingworth was remanded to HMP Exeter on 3 December 2015. His trial was ongoing when he died. Doctors had diagnosed him with prostate cancer in 2009, but Mr Chellingworth stopped turning up for treatment in 2015. The prison received his community health records on 9 December and, although Mr Chellingworth was not interested in receiving treatment if he was found guilty, staff established contact with specialists to discuss steps forward.

2. At the beginning of 2016, Mr Chellingworth reported problems urinating and with his balance and, by March, that he was losing weight. Healthcare staff referred him to an urologist for a head CT scan and for an urgent two week gastroenterology referral. The CT scan revealed a clot in his brain and the urology investigations were indicative of water retention and an infection. Some blood tests were recorded as abnormal but 'expected'. The gastroenterology referral was not made because the pro-forma requesting one went missing between the GP and the admin team. A re-referral was made on 27 April and an appointment for an endoscopy came through for 5 May.

3. On 1 May, Mr Chellingworth was admitted to hospital with a suspected deep vein thrombosis (DVT). During the period of the admission (which lasted until 25 May), hospital staff told prison healthcare staff, by telephone, that he had progressive prostate cancer on 11 May. On 17 May, specialists confirmed that the disease was widespread and likely to be in his rectum, bladder wall, liver, lungs and bones. He signed an order saying he did not wish to be resuscitated while he was in hospital.

4. When Mr Chellingworth returned to prison, healthcare staff implemented appropriate care plans and he moved to the palliative care suite. A doctor assessed that he lacked capacity to make decisions but he should be included in them where possible. Mr Chellingworth's pain was managed and he died on 4 June 2016, with his family present.

Findings

5. Although, in general, the clinical reviewer believed that the care Mr Chellingworth received was equivalent to that he could have expected to receive in the community, we are concerned that an urgent referral to a specialist was lost before it was sent to the hospital.

6. We are also concerned that a manager approved a decision to restrain Mr Chellingworth during his last admission to hospital without any medical input and when all his risks were noted to be low. Further to this, we are particularly concerned that Mr Chellingworth was restrained using double handcuffs for the journey to hospital.

Recommendations

- The Head of Healthcare should ensure that all urgent referrals reach the administrative team safely and are sent within 24 hours.

- The Governor and the Head of Healthcare should take active steps to ensure that staff authorising the use of restraints for prisoners taken to hospital understand the legal position, and that risk assessments are completed which fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

The Investigation Process

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

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

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

10. We informed HM Coroner for Exeter and Greater Devon District of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.

11. We wrote to Mr Chellingworth's son to explain the investigation and to ask if they had any matters they wanted the investigation to consider. He did not respond to our letter.

12. The investigation has assessed the main issues involved in Mr Chellingworth'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. The initial report was shared with the Prison Service. The Prison Service pointed out some factual inaccuracies and this report has had some amendments made accordingly.

Background Information

HMP Exeter

14. HMP Exeter is a local prison holding 565 men. Dorset Healthcare University NHS Foundation Trust provides health services. There are ten cells on F Wing for prisoners who need social care and one cell for end of life palliative care. The wing has facilities for visiting relatives.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Exeter was in August 2013. Inspectors reported that care for prisoners with complex social care needs and disabilities was impressive. There were 24-hour health services and a wide range of clinics, including for chronic diseases. Palliative care was supported through an excellent new suite, which had been created for the care of terminally ill prisoners.

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 most recently published annual report, for the year to December 2015, the IMB reported that it believed that Exeter was a well-run and generally safe establishment and staff made a genuine effort to treat prisoners with dignity and respect. The IMB made special mention of the work of healthcare staff but considered that healthcare resources were inadequate and did not reflect community provision.

Previous deaths at HMP Exeter

17. Mr Chellingworth was the eleventh prisoner to die from natural causes at HMP Exeter since June 2015. We have consistently found that Exeter has provided good palliative and end of life care. However, we have also made recommendations about the unnecessary use of restraints before.

