

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Leslie Danton a prisoner at HMP Elmley on 27 November 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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*



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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 Leslie Danton died on 27 November 2016 of bronchopneumonia caused by lung cancer, while a prisoner at HMP Elmley. He was 68 years old. I offer my condolences to Mr Danton's family and friends.

Healthcare staff at HMP Elmley completed thorough care plans and reviewed Mr Danton's care and mental capacity regularly. I am satisfied that the care Mr Danton received was at least equivalent to that which he could have expected to receive in the community.

However, I am disappointed that a prison GP authorised Mr Danton's transfer to hospital despite his end of life care and desire not to be resuscitated. This led to him dying in transit, rather than peacefully and with dignity in his palliative care cell. This suggests a need for staff at Elmley to be more confident in applying end of life care appropriately.

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

July 2017

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Summary

Events

1. Mr Leslie Danton was remanded into the custody of HMP Elmley in January 2015. He was sentenced to five years and four months imprisonment for sexual offences in April. He had a history of Chronic Obstructive Pulmonary Disease (COPD), asthma, and had poor mobility.
2. In October, Mr Danton saw a prison GP to discuss his application for a wheelchair. During this meeting, Mr Danton told the GP he had a weak heart and had shortness of breath on exertion. The GP arranged for Mr Danton to have blood tests and a chest X-ray.
3. On 10 November, Mr Danton saw a prison GP, who referred him for further investigations. The results showed Mr Danton might have lung cancer and he was sent to hospital for more thorough investigations.
4. At the end of November, Mr Danton had a CT scan. On 9 December, a consultant at the hospital informed Mr Danton that he had cancer. The consultant told him that he would be cared for as a palliative patient.
5. Mr Danton remained in single cell and healthcare staff regularly reviewed him as part of his care plan. On numerous occasions, staff at Elmley asked him if he wanted to change location in order to assist with his palliative care. He declined to move cells each time. Healthcare staff checked his mental capacity on a weekly basis to determine if he was capable of making decisions that would impact upon his clinical care.
6. A nurse assessed Mr Danton on 28 August 2016. A decision was made to move him to the Inpatient Department, as his health had started to deteriorate further and it was too difficult to care for him in his single cell on a general wing.
7. In September, Mr Danton signed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order, where he agreed that he would not be resuscitated in the event of cardiac or respiratory arrest.
8. Mr Danton's condition began to deteriorate significantly on 26 November and the following day a prison GP decided to send him to hospital for treatment. Mr Danton died while leaving the prison in the ambulance on 27 November.

Findings

9. We agree with the clinical reviewer that the care Mr Danton received at Elmley was at least equivalent to that he could have expected to receive in the community.
10. When Mr Danton's condition deteriorated significantly, a prison GP decided to send him to hospital, despite healthcare staff managing Mr Danton under palliative care arrangements and with a signed and active DNACPR. This led to

him dying in transit, rather than peacefully and with dignity in his palliative care cell.

Recommendation

- The Head of Healthcare should ensure that all staff understand the process of end of life care and are confident in implementing DNACPR agreements.

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 her. No one responded.
12. The investigator obtained copies of relevant extracts from Mr Danton's prison and medical records.
13. NHS England commissioned a clinical reviewer to review Mr Danton's clinical care at the prison.
14. We informed HM Coroner for Mid Kent and Medway Maritime 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 Danton's next of kin to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They did not respond to our letter.
16. The investigation has assessed the main issues involved in Mr Danton'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 prison received a copy of the report and did not identify any factual inaccuracies in the report.

Background Information

HMP Elmley

18. HMP Elmley is a local prison on the Isle of Sheppey, which serves the courts in Kent. It holds around 1,250 men in 6 accommodation units, 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 21-bed inpatient department.

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 good care for prisoners with the most acute needs, though general access to healthcare services remained a problem. They also found that prisoners sometimes missed routine external hospital appointments because of competing prison priorities for escort staff.

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 October 2015, the IMB reported that long-term chronic diseases were monitored by well trained healthcare staff. However, they were concerned about the number of prisoners who did not attend healthcare appointments.

Previous deaths at HMP Elmley

21. Mr Danton was the seventh person to die from natural causes at Elmley since January 2015. There were no significant similarities to any of the previous deaths.

