Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Patrick Higgins a prisoner at HMP Dartmoor on 16 October 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.

The 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 Patrick Higgins died in hospital on 16 October 2016 of heart failure. He was 71 years old. I offer my condolences to Mr Higgins' family and friends.

Mr Higgins was in hospital recovering from an operation to treat liver cancer when he suffered a cardiac arrest and died. His conditions were managed appropriately and he was fully aware of the risks of surgery. I am satisfied that Mr Higgins received effective care at HMP Dartmoor and I am satisfied that the prison could not have predicted or prevented his sudden death. I am, though, concerned at the inconsistent and inappropriate decision to use restraints when Mr Higgins went to hospital on 27 July.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **May 2017**

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Summary

Events

1. On 17 January 2013, Mr Patrick Higgins was sentenced to 12 years in prison for sexual offences. He was moved from HMP Exeter to HMP Dartmoor on 1 March 2013.

2. At his initial health screen at Dartmoor, a nurse noted that Mr Higgins had type 2 diabetes, ischemic heart disease, and pain in his hip. He took five medications and aspirin to manage these conditions.

3. On 20 November 2014, Mr Higgins told a nurse that he had had a rash on his penis for approximately two and a half months. The nurse prescribed an anti-fungal cream and referred him to the prison GP. A few days later the prison GP examined Mr Higgins, diagnosed fungal dermatosis (a skin infection) and balantis (inflammation of the head of the penis), and advised him to continue with the anti-fungal cream. He scheduled a 7-day review.

4. The rash did not improve and on 1 December, the prison GP referred Mr Higgins to the sexual health outreach clinic and changed the anti-fungal cream. A sexual health outreach worker examined him on 9 December and referred him for tests for sexually transmitted infections, all of which were negative.

5. On 23 December, the prison GP referred Mr Higgins to the dermatology department at Derriford Hospital. On 4 February 2015, the dermatology consultant agreed with the diagnosis, prescribed polyfax ointment (to help prevent a skin infection), and scheduled a one-month review. There was a delay at the dermatology department and the consultant did not see Mr Higgins again until 9 June when she referred him to the urology department.

6. A urology consultant examined Mr Higgins on 27 October, and referred him for a circumcision and biopsy, carried out on 26 January 2016. The biopsy identified cancerous cells and the urology consultant referred him for a CT scan (computed tomography - uses X-rays to make detailed pictures of parts of your body). to see if the cancer had spread. He also prescribed fluorouracil cream (which kills potentially harmful and fast-growing skin cells). On 18 April, the CT scan of Mr Higgins chest, abdomen and pelvis identified possible liver cancer and he was referred for further investigations.

7. An ultrasound on 4 May, and MRI scan (uses magnetic and radio waves to make pictures of the inside of the body) on 16 May identified a lesion on Mr Higgins liver. The urology consultant and oncology consultant told Mr Higgins that the two cancers were not related. On 27 June, a biopsy confirmed the liver lesion was cancerous and he was referred for a PET scan (positron emission tomography that uses a special dye with radioactive tracers to find diseases in the body). On 26 August, a hospital doctor told Mr Higgins that the only treatment was surgery to remove half his liver. After hearing in detail the risks involved, Mr Higgins agreed to surgery.

8. Mr Higgins' operation took place on 11 October. On 14 October, hospital doctors said that he was recovering well. However, he began to experience chest pains and, on 16 October, he suffered a cardiac arrest and died at 3.30pm.

Findings

9. We are satisfied that Mr Higgins received a good standard of health care at Dartmoor, equivalent to that he could have expected to receive in the community. Mr Higgins was appropriately treated for penis cancer before a separate liver cancer was identified. Mr Higgins was aware that the operation to partially remove his liver posed a high risk of complications from the surgery, due to his age. His death was sudden and there was nothing healthcare staff at Dartmoor could have done to prevent it.

10. We are not satisfied that when Mr Higgins went to hospital on 27 July, a senior manager authorised the use of restraints without medical input about Mr Higgins' condition at that time, and when he had been assessed as a low risk to the public.

Recommendation

- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments 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 Dartmoor informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

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

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

14. We informed HM Coroner for Plymouth, Torbay and South Devon of the investigation who gave us the results of the post-mortem examination. We sent the coroner a copy of this report.

15. One of the Ombudsman's family liaison officers contacted Mr Higgins' sister to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not have any specific issues she wanted considered.