Findings

The diagnosis of Mr Chellingworth terminal illness and informing him of his condition

18. Mr Robert Chellingworth was on remand and had been at HMP Exeter since 3 December 2015. Doctors had diagnosed him with prostate cancer when he was in the community in 2009. He had had radiotherapy in the past and more recently anti hormone and injection therapy. The injection therapy had contributed to him having low moods and the type of injection was changed from goserelin to decapeptyl in March 2015. However, after that initial dose, the community GP had no record of him attending for further injections

19. On 3 December, a nurse saw Mr Chellingworth for a first night health screen. She noted that he had prostate cancer, depression, wore a hearing aid and had cartilage damage to his left knee. She arranged for him to speak to a mental health nurse the same day and for someone in the administration team to chase up his community health records. She was concerned that Mr Chellingworth might be due another of his injections.

20. The prison chased his community records on 4 December and received them on 9 December. A prison GP reviewed the notes on 11 December and arranged for Mr Chellingworth to see a doctor to discuss his case. Mr Chellingworth saw the doctor on 15 December and told him he had missed his last injection appointment because he felt he wanted a break from them. He agreed to restart them, but also said that he understood his treatment was palliative and, if a jury found him guilty at his trial, he was unlikely to accept any further treatment. The doctor referred him to a urology service and administrative staff sent this on 17 December.

21. On 6 January 2016, the prison GP reviewed blood test results for Mr Chellingworth and noted that his prostate specific antigen (PSA – protein produced by the prostate gland, which are usually elevated in men with prostate cancer) was normal. She confirmed that, due to the limited sensitivity of the test, it should be repeated in three to six months.

22. On 26 January 2016, Mr Chellingworth had his urology appointment (rearranged at his request from 12 January). The urology specialist wrote to the prison and explained that she intended to discuss whether Mr Chellingworth should restart hormone therapy and whether to refer him to a consultant oncologist. Mr Chellingworth had told her he had had some problems urinating, which she thought might be ‘radiation cystitis’ or a stricture and she had suggested he have a cystoscopy (a procedure to examine the bladder with an instrument).

23. On 29 January, the urology specialist wrote again to the prison to confirm that she had spoken to a consultant and they wished him to restart hormone therapy, which the prison was to arrange, and check his prostate specific antigen. She said the hospital would be in contact again following Mr Chellingworth’s cystoscopy, but, apart from that, they would like to see him in at the clinic in a year’s time.

24. On 2 February, the prison GP referred Mr Chellingworth for a CT scan of his head, as she was concerned that his cognitive abilities appeared to be declining. She also arranged for blood tests to be done and the results were noted to be abnormal. However, in isolation, the results were not specific enough to diagnose a particular disease and the doctor noted that Mr Chellingworth had been given the all clear after a colonoscopy (procedure investigating the intestine) and cystoscopy (procedure investigating the bladder) just before he came into prison.

25. On 19 February, Mr Chellingworth had a cystoscopy and the urologist referred him for a catheter assessment. He thought Mr Chellingworth had chronic urinary retention.

26. Mr Chellingworth had a CT scan on 26 February. It identified that he had a blood vessel clot in an area of the brain responsible for balance information.

27. On 14 March, the prison GP saw Mr Chellingworth. He reported problems with his balance, felt that all food smelt awful and had lost weight. The doctor weighed him and found that he had lost 18 kilograms in weight (on reception he was 104.3 kilograms and at the appointment weighed 86 kilograms). She recorded that she did a two week referral for a gastroenterology appointment but there was no trace of the actual referral pro-forma on the medical record.

28. On 4 April, Mr Chellingworth went to hospital for his catheter assessment. He was very unwell and only able sip water before vomiting. Hospital staff found it difficult to complete their assessment and recommended that a prison GP examine him regarding what appeared to be gastric problems. On the same day, Mr Chellingworth attended A&E at hospital. He was admitted and a hospital doctor thought he had urine retention so they inserted a catheter. They also treated Mr Chellingworth for a suspected urinary infection. The levels of creatinine in his kidneys were very high but were treated and significantly lowered. Hospital staff did an ultrasound which showed one of his kidneys was swollen because of water retention.

