Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Sands a prisoner at HMP Garth on 13 July 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.

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 David Sands died on 13 July 2017 of an infection caused by underlying thyroid cancer, while a prisoner at HMP Garth. He was 60 years old. We offer our condolences to Mr Sands' family and friends.

Mr Sands received a good standard of clinical care at Garth and at HMP Preston, where he received palliative care following his cancer diagnosis. We are satisfied that the care he received was at least equivalent to that which he could have expected to receive in the community.

However, the investigation found that prison staff at Garth did not follow the correct procedures when clearing Mr Sands' cell and his belongings were returned to his next of kin in a very poor condition, which caused unnecessary distress to his family.

We also found that Preston was unable to provide all the escort documentation for Mr Sands' hospital visits. We repeat a previous recommendation to Preston that they must ensure all prisoner records are stored securely so that they can be provided to us during an investigation.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Elizabeth Moody
Acting Prisons and Probation Ombudsman **February 2018**

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Summary

Events

1. Mr David Sands was serving a 14 year sentence for sexual offences. He was sentenced in January 2016 and moved to HMP Garth on 17 June 2016.

2. On 9 January 2017, Mr Sands reported a lump on his neck to a nurse and she arranged for a GP review. Four days later, a prison GP reviewed Mr Sands and made an urgent referral to a hospital specialist under the suspected cancer pathway. On 1 February, following hospital tests, a consultant told Mr Sands the lump was likely to be cancer. He underwent a thyroidectomy (removal of the thyroid gland) on 15 February. On 24 February, Mr Sands was transferred to the inpatient unit at HMP Preston for monitoring.

3. On 30 March, a consultant oncologist told Mr Sands that his cancer had spread to his lungs and chest. The consultant told Mr Sands that he had a prognosis of less than 12 months and advised he continue with radiotherapy to help slow the progression of the disease. Mr Sands was transferred to the inpatient unit at HMP Preston, where healthcare staff monitored and reviewed him frequently.

4. On 27 May, a prison family liaison officer made arrangements for Mr Sands' wife to collect his property from Garth. She told us that she received his property in clear plastic bags that had been torn and contained items of rotting food that had damaged the property to such an extent it could not be kept.

5. On 3 July, a specialist palliative care nurse and a prison GP saw Mr Sands for a joint examination. The GP requested blood tests and prescribed medication to treat a chest infection and oral thrush. Five days later, the same GP saw Mr Sands for a review and diagnosed dehydration that was caused by an underlying infection. He sent Mr Sands to hospital where his condition declined. He died in hospital, with his family present, on 13 July. The coroner gave the preliminary cause of death as septicaemia (blood infection) and mediastinitis (infection of the tissues in the mid-chest), caused by thyroid cancer.

Findings

6. We are satisfied that healthcare staff at Garth referred Mr Sands to a hospital specialist promptly and that there was no delay in his diagnosis. Palliative care at Preston was good and staff appropriately involved Mr Sands in decisions about his care. The clinical reviewer considered that his care was at least equivalent to that which he could have expected to receive in the community.

7. Based on the information provided to us, we found that the use of restraints on Mr Sands was proportionate to his level of risk and clinical presentation. However, we are concerned that Preston was unable to locate all the escort paperwork for Mr Sands' radiotherapy treatment in March and April.

8. The investigation indentified a need to ensure that staff at Garth follow the correct cell clearance procedures and that they return prisoners' property to their families in an appropriate condition.

Recommendations

- The Governor of HMP Preston should ensure that prisoners' documentation is stored securely and able to be retrieved as necessary.
- The Governor of HMP Garth should ensure that staff follow the correct procedures when clearing prisoners' cells following deaths in custody and that prisoners' property is returned to their families in an appropriate condition.