Findings

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

22. Mr Leslie Danton was remanded into the custody of HMP Elmley on 6 January 2015 and on 17 April he was sentenced to five years four months in prison for sexual offences.
23. During Mr Danton's initial health screening, a nurse noted that Mr Danton reported he was disabled and it was his first time in prison. He recorded that Mr Danton appeared unwell and was breathing heavily. He referred him to a doctor and organised for him to be located in the Inpatient Department (IPD) due to his health problems. On 12 February, Mr Danton returned to a regular cell on normal location.
24. On 27 October, a prison GP saw Mr Danton to discuss his care needs and an application for a wheelchair. Mr Danton told him that he had a weak heart but had not been taking any medication for it. He also said that he did not have any chest pain but suffered from shortness of breath on exertion. The GP arranged for Mr Danton to have blood tests on 2 November to ensure that he was not suffering from heart failure. He also requested a chest X-ray, which appears to have happened on 6 November.
25. A prison GP saw Mr Danton to discuss his blood test results on 10 November. He noted that Mr Danton's blood test results suggested he had iron-deficiency anaemia (IDA). Mr Danton said he had never been told he was anaemic. The GP noted that his IDA would need to be assessed further as would his chest, to rule out the cause being cancer. He made an urgent referral under the NHS pathway, which requires patients with suspected cancer to be seen by a specialist within two weeks.
26. On 13 November, a prison GP noted that he had seen a chest X-ray report from 6 November. He recorded that Mr Danton had a lung mass that required an urgent CT scan. He saw Mr Danton in his cell and informed him of the results of his chest x-ray.
27. On 24 November, a nurse saw Mr Danton. He told her that he had noticed problems with his breathing for the past two years. She recorded he had recently had a chest X ray which had shown a soft tissue mass in the base of his right lung. On 30 November, Mr Danton attended hospital for a computerised tomography scan (a CT scan uses produce detailed images of many structures inside the body, including the internal organs, blood vessels and bones).
28. On 9 December, a senior manager noted that Mr Danton had a telephone consultation with the hospital, when it was confirmed he had lung cancer. She noted that there were no plans to treat Mr Danton actively, as the consultants did not feel he would be able to cope with it, due to his poor physical health. She referred Mr Danton to the palliative care team.
29. The clinical reviewer concluded that Mr Danton's medical records show that he received care equivalent to the care he could have expected to receive in the

community. Prison GPs investigated Mr Danton's symptoms in a timely manner and he was well informed of his diagnosis and treatment.

Mr Danton's clinical care

30. After his diagnosis Nurse A saw Mr Danton on 10 December, as part of his care plan. She noted that he was upset but was coming to terms with his diagnosis. She contacted the palliative care team who confirmed they had received the referral.
31. Nurse A saw Mr Danton on 6 January 2016, for a care plan review. He told her that the palliative care team had visited him and he said that he did not want to move from his current location to the IPD. Mr Danton said he did not want to move to IPD because too many staff from ethnic minorities worked there. She told him that when his condition deteriorated he would need to move to somewhere that could provide better care than he could receive on a general wing.
32. On 19 January Nurse A saw Mr Danton in his cell. He told her he was suffering from intermittent pain in his chest at night. She told him to discuss this concern with the prison GP at his review on 26 January, but if the pain worsened to alert someone. A prison GP saw Mr Danton on 26 January. Mr Danton complained of pain in his hip, knee and elbow, but there is no record of him complaining of pain in his chest. She recorded that Mr Danton was taking opioid pain relief.
33. Nurse A saw Mr Danton on 15 February, to complete a social care assessment and general review. She recorded that they discussed his difficulties with managing his personal care. She asked him if he wanted a carer, which he declined as he did not feel he needed one.
34. On 8 March, a prison GP examined Mr Danton after he had complained of vomiting and constipation. He also said he had been coughing and had an irritation in his chest. The GP called the hospital, who advised him to send Mr Danton in as an urgent admission. On 13 March, Mr Danton arrived back at Elmley after being discharged from the hospital. A nurse recorded that Mr Danton was located in the IPD due to his physical health and poor mobility. He returned to a general wing on 17 March.
35. A prison GP saw Mr Danton on 9 April. They discussed Mr Danton's palliative care. The GP noted that Mr Danton was not in pain or constipated and his lungs were clear, and that Mr Danton understood that he was in the last stages of his life. A Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order means that in the event of cardiac or respiratory arrest no attempt at resuscitation will be made. All other appropriate treatment and care will continue to be provided. Mr Danton agreed to a DNACPR.
36. On 20 April, Nurse A reviewed Mr Danton. She noted that Mr Danton refused to relocate to the IPD due to his racist beliefs and he told her he was comfortable where he was. When asked at other times to relocate, he often said he felt the wing was his home, and he was among friends.
37. On 26 May Nurse B saw Mr Danton to assess his mental capacity. She noted that he was physically unwell and unable to have his care needs appropriately

met on the wing. He still declined to move to the IPD, and she noted that he needed to have his capacity assessed on a weekly basis to ensure he was still able to make decisions about his location and care.

