Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Brian Dubey a prisoner at HMP Elmley on 4 February 2017

A report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

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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.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Brian Dubey died on 4 February 2017 of stomach cancer while a prisoner at HMP Elmley. He was 67 years old. I offer my condolences to Mr Dubey's family and friends.

Mr Dubey was diagnosed with stomach cancer in prison. I am satisfied that, overall, Mr Dubey received good clinical care throughout his illness which was equivalent to that which he could have expected to receive in the community. However, I am concerned that there was poor management of Mr Dubey's nutritional requirements and a delay in accessing appropriate care aids and equipment, which was demeaning for Mr Dubey. There were also occasions when there was unjustified use of restraints.

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. In April 2016, Mr Brian Dubey was remanded in custody and was sent to HMP Belmarsh. He transferred to HMP Elmley on 21 April 2016. and on 20 May 2016, he was sentenced to 15 years in prison for sexual offences

2. Mr Dubey had severe iron deficiency anaemia and he attended hospital for a series of emergency blood transfusions. Mr Dubey's blood count rapidly declined and the hospital undertook further tests to look for possible gastrointestinal sites of bleeding.

3. In June, Mr Dubey was diagnosed with stomach cancer and further tests confirmed that it had spread to his lungs. It was agreed that he would undergo chemotherapy treatment and a palliative care link nurse created a palliative disease care plan for him and visited on a regular basis.

4. Mr Dubey continued to lose weight and became frail. Healthcare staff reviewed him frequently and tried to facilitate his hospital appointments. Healthcare staff referred him to a hospice for palliative care and on 7 September, a palliative care nurse from the hospice assessed his needs and continued to review him during his illness. He received further blood transfusions and became too ill for chemotherapy treatment. Instead, he received radiotherapy treatment and reported an improvement in his pain symptoms.

5. On 24 January, Mr Dubey was admitted to the inpatient department for palliative care and end of life support. He continued to deteriorate and by 27 January he became nutritionally compromised with no interest in food and limited fluid intake. Mr Dubey continued to receive medication for agitation and pain.

6. Mr Dubey died in the In Patient Department (IPD) on 4 February at 2.20am.

Findings

7. The clinical reviewer concluded that Mr Dubey received good clinical care throughout his illness and was equivalent to that which he could have expected to receive in the community.

8. However, we are concerned that there was poor communication between clinicians, carers and catering staff who meant inappropriate food was provided and he was not given assistance with eating.

9. There was an unacceptable delay in providing Mr Dubey with a commode which meant that he was using a bucket in his cell as a toilet; access to a syringe driver during his end of life care would have reduced the need for frequent injections and would have given a more stable control of his symptoms.

10. Mr Dubey was restrained by an escort chain during visits to hospital on three occasions; risk assessments did not take into account his health and mobility needs. It is difficult to understand why the decision was made to restrain him and how it was justified.

Recommendations

- The Head of Healthcare should review the identification, implementation and monitoring of special dietary needs.
- The Head of Healthcare should review access to aids and equipment, and ensure they are provided promptly both in cells and the IPD.
- The Governor should ensure that when restraints are used for prisoners taken to hospital, there are properly considered risk assessments, in line with the legal guidance, 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

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

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

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

14. We informed HM Coroner for Mid Kent and Medway District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

15. The investigator wrote to Mr Dubey's named next of kin, a friend, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond.

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

17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HM Prison Elmley

18. HMP Elmley is a local prison on the Isle of Sheppey, which serves the courts in Kent. It holds more than 1,200 men in five wings, with a mixture of single, double and triple cells. Integrated Care 24 Ltd (IC24) provides primary healthcare services, with input from Minster Medical Group. The prison's healthcare centre includes a 29-bed inpatient unit.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Elmley was in November 2015. Inspectors reported that healthcare services at the prison had improved since the last inspection in June 2014 and were generally good. The inpatient unit provided calm and well run environment with good care for prisoners with the most acute needs. Palliative care pathways were used appropriately and sensitively.

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 1 November 2016, the IMB reported Elmley's outpatient department continued to run efficiently with a very caring team, monitoring and caring for a wide variety of chronically ill prisoners and staff in the prison's inpatient department were commended for their continuing excellent care under sometimes very challenging conditions.