The Investigation Process

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

10. The investigator obtained copies of relevant extracts from Mr Sands' prison and medical records.

11. NHS England commissioned a clinical reviewer to review Mr Sands' clinical care at the prison.

12. We informed HM Coroner for Preston and West Lancashire District of the investigation who gave us the provisional cause of death. We have sent the coroner a copy of this report.

13. The investigator contacted Mr Sands' wife, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Sands' wife raised a number of issues, including:

    - she was concerned that when Mr Sands was diagnosed with cancer in February 2017, no urgency was placed on his condition;
    - she wanted to know why Mr Sands' property contained rotting food;
    - she asked why visits at Preston were regularly cut short;
    - Mr Sands had difficulty swallowing and she wanted to know if the prison provided a suitable diet;
    - she was concerned that Mr Sands was not supervised taking medication and was sent to hospital as a result;
    - she wanted to know why Mr Sands was restrained by double handcuffs and why his family could not sit with him in hospital;
    - she was concerned about communication with the family liaison officer from Garth.

14. The investigation has assessed the main issues involved in Mr Sands' 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.

15. Mr Sands' wife received a copy of the initial report. She did not make any comments.

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

Background Information

HM Prison Garth

17. HMP Garth holds up to 846 men, many serving indeterminate sentences for public protection (IPP), life sentences, or other long sentences. Lancashire Care Foundation Trust provides health services. Nurses are on duty between 7.00am and 9.00pm every day. Chorley Medics provide a service outside these times. GP clinics are held every day, normally from 9.00am to 1.00pm but occasionally from 1.00pm to 5.00pm. There is no in-patient unit.

HM Prison Preston

18. HMP Preston is a category B local prison serving the courts in Lancashire and Cumbria. It holds up to 811 male prisoners. Since 1 April 2017, Spectrum CIC (community interest group) has provided primary healthcare services 24 hours a day, seven days a week. The service was previously provided by Lancashire Care NHS Foundation Trust. GPs provide daytime cover between 8.00am and 9.00pm Monday to Friday and 3.00pm to 5.30pm on Saturdays. Outside of these hours a Registered General Nurse is on duty. An out of hours service is provided by GTD Healthcare.

19. Preston is a regional healthcare facility taking patients from other prisons. The facility has a 10 bed physical care inpatient unit provided in two three bed dormitories and four single cells. Palliative care is provided within that setting.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Garth was in January 2017. Inspectors reported that the range of primary healthcare clinics was appropriate but waiting times were unacceptably long for GP appointments, at around 5 weeks. Prisoners with urgent health needs were seen promptly and access to the community out-of-hours GP service was appropriate and prisoners with acute health needs or injuries could access daily nurse assessment clinics.

21. The most recent inspection of HMP Preston was in March 2017. Inspectors noted that there had been eight deaths from natural causes since the last inspection in 2014, and that an action plan to address health-related recommendations made by the Prisons and Probation Ombudsman following deaths in custody was incomplete. Inspectors reported that the 24 hour health service was short staffed, which affected service delivery, including nurse-led clinics for long-term conditions and primary mental health care.

Independent Monitoring Board

22. 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.

23. In its latest annual report for the year to 30 November 2016, the IMB at HMP Garth reported that GP waiting times had reduced from 4-5 weeks to 3 weeks and that there were fewer missed hospital appointments from lack of escorts, due

to the attendance at the establishment of a Medical Mobile Unit which was used for CT Scans/X Rays/MRI Scans and Ultra Sound appointments.

24. In its latest report for the year to 31 March 2016, the IMB at HMP Preston reported that the prison operated a regional hospital facility and had an in-patient capability and a palliative care role. During that period three deaths from natural causes had occurred.

Previous deaths at HMP Garth

25. Mr Sands was the fifth prisoner to die of natural causes while in the custody of Garth since January 2016. There were no similarities between Mr Sands' death and the other deaths.

Previous deaths at HMP Preston

26. Three prisoners at Preston have died from natural causes since January 2016. In our last investigation into a death at Preston, the prison was unable to produce all the prisoner's escort documentation and we made a recommendation about this.