29. He was discharged on 12 April and, on 14 April, a prison GP recorded that Mr Chellingworth's haemoglobin count had fallen and his other blood test results were abnormal but as expected.

30. On 18 April, a consultant urologist made a referral to a consultant renal physician explaining what had happened during Mr Chellingworth's admission and asking him for some input.

31. On 21 April, a prison GP saw Mr Chellingworth again. She recorded that he was very anaemic, his haemoglobin count was low and he was very frail. She also recorded that following her urgent two week referral on 14 March no appointment had come through. She looked for the pro-forma and tried to find out if it had been sent, but not scanned onto the record, over the following days but she could not find any evidence of this.

32. On 27 April, the prison GP made another urgent referral to specialists under the NHS pathway, which requires patients with suspected cancer to be seen by a specialist within two weeks. Mr Chellingworth had presented with anaemia,

weight loss and rectal bleeding the previous month but no appointment had come through. The hospital gave Mr Chellingworth an appointment for 5 May.

33. On 1 May, Mr Chellingworth was admitted to hospital with a suspected deep vein thrombosis (DVT) in his leg. He had a number of investigative procedures including scans, camera probes and biopsies. On 11 May, a member of healthcare staff was told by hospital staff on the telephone that he had progressive prostate cancer (although they were not clear that this was actually the primary site) and, on 17 May, that the disease was widespread, citing the rectum, bladder wall, liver, lungs and bones as likely diseased areas.

34. When, on 14 March, the prison GP decided to refer Mr Chellingworth to a specialist under the two week rule she noted the decision on SystmOne in a journal entry but the pro-forma she filled in by hand did not reach the administration team. She told us that the process for urgent referrals was to complete the referral pro-forma by hand and to then put it in the GP admin box, the contents of which the admin staff deal with on a daily basis. Unfortunately, on this occasion, the referral seems to have been lost. She told us that after realising that Mr Chellingworth had not been given an appointment, she spent the next few days trying to find out what had happened to it but was unable to. She eventually made another referral on 27 April.

35. The clinical reviewer believes that the delay did not have a meaningful impact on the outcome for Mr Chellingworth, as he was admitted to hospital on 5 April. This admission occurred a week after he would have been expected to be seen had the initial two week wait referral gone through smoothly. However, in the future, delays progressing urgent two week referrals could have an impact on a prisoner's care. We make the following recommendation:

The Head of Healthcare at HMP Exeter should ensure that all urgent referrals reach the administrative team safely and are sent within 24 hours.

Mr Chellingworth's clinical care

36. Mr Chellingworth was not discharged from hospital until 25 May. A nurse formulated a number of care plans in preparation for his return. The care plans covered continence, skin care, personal care and his mobility. On his return, he was moved to the prison's dedicated palliative care suite.

37. On 27 May, a prison GP discussed Mr Chellingworth's diagnosis with him and noted that he lacked capacity to retain information or make decisions. She noted he was to be treated in his best interests at all times, but to be included in decision making where possible. While in hospital, he signed an order that he did not want to be resuscitated if his heart or breathing stopped.

38. The prison GP also opened care plans for food and fluids, catheter care and bowel care. In terms of pain relief, she noted that he was taking oral codeine and this seemed to be settling his pain. His main issue seemed to be confusion and, later that day, he refused his pain medication, screaming out that staff were trying to kill him. He also began shouting in apparent pain but rejected staff attempts to give him fentanyl injections. He also refused oramorph the following day.

39. On 28 May, a prison GP noted that it was difficult to tell when Mr Chellingworth was generally distressed and when he was in actual pain. He applied fentanyl patches to the base of Mr Chellingworth's spine and prescribed them for future use. Mr Chellingworth went on to refuse other forms of pain relief but tolerated the patches well.