Previous deaths at HMP Elmley

21. Mr Dubey was the tenth person to die of natural causes at Elmley since February 2015. We have raised the issue of the unjustified use of restraints before.

Findings

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

22. On 7 April 2016, Mr Brian Dubey was remanded in custody and was sent to HMP Belmarsh. He was transferred to HMP Elmley on 21 April. On 20 May, he was sentenced to 15 years in prison for sexual offences.

23. Mr Dubey's past medical history showed that he had hepatitis C (a virus primarily affecting the liver), high blood pressure and poor short-term memory.

24. On arrival at Elmley, a nurse noted that Mr Dubey looked jaundiced and referred him to a prison GP. The GP prescribed him amlodipine and ramipril for hypertension and requested a blood test.

25. On 3 May, a prison GP examined Mr Dubey and diagnosed a chest infection, prescribed antibiotics and referred him to hospital for a chest x-ray, which showed abnormal shadowing on the right side of Mr Dubey's chest and was referred for a blood test and CT scan. On 5 May, a prison GP made an urgent referral to the respiratory clinic under the NHS pathway (patients with suspected cancer are to be seen by a specialist within two weeks).

26. Mr Dubey was unable to attend his CT scan on 11 May because prison staff did not escort him to reception on time. The appointment was rescheduled for 3 June. On 17 May, healthcare staff received an appointment letter for Mr Dubey to attend the respiratory clinic on that day. He was unable to attend at such short notice and the appointment was rescheduled for 24 May.

27. Mr Dubey's blood sample showed severe iron deficiency anaemia and he was sent to hospital for an urgent blood transfusion. He received ongoing medication for iron deficiency, and required appointments for an endoscopy (an endoscope is inserted to examine inside the body) and a CT scan.

28. Following sentencing on 20 May, Mr Dubey attended hospital for a blood transfusion. Because his blood count had rapidly declined, the hospital arranged for further tests to look for possible gastrointestinal sites of bleeding. Following an endoscopy and colonoscopy on 6 June, doctors informed Mr Dubey that he had cancer of the stomach which had spread to his lungs.

29. Mr Dubey was already seriously ill when he was remanded to prison with, at that stage, an undiagnosed gastric carcinoma. His detention in prison prompted a series of medical assessments that identified signs that were investigated appropriately, and which led to his diagnosis of stomach cancer. The clinical reviewer found that it was likely that his diagnosis would have taken longer in the community because Mr Dubey might not have presented himself to health care services outside prison any sooner. A number of key hospital appointments were missed in the pre-diagnostic stage which delayed his diagnosis. These delays were, though, unlikely to have had any significant effect on the course or management of his illness. The clinical reviewer concluded that the diagnosis of Mr Dubey's terminal illness was handled appropriately.

Mr Dubey's clinical care

30. On 10 June, the palliative care link nurse manager saw Mr Dubey in the palliative care clinic. He said he was aware of his diagnosis, felt slight discomfort in his abdomen and felt that he was losing weight. She organised a monthly weight clinic for Mr Dubey, created a palliative disease care plan and told him she would visit him every two weeks.

31. On 26 July, Mr Dubey attended hospital for chemotherapy treatment. The consultant cancelled the treatment because his blood levels were too low and he returned to the hospital on 29 July for two more blood transfusions.

32. On 1 August, the nurse manager saw Mr Dubey in the care plan clinic. He said he felt very unwell and exhausted. He said he was being pushed in a wheelchair, had not eaten properly for six weeks due to a metal plate in his lower jaw and had constant pain in his stomach. She discussed A Do Not Attempt Cardiopulmonary Resuscitation order (DNACR) with Mr Dubey. (In the event of cardiac or respiratory arrest no attempt at resuscitation will be made. All other appropriate treatment and care would continue to be provided). Mr Dubey said he wanted every effort to be made to resuscitate him. She referred Mr Dubey to the doctor, the dentist and the palliative care team and requested that the kitchen provide him with a soft diet.

33. On 2 August, a prison GP carried out a cancer care review. He referred Mr Dubey to hospital for a blood transfusion, transferred him to the inpatient department (IPD) and requested that he be provided with a soft diet. He informed the hospital that Mr Dubey was in clinical decline and was too ill to receive chemotherapy treatment.