16. Mr Higgin's sister received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.

17. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Dartmoor

18. HMP Dartmoor holds up to 640 adult male prisoners. The prison comprises six residential wings. Dorset Healthcare Unit Foundation Trust provides the prison's healthcare. Healthcare staff are on duty between 7.45am and 6.00pm on weekdays and between 8.15am and 5.15pm at weekends.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Dartmoor was in December 2013. Inspectors reported improved waiting times to see the doctor, and improved quality of health care. Prisoners could see a GP within a week and access to outside hospital appointments had improved. Cancellations were rare and the process was well managed.

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 September 2016, the IMB report noted a significant increase in the age of prisoners aged over 50 and the increase in interventions needed by Healthcare. Services now include annual retinal screening, aortic aneurism screening, flu and shingles jabs and bowel cancer screening, and the introduction of The Macmillan Clinic and The St Luke's Clinic for end of life/life limiting conditions.

Previous deaths at HMP Dartmoor

21. Mr Higgins was the third prisoner to die from natural causes at Dartmoor since January 2015. There have been two other deaths since. There are no significant similarities between the investigations.

Key Events

22. On 17 January 2013, Mr Patrick Higgins was sentenced to 12 years in prison for sexual offences. He was moved from HMP Exeter to HMP Dartmoor on 1 March 2013.

23. At his initial health screen at Dartmoor, Nurse A, noted that Mr Higgins had type 2 diabetes, ischaemic heart disease, and pain in his left hip. He was taking metformin, actos and gliclazide to treat diabetes, ramipril to treat high blood pressure, simvastatin for high cholesterol and aspirin. The nurse noted he had reduced mobility but assessed him as suitable for a normal location in a single cell.

24. During his first few months at Dartmoor, Mr Higgins suffered with depression. Dr A, a prison GP, prescribed anti-depressant medication and Nurse B, a mental health nurse, assessed him. He did not require any further support from the mental health team.

25. On 20 November 2014, Mr Higgins told Nurse C that he had a rash on his penis and it had been there for approximately two and a half months. The nurse prescribed clotrimazole (antifungal cream) and referred him to Dr B, a prison GP.

26. Dr B examined Mr Higgins on 24 November. He diagnosed fungal dermatosis (skin infection) and balantis (inflammation of the head of the penis), advised him to continue applying clotrimazole and booked a 7-day review. On 1 December, the condition had not improved and the doctor prescribed terbinafine cream (a different antifungal treatment), and referred him to the prison sexual health outreach clinic.

27. Nurse D, a sexual health outreach worker, examined Mr Higgins on 9 December, and referred him for several tests for sexually transmitted infections, all of which were negative.

28. On 23 December, Dr B referred Mr Higgins to the dermatology department at Derriford Hospital. On 4 February 2015, a dermatology consultant examined Mr Higgins. She confirmed the balantis diagnosis, prescribed polyfax ointment (to prevent skin infection), and planned a follow-up appointment in one month. A prison healthcare administrator chased the dermatology department on 10 March but they could not provide an appointment. She contacted them again on 1 May and they booked an appointment for 9 June.

29. During the examination on 9 June, the dermatology consultant concluded that Mr Higgins' condition had not improved. She referred him to the urology department (urinary/reproductive tracts specialists) at Derriford Hospital.

30. A urology specialist examined Mr Higgins on 27 October and referred him for a circumcision and biopsy. A urology consultant at Derriford Hospital carried out the procedure on 26 January 2016.

31. On 22 March, Dr B received the biopsy results, which identified cancerous cells. On 11 April, the urology consultant referred Mr Higgins for a CT scan to see if the

cancer had spread. The consultant also recommended fluorouracil cream (which kills potentially harmful and fast-growing skin cells), which Dr B prescribed.

32. A CT scan of Mr Higgins chest, abdomen and pelvis on 18 April identified possible liver cancer. The urology consultant referred Mr Higgins to the oncology department for an ultrasound scan of his liver, which took place on 4 May, but the result was not clear and the hospital radiologist referred him for an MRI scan, carried out on 16 May.

33. A Macmillan cancer nurse met Mr Higgins on 1 June. They discussed Mr Higgins' hospital visits to date and noted that he was in touch with his sister, which he said was a great comfort. The nurse visited him on 29 June and 3 August, where they discussed his treatments. He did not require any physical or psychological intervention.

34. On 2 June, Dr C, a prison GP, received the MRI results, which were abnormal. He told Mr Higgins it was probable that he had a cancerous lesion on his liver, which would be determined with blood tests and a biopsy.

35. Mr Higgins had an appointment with the urology consultant on 14 June. He told Mr Higgins that it was highly unlikely that the cancer in his liver was related to his penis cancer. The consultant noted that the lesion on his penis was healing well.