Findings

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

27. On 18 December 2015, Mr David Sands was convicted of sexual offences and sent to HMP Liverpool. He was sentenced to 14 years imprisonment on 18 January 2016 and was moved to HMP Garth on 17 June. Mr Sands had a number of chronic health conditions, including diabetes and high blood pressure.

28. On 9 January 2017, Mr Sands reported a lump on the left side of his neck and difficulty swallowing to a nurse who requested an urgent GP appointment. There is no indication in SystmOne (the prison's electronic medical record) that Mr Sands had previously reported any concerns about his neck. On 13 January, a prison GP examined Mr Sands and made an urgent Ear Nose and Throat (ENT) referral under the NHS pathway that requires patients with suspected cancer to be seen by a specialist within two weeks. A specialist nurse saw Mr Sands at a hospital on 25 January and arranged for him to have a fine needle aspiration biopsy (where cell samples are taken) and a computerised tomography (CT) scan.

29. On 1 February, a consultant head and neck surgeon informed Mr Sands that his test results indicated the lump on his neck was growing rapidly and was likely to be cancer. He recommended a total thyroidectomy (the surgical removal of the entire thyroid gland) and transferred his care to another consultant head and neck surgeon. On 10 February, Mr Sands had a core biopsy (where a hollow needle is used to take a tissue sample) to confirm the type of cancer cells, and saw a consultant, who informed him that he was likely to have an aggressive form of thyroid cancer. Mr Sands had a thyroidectomy, at a hospital, five days later.

30. On 24 February, Mr Sands was discharged to the regional inpatient unit at HMP Preston for monitoring. A nurse conducted an initial reception screen and healthcare staff continued to monitor Mr Sands until he returned to Garth on 28 February. On 9 March, a consultant oncologist saw him for a review at a hospital and recommended a course of radiotherapy, followed by chemotherapy. Mr Sands was readmitted to the inpatient unit at HMP Preston on 22 March for monitoring and support during treatment.

31. On 30 March, a consultant oncologist saw Mr Sands at the Royal Preston Hospital and told him that a CT scan taken to plan his radiotherapy had identified that his cancer had spread rapidly to his lungs and chest. The consultant told Mr Sands that the aggressive nature of his disease meant his life expectancy was less than12 months, and suggested he continue radiotherapy to help prevent the development of additional symptoms. A nurse reviewed Mr Sands when he returned to prison and made a specialist palliative care referral the next day.

32. The clinical reviewer considered that the prison GP appropriately referred Mr Sands to a specialist for further investigations when he presented with the lump on his neck, which resulted in his subsequent cancer diagnosis. We are satisfied that Mr Sands' diagnosis was made in a timely manner.

Mr Sands' clinical care

33. A consultant oncologist met Mr Sands and his wife at the hospital on 6 April, to discuss his ongoing treatment plan. A dietician saw him for a review and later contacted a nurse, to relay concerns that Mr Sands had lost weight and had difficulty swallowing. The nurse made a note of the suitable foods suggested by the dietician and arranged for a locum GP to prescribe high calorie food supplements to help address Mr Sands' weight loss. Two days later, she completed a comprehensive end of life care plan and liaised with kitchen staff about the provision of a soft diet for Mr Sands.

34. Clinical records indicate that Mr Sands had a range of prescribed medication, which healthcare staff changed to liquid form where possible, to make it easier for him to swallow. Mr Sands was permitted to have his medication "in possession" (in his cell with him) rather than have it dispensed and administered under the supervision of healthcare staff. Records also indicate that although Mr Sands remained independent and could walk short distances, he became more tired as his condition deteriorated. The nurse told the investigator that staff offered Mr Sands the use of a wheelchair on a number of occasions, but he declined.