40. On 2 June, staff discussed his pain relief with family members and they said that they would like him to be on a syringe driver in case staff were missing indicators that he was in pain. (Staff had in fact previously discussed this with Mr Chellingworth as staff felt it would actually help calm his agitation.) Healthcare staff set up a syringe driver the same day. Mr Chellingworth's condition deteriorated and he died, with his family around him, at approximately 2:50am on 4 June.

41. We are satisfied that, following his diagnosis, the care Mr Chellingworth received was equal to that he could have expected to receive in the community. There were appropriate care plans in place and he was looked after in a dedicated palliative care suite.

Mr Chellingworth's location

42. Mr Chellingworth had initially been on a normal wing in the prison but when he developed continence issues he was cared for in a cell on the social care wing. Care plans were in place covering his needs and staff from social care providers 'ARC' helped to look after him. When he returned to the prison on 25 May, following a palliative diagnosis from hospital specialists, he moved to the prison's dedicated palliative care suite. Family members were able to visit him and did so regularly.

43. We are satisfied that Mr Chellingworth's location was appropriate and that staff were able to deliver a good standard of palliative care.

Restraints, security and escorts

44. 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.

45. Mr Chellingworth's last admission to hospital was on 1 May when he was admitted to hospital with a suspected DVT. There was no evidence on the risk assessment document that a medical assessment was done or medical opinion sought when decisions about escorts and restraints were considered. A prison manager completed the security part of the risk assessment and recorded that Mr Chellingworth's risk of escape, hostage taking and of harm to others rated as

'normal' (on a scale of normal, medium and high). Double cuffs were authorised for transit and an escort chain the rest of the time, although it is not clear if the manager authorised his own decision as there were no other signatures on the document. Double cuffing is when the prisoner's hands are handcuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs. 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.

46. From the bedwatch notes, it appears that Mr Chellingworth was vomiting on occasion but sat up in bed, feeding, reading and washing himself. From 7 May, it seems that he spent a lot of time asleep. Following various investigative procedures, doctors told Mr Chellingworth, on 11 May, that he had cancer. A prison manager performed a management check on 12 May and, at approximately 3.50pm, all restraints were removed. They were not reapplied during the rest of his stay, which ended on 25 May.

47. Although we are pleased to see that restraints were eventually removed when authorised by the manager, we are concerned that there was no evidence of medical input into the risk assessment procedure when Mr Chellingworth was initially taken to hospital. Double cuffs are usually used for moving category A or category B prisoners in good health. While Prison Service Order 4600 'Unconvicted, Unsentenced and Civil Prisoners', confirms that unconvicted prisoners are usually held in category B prisons, as Mr Chellingworth was being escorted to hospital, we do not believe that prison managers could have considered him to have been in good health. Therefore, we cannot see how the decision to use double cuffs could be justified. We have raised the issue of the unjustified use of restraints, including the use of double handcuffs, with the prison before. We make the following recommendation:

The Governor and the Head of Healthcare should take active steps to ensure that staff authorising the use of restraints for prisoners taken to hospital understand the legal position, and that risk assessments are completed which 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 Chellingworth's family

48. From early May, Mr Chellingworth had telephoned his son to tell him that he had cancer and was dying. On 17 May, the prison appointed an officer as the family liaison officer, after hospital staff concluded that Mr Chellingworth had tumours in multiple sites. She tried to contact Mr Chellingworth's next of kin (over three days) but her calls were not answered until 20 May. She explained Mr Chellingworth's situation and arranged a further conversation for 23 May but there was no answer then or over subsequent days.

49. On 1 June, family members made contact and were granted unlimited access to the prison to visit Mr Chellingworth. They were with him when he died

50. Mr Chellingworth's funeral was on 28 June 2016. In line with national policy, the prison offered to contribute to funeral costs. We consider that the prison's liaison with the family was good.

Compassionate release

51. Prisoners can be released from custody before their sentence has expired 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. However, as Mr Chellingworth had not even been sentenced, he could not be considered for early release.

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