36. On 20 June, Mr Higgins had a check-up with the oncology consultant who advised that he no longer needed to apply the fluorouracil cream and confirmed that the two cancers were unrelated.

37. A liver biopsy on 27 June confirmed that Mr Higgins had liver cancer. He was referred for a PET scan, carried out on 27 July.

38. On 25 August, a surgeon told Mr Higgins that removing half of his liver was the only treatment available. He explained the risks of surgery and that due to his age there was a 4 percent risk that he would not survive the operation, and a high risk of complications in the 30 days after surgery. After careful consideration, Mr Higgins agreed to surgery.

39. The following day, Mr Higgins became upset about his illness. He discussed it with Nurse E from the mental health team and later with Nurse F. Talking about his concerns improved his mood and by 29 October, he was positive about his forthcoming surgery.

40. Mr Higgins operation took place at Derriford Hospital on 11 October. The following day he was moved from intensive care to a ward and after a few days hospital doctors reported that Mr Higgins was recovering well. However, on the evening of 15 October, he began to experience chest pains. At 12.15pm the following day, he suffered a cardiac arrest, and died at 3.30pm.

Contact with Mr Higgins' family

41. Mr Higgins told his sister about his illness and operation and designated her as his next of kin. On 11 October 2016, the prison appointed an officer support grade, as the family liaison officer. However, chaplain was better acquainted with Mr Higgins and when he suffered a cardiac arrest the officer grade and the

chaplain decided that the chaplain would be a more suitable family liaison officer. Mr Higgins' sister did not live locally so when Mr Higgins died the senior manager and the chaplain, decided that it would be more appropriate for local police to notify her of his death.

42. The police visited Mr Higgins' sister's address on two occasions on the afternoon of 16 October, but nobody was there. The chaplain telephoned her at 6.35pm. Mr Higgins' sister said she had telephoned the hospital shortly before, and been told of Mr Higgins' death by hospital staff. She offered her condolences and ongoing support. She maintained regular contact and returned Mr Higgins' belongings to Mr Higgins' sister on 3 November.

43. Mr Higgins' funeral was held on 4 November. The prison service contributed towards the costs of the funeral in line with national policy and held a memorial service the same day.

Support for prisoners and staff

44. The Governor posted notices to staff informing them of Mr Higgins death and offering support.

45. The prison posted notices informing other prisoners of Mr Higgins death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Higgins death.

Post-mortem report

46. The post-mortem concluded that Mr Higgins died of acute cardiac failure caused by ischaemic and hypertensive heart disease. A hepatectomy and type 2 diabetes were contributing factors to his death.

Findings

Clinical care

47. Mr Higgins had several age related health conditions when he arrived at Dartmoor, which were managed appropriately. When he reported a rash on his penis, prison healthcare staff treated and referred him appropriately, and prison staff facilitated numerous hospital visits.

48. There was 15 months between Mr Higgins presenting with the lesion on his penis and the resulting circumcision and biopsy. The clinical reviewer considered that this delay was not due to a failure by prison healthcare staff and that they followed up his appointments appropriately. The clinical reviewer also considered that Mr Higgins liver cancer was found by chance following a routine scan assessing the extent of his penis cancer, and that the two illnesses were unrelated.

49. The clinical reviewer considered that Mr Higgins' care was equivalent to that he could have expected to receive in the community and that he fully understood the risks of surgery. We are satisfied that the prison's healthcare team had a well-coordinated approach to Mr Higgins care. Mr Higgins death was sudden and unexpected and there was nothing that healthcare staff at Dartmoor could have done to prevent it.

Restraints, security and escorts

50. 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.

51. Mr Higgins went to hospital on sixteen occasions from January 2016. Initially, a senior manager authorised the use of single cuffs on each hospital escort. At times risk assessments noted that Mr Higgins had mobility issues, and on others medical input was not included. By 13 July, medical opinion stated that Mr Higgins was elderly and frail, and he was assessed as low risk to the public. The senior manager authorised that restraints were not necessary. Two weeks later on 27 July, medical opinion was not provided and Mr Higgins was assessed as a low risk to the public. The senior manager authorised the use of restraints, despite the fact he had not two weeks previously. Thereafter, Mr Higgins was assessed as a high risk to children, but a low risk to the public with no objection on medical grounds to the use of restraints. The senior manager then authorised that restraints were not necessary.

52. It was appropriate that Mr Higgins was not restrained for a majority of hospital visits during the last few months of his life. However, there were inconsistencies in the consideration of risk assessments, particularly on 27 July when he was restrained without medical opinion about his condition and with an assessment deeming him a low risk to the public. We therefore make the following recommendation:

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

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