35. On 23 April, a nurse recorded that Mr Sands' general health and ability to tolerate fluids had deteriorated throughout the day. She contacted an out of hours GP for advice and sent him to the hospital by ambulance. Staff found Mr Sands' medication from the last round untouched in his cell shortly afterwards. A nurse told us that although staff would not have issued Mr Sands' medication had he presented as confused or disorientated, they decided to supervise his medication following this discovery. Hospital staff admitted Mr Sands to treat an acute kidney injury and subsequently stopped his radiotherapy treatment. He returned to HMP Preston a week later and a nurse saw him for a review.

36. On 16 May, prison and healthcare staff from Garth and Preston attended a multidisciplinary meeting to discuss Mr Sands' ongoing care, with his wife and daughter also present. Later the same day, Mr Sands told a locum GP that he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect. Over the next six weeks, healthcare staff at Preston monitored and reviewed Mr Sands frequently. They issued appropriate medication and liaised with palliative care specialists, when required. Although Mr Sands' condition deteriorated, records indicate that he remained relatively mobile and was able to care for himself. He also had regular contact with kitchen staff about appropriate variations to his diet.

37. On 3 July, a specialist palliative care nurse and a locum GP, saw Mr Sands for a joint examination. The locum GP requested a series of blood tests and prescribed amoxicillin (an antibiotic medication) to treat a chest infection and nystatin (an anti-fungal medication) to treat oral thrush. On 8 July, he reviewed Mr Sands and diagnosed dehydration caused by underlying infection. He sent him by ambulance to the hospital, where staff confirmed that his cancer had spread further within his chest and lungs. Prison healthcare staff kept in frequent contact with the hospital for updates on his condition. Mr Sands' health deteriorated rapidly and he died in hospital on 13 July, with his family present.

38. The clinical reviewer considered that Mr Sands received a good standard of care in prison. Healthcare staff at HMP Preston managed his terminal illness well and followed instructions from specialist palliative care nurses in relation to his end of life care. Staff planned his care effectively, prescribed appropriate medication and involved Mr Sands in discussions about his ongoing care. We are satisfied that the care Mr Sands received in prison was equivalent to that which he could have expected to receive in the community.

Mr Sands' location

39. We are satisfied that staff at Garth appropriately took account of Mr Sands' declining health and facilitated his transfer to the regional inpatient unit at Preston, which was appropriate for his needs.

Restraints, security and escorts

40. When prisoners have to travel outside the prison, a risk assessment determines the nature and level of security arrangements, including 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 decisions should be based on the security risk taking into account factors such as the prisoner's health and mobility.

41. Mr Sands went to hospital on a number of occasions and the escort risk assessments provided by Garth and Preston indicated that he presented a low risk of escape and a medium risk of harm to others. Medical staff assessed that he could mobilise independently and there were no medical objections to the use of restraints. Initially, Mr Sands' risk assessments recommended that officers restrain him with double handcuffs, in line with his security category, but to ensure their removal during treatment. (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.)

42. Prison staff at Preston kept Mr Sands' risk assessments under frequent review and reduced the level of restraints used as his condition deteriorated, taking into account medical opinion. Generally, a single handcuff or an escort chain was used to restrain Mr Sands as his cancer progressed. (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.) Mrs Sands reported concern to staff that double cuffs were used to restrain Mr Sands when she accompanied him to an outpatient appointment on 6 June. However, his risk assessment indicates that staff restrained Mr Sands with a single handcuff due to his terminal illness.

43. Records obtained from Preston indicate that escort officers removed Mr Sands' restraints during radiotherapy treatment throughout March and April. However, despite requesting the escort paperwork, we have not been able to confirm whether staff removed restraints between 14-17 April and 20-21 April, as the prison could not locate the paperwork for these escorts.

44. When Mr Sands went to hospital on 8 July, a prison manager decided that staff should use an escort chain to restrain him. Shortly after Mr Sands arrived at

hospital, the prison manager authorised the removal of the escort chain as he was nearing the end of life. It was not reapplied.