38. On the 27 May, Nurses A and B, the Head of Healthcare, the Governor and the Head of Safer Custody attended a multi disciplinary team meeting to discuss Mr Danton's care. They decided Mr Danton could remain in his current cell. They agreed that they would refurbish Mr Danton's cell to make it more comfortable and that healthcare staff would continue to provide daily support. On 1 June, Nurse A saw Mr Danton in his cell. He told her that he was very happy with the new hand rails fitted in his cell.
39. On the 3 June, Nurse B recorded that Mr Danton had about four to six months to live. Healthcare staff continued to monitor him.
40. On 2 August, Nurse B assessed Mr Danton's mental capacity. She found he had capacity to make decisions about his care but she told him that if his health continued to deteriorate he would have to be admitted to IPD. She then planned to assess his capacity twice weekly.
41. Nurse C attended Mr Danton's cell on 8 August, after wing officers informed her that he had fallen and was unable to get up. When she arrived he was lying on the floor of his cell. She assisted him back into his wheelchair and discussed deterioration of his health. He still declined a move to the IPD.
42. Nurses and doctors monitored Mr Danton, and discussed his care and location. On 20 August, Mr Danton was admitted to the IPD because of the decline in his physical health, and his increased risk of falling. He remained there until he died.
43. A prison GP assessed Mr Danton on 16 September 2016, after his health deteriorated and diagnosed a chest infection. She sent Mr Danton to hospital. Another GP noted that a new DNACPR form had been completed.
44. On 4 October, Mr Danton was discharged back to HMP Elmley from the hospital. Prison doctors reviewed him and healthcare staff continued to provide palliative care.
45. On 26 November, Nurse C noted that Mr Danton was struggling to breath, his mouth was dry and he was finding it difficult to take fluids. He appeared tired, not in any pain but was anxious about his difficulty breathing. She organised for him to be given anxiety medication and for him to receive a dose of morphine.
46. The next day, a prison GP noted that Mr Danton was rapidly deteriorating and recorded that Mr Danton had lung cancer, was receiving palliative care and was unable to eat and drink. He noted that Mr Danton was dehydrated with possible sepsis and arranged for Mr Danton to be taken to hospital for admission. The prison requested an ambulance at 9.55am and it arrived at the prison at 10.19am. They attended the IPD unit and Mr Danton was taken from the unit to attend hospital at 10.45am. At 11.06am, while the ambulance was in the sterile area before the main gate, paramedics confirmed Mr Danton had died.

47. The clinical reviewer concluded that the clinical care Mr Danton received was generally of a good standard. However, he was concerned that Elmley attempted to transfer Mr Danton to hospital on 27 November.
48. Mr Danton had been cared for under palliative arrangements since his diagnosis and had signed a DNACPR, which staff gave paramedics on 27 November. The clinical reviewer concluded that it was not appropriate that a GP at Elmley arranged to transfer Mr Danton to hospital given it was likely he would die in transit, and despite a signed DNACPR and end of life care arrangements being in place. As a result, he was not able to die peacefully and with dignity in his palliative care cell. We agree with the clinical reviewer that this suggests staff were not confident in their capacity to provide end of life care. This needs to be addressed and we therefore make the following recommendation:

The Head of Healthcare should ensure that all staff understand the process of end of life care and are confident in implementing DNACPR orders.

Mr Danton's location

49. Mr Danton was located in a shared cell until 13 January 2016 before moving to a more appropriate single cell. He was then moved to a different cell on a general wing where nursing staff saw him regularly to assist with his personal care and to clean his cell.
50. Healthcare staff consistently reviewed Mr Danton's mental capacity to ensure he was able to make decisions about his location and his care. He was found to have capacity, but staff at Elmley permanently moved him to the IPD after his physical health deteriorated 20 August. We are satisfied that healthcare staff regularly reviewed Mr Danton's location and that he was appropriately accommodated while at Elmley.

Restraints, security and escorts

51. When prisoners have to travel outside of 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.
52. Elmley did not restrain Mr Danton for hospital visits from January 2016 or on his transfer to hospital on 27 November. Each escort risk assessment indicates he was not restrained as he was in poor health and needed a wheelchair to mobilise. We are satisfied that the decisions not to restrain Mr Danton were appropriate.

Liaison with Mr Danton's family

53. On 27 November, Elmley appointed a chaplain as the family liaison officer. On the same day, he located Mr Danton's next of kin, his ex-partner, and went with a senior officer to her home to inform her of his death and offer support.
54. The chaplain spoke to Mr Danton's ex-partner again on 5 December and arranged for her to visit the prison on 8 December. He supported Mr Danton's

ex-partner to arrange the funeral and she requested he conduct the service. Mr Danton's funeral was held on 6 January 2017. The family arranged the funeral and the prison contributed towards the cost, 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. Healthcare at Elmley first applied for compassionate release in December 2015. However, his prognosis needed further clarification so it was too early to apply at that time. A second application was started in April 2016. The application was not supported as Mr Danton was considered a risk, partly because there was not a suitable address for him to be released to. Staff at Elmley regularly reviewed Mr Danton's care at multi disciplinary team meetings. On 18 May, Nurse A noted that Mr Danton was palliative, with no active treatment. She also recorded that she had spoken to Mr Danton on numerous occasions about compassionate release and he had stated he wanted to die in prison. We are satisfied that the prison appropriately considered the possibility of compassionate release.

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