34. On 5 August, a prison GP reviewed Mr Dubey on his return from hospital following a blood transfusion. Mr Dubey said he felt much better and did not want to stay in the IPD because he felt comfortable on the wing and had very good support from prisoners and officers. The next day, Mr Dubey returned to his wing. Healthcare staff regularly reviewed Mr Dubey; they monitored and managed his care and wellbeing, attended to his pain management, nutrition, bowels, mood, mobility and pressure areas.

35. On 24 August, a senior manager wrote to the oncology consultant and requested a medical report to help inform a compassionate release application for Mr Dubey so that they could apply for his early release on compassionate grounds. The oncologist gave an average life expectancy of about six months.

36. On 26 August, a nurse completed a mental health assessment. Mr Dubey told her he had recently been prescribed a morphine based pain relief which really helped him and he felt good. She found Mr Dubey to be oriented to time and place and expressed no thoughts of self harm. She concluded that no further input was required from the mental health team.

37. Mr Dubey could not have chemotherapy treatment due to his anaemia and was referred to hospital for radiotherapy. On 7 September, a palliative care nurse from the hospital visited Mr Dubey. She assessed his needs and continued to review him during his illness.

38. On 19 September, a prison GP examined Mr Dubey and noted he had a chest infection, and prescribed him antibiotics. Mr Dubey went to hospital for radiotherapy treatment until 23 September. He reported an improvement in his pain symptoms.

39. On 22 October, the nurse manager noted Mr Dubey's pain was well controlled with no new concerns. On 26 November, a nurse manager reviewed Mr Dubey's palliative care, noted that his pain appeared well controlled and he had a carer to assist with hygiene. Mr Dubey said he had plenty of prisoner visitors, was sleeping well and had no concerns.

40. On 8 December, a prison GP reviewed Mr Dubey on the wing. She noted he was not mobilising much and referred him to a physiotherapist for a walking aid. Mr Dubey said he had not been given soft food and continued to lose weight. The doctor discussed DNACR with him and provided him with a leaflet. Mr Dubey said he would think about it. She prescribed a soft diet with a high calorie intake.

41. On 9 December, Mr Dubey attended a review at the oncology clinic. The consultant noted a recent CT scan showed Mr Dubey's tumour was stable but his general health had continued to deteriorate. His self-care was limited and he was confined to a bed or chair for most of the day. Chemotherapy was discussed but Mr Dubey was too frail and treatment would have caused him further deterioration.

42. On 10 January, a prison GP and the palliative care nurse reviewed Mr Dubey. He told them he was not eating much at all and when his carer brought food to his cell, he often left it for a few hours and after trying a couple of mouthfuls, threw it away. Mr Dubey declined a move to the IPD but he agreed to DNACR. The nurse referred Mr Dubey to the social care team for an assessment of needs and equipment.

43. On 16 January, the palliative care nurse visited Mr Dubey on the wing and noted he was still struggling to eat, his appetite was poor and the food being delivered to him was not appropriate. He continued to receive food that he could not chew or swallow with ease. She spoke to the kitchen and they agreed to provide a soft diet. The clinical reviewer was disappointed to see that the oncology letter to healthcare commented that Mr Dubey's diet was "monotonous and savoury only". Healthcare records indicated that Mr Dubey was still receiving food that was inappropriate and food was being brought to him in his cell and left without being helped with eating his meals. At this stage of his illness, the clinical reviewer noted that he might have required some assistance with eating. We make the following recommendation:

The Head of Healthcare should review the identification, implementation and monitoring of special dietary needs.

44. On 25 January, Mr Dubey was admitted to the IPD for palliative care and end of life support. In IPD the nurse manager prepared care plans that included daily living, hydration assessment, physical observations, mental capacity, sleep, and hygiene and resuscitation status. Healthcare staff maintained close contact with the palliative care specialist nurse and the palliative care link nurse,

and on 26 January an air-flow mattress was ordered for him. Mr Dubey was still using a bucket for toileting and a commode was requested. The clinical reviewer found that for someone who by this stage would have been significantly weakened by his condition, being provided with a commode seemed a late consideration.