45. Based on the information provided to us, we consider that the prison appropriately considered the use of restraints. However, we are concerned that we were not provided with all the escort paperwork to cover Mr Sands' radiotherapy treatment in March and April. We have therefore been unable to confirm whether or not restraints were always removed during treatment. In the absence of the documentation we make no finding or recommendation on the question of restraints. However, we repeat a recommendation we made to Preston previously about ensuring prisoner records are stored securely:

The Governor of HMP Preston should ensure that prisoners' documentation is stored securely and able to be retrieved as necessary.

Liaison with Mr Sands' family

46. On 27 April, Garth appointed a Supervising Officer (SO) as family liaison officer. She contacted Mr Sands' wife, his nominated next of kin, to explain her role. As her role often required her to move between different prisons, the SO arranged to provide ongoing support to Mrs Sands by email because this enabled her to communicate with Mrs Sands more quickly. She also said that staff provided Mrs Sands with relevant contact numbers should she wish to speak to anyone. Mrs Sands told us that email was not her preferred option but the SO said Mrs Sands had never told her that she was unhappy with the contact arrangements. In the circumstances, we consider that the method of communication was acceptable.

47. On 27 May, the SO arranged for Mrs Sands to collect Mr Sands' property from Garth. Mrs Sands told us that prison staff had put his property into clear plastic bags that had split and contained items of rotting food. This meant that Mrs Sands could not keep the property, which caused her distress. A prison manager told us that officers had not followed local procedures when clearing Mr Sands' cell and had failed to remove the food items. She said the family liaison officer would normally be involved in cell clearances following a death in custody, but as Mr Sands was still alive and the SO was not always at Garth, this did not happen.

48. Prison Service Instruction (PSI) 64/2011, Safer Custody, says, "Where prisoners have a terminal illness or suffer an unpredicted and/or rapid deterioration in their physical health, prisons must have in place procedures for supporting the prisoner [and] engaging with their next of kin". Although there were some initial delays transporting Mr Sands to visits at Preston, which meant visits were cut short, staff did facilitate unlimited family visits as his health deteriorated. Staff arranged for Mr Sands to have regular telephone contact with his family and for Mrs Sands to accompany him to some of his outpatient hospital appointments. A nurse provided Mrs Sands with frequent updates on Mr Sands' condition, which included letting her know when he went to hospital.

49. Following Mr Sands' admission to the hospital on 8 July, a prison manager authorised daily family visits. At 9am, on 13 July, an offender manager appointed to assist the SO, telephoned Mrs Sands to inform her that her

husband's health had declined. Mrs Sands did not answer and the offender manager sent her an email requesting a convenient time to meet her at the hospital. At 11.30am, the offender manager and the SO, met with Mr Sands' family and offered support. On 14 July, following Mr Sands' death, at 11.40am, the SO called Mrs Sands to offer her condolences the offender manager provided ongoing support until his funeral, which took place on 26 July. The prison contributed towards the costs in line with national policy.

50. Although we are satisfied that, overall, there was appropriate contact and liaison with Mr Sands' family, we are concerned that prison staff at Garth were insensitive about the state in which his property was returned to his family. We therefore make the following recommendation:

The Governor of HMP Garth should ensure that staff follow the correct procedures when clearing prisoners' cells following deaths in custody and that prisoners' property is returned to their families in an appropriate condition.

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.

52. On 21 April, a locum GP completed the medical part of the compassionate release application, indicating that Mr Sands had a life expectancy of a few months. The Governor considered the completed application on 5 May, but did not support compassionate release. His reasons included the lack of an accurate prognosis, the nature of Mr Sands' offending and the limited time he had served.

53. Records indicate that a nurse contacted a prison manager from Garth, to enquire about resubmitting Mr Sands' early release application on 3 July, following a decline in his condition. Sadly, Mr Sands died before the prison could resubmit the application.

54. We are satisfied that Garth appropriately considered early release.

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