45. Mr Dubey continued to deteriorate and by 27 January he became nutritionally compromised with no interest in food and limited fluid intake. On 30 January the air-flow mattress had arrived for Mr Dubey. The clinical reviewer found that as Mr Dubey had been identified as being at great risk of pressure sores, this was an unacceptable delay.

46. The clinical reviewer found that at that stage, Mr Dubey was unable to swallow medication and received subcutaneous injections which gave adequate relief of his symptoms and access to a syringe driver was not available. While this might be an expensive piece of equipment for occasional use, it would have been desirable if staff accessed the equipment on loan. We make the following recommendation:

The Head of Healthcare should review access to aids and equipment, and ensure they are provided promptly both in cells and the IPD.

47. On 1 February, a prison GP noted Mr Dubey did not want to see a chaplain and he did not want staff to contact his family. Mr Dubey continued to receive medication, midazolam for agitation and morphine for pain and on 3 February, the Governing Governor authorised Mr Dubey's early release on compassionate grounds to hospital.

48. Mr Dubey died on 4 February at 2.20am. A post-mortem report confirmed that his death was caused by metastatic adenocarcinoma of stomach.

49. Overall, we are satisfied that the care Mr Dubey received was equivalent to that which he could have expected to receive in the community.

Mr Dubey's location

50. Mr Dubey was admitted to the IPD on 21 July and 2 August. The prison GP discussed the options of staying on IPD or returning to the wing with Mr Dubey. He opted to return to his cell as he felt he had good support. The clinical reviewer concluded this was an appropriate decision and was made with Mr Dubey's full involvement. Mr Dubey declined a move back to the IPD on 10 January but was transferred to IPD 25 January and was placed on the end of life care plan.

51. Attempts were made to admit him to Wisdom Hospice on 30 January but no beds were available at that time. Healthcare staff monitored and managed his care and wellbeing effectively on IPD and in cell. We are satisfied that Mr Dubey's accommodation was appropriate throughout his illness.

Restraints, security and escorts

52. The Prison Service has a duty to protect the public when escorting prisoners outside prison. It 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 Dubey was a 67 year old prisoner and was escorted by two prison officers when he attended outside hospital on 3 May 2016 to 13 January 2017. He was frail, undergoing cancer treatment and attended hospital regularly for blood transfusions. He was initially restrained by 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). On 29 July, Mr Dubey attended hospital with no restraints due to his age and mobility. Mr Dubey was restrained on a further three occasions by an escort chain, on 23 August, 8 September and 12 December. The use of restraints was inconsistent and, when their use was authorised, risk assessments did not take into account Mr Dubey's health, age or mobility and did not make it clear why the decision to restrain him was justified. We make the following recommendation:

    The Governor should ensure that when restraints are used for prisoners taken to hospital, there are properly considered risk assessments, in line with the legal guidance, 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 Dubey's family

54. Mr Dubey was divorced from his wife, had lost contact with his children and had had little contact with friends following his conviction. He named a friend as his next of kin. On 31 January, the Managing Chaplain was appointed as Mr Dubey's family liaison officer and he informed the next of kin and her daughter about Mr Dubey's condition. They arranged to visit him on 4 February, but Mr Dubey died before they could visit him. Two chaplains informed her and her daughter of Mr Dubey's death in person. She agreed for the prison to arrange Mr Dubey's funeral, which was held on 20 March. The prison contributed to funeral costs in line with national policy.

Compassionate release

55. 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.

56. Mr Dubey had little contact with his family and friends and there was no suitable release address for Mr Dubey to reside that would have met his care needs. On 7 July, a senior manager sent Mr Dubey's medical reports to the Offender Management Unit (OMU) to support any compassionate release application. She wrote to the consultant oncologist requesting a medical report in support of Mr Dubey being released on compassionate grounds. The oncologist gave an average life expectancy of about six months. In view of Mr Dubey's deterioration in health, the clinical reviewer was of the view that his life expectancy was likely to be less than six months.

57. On 30 January, healthcare requested a transfer to a hospice. The next day, the hospice informed healthcare that there were currently no beds available. The Governing Governor had authorised Mr Dubey's early release but Mr Dubey died before a bed became available. We are satisfied that Elmley appropriately considered Mr Dubey's early release on compassionate grounds.

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