Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Robert Shepherd a prisoner at HMP Stafford on 5 February 2018

A report by the Prisons and Probation Ombudsman

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

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 Robert Shepherd died in hospital on 5 February 2018 of lung cancer while a prisoner at HMP Stafford. He was 69 years old. I offer my condolences to those who knew him.

I am concerned that healthcare staff at HMP Stafford missed an opportunity to diagnose Mr Shepherd's cancer earlier. I am also concerned that following his diagnosis, staff did not put a palliative care plan in place and there was a two-week delay in administering pain relief. Overall his care was not equivalent to that which he could have expected to receive in the community.

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
Deputy Prisons and Probation Ombudsman **August 2018**

Contents

Summary 1

The Investigation Process 2

Background Information 3

Findings 4

Summary

Events

1. Mr Robert Shepherd was sent to prison in November 2014 and arrived at HMP Stafford on 4 January 2016. He had a history of poor health.

2. In April 2016, Mr Shepherd complained of a persistent cough. A chest X-ray showed no abnormalities. A further chest X-ray, in March 2017, also had normal results.

3. On 3 August 2017, Mr Shepherd was taken to hospital with a swollen tongue and neck and shortness of breath. He had a chest X-ray which revealed a pleural effusion (fluid between the linings of the lung). A hospital doctor advised prison GPs to make an urgent referral to the respiratory clinic under the suspected cancer pathway.

4. On 22 August, a prison GP made a routine referral to the respiratory clinic and Mr Shepherd was seen in the clinic on 12 September. Investigations revealed that Mr Shepherd had lung cancer and a hospital consultant informed him of his diagnosis on 13 November.

5. Mr Shepherd's condition was only suitable for palliative care. On 21 December, a prison GP prescribed morphine sulphate and Oramorph (liquid morphine) for pain. Mr Shepherd did not receive the Oramorph until 4 January.

6. Mr Shepherd's condition continued to deteriorate and on 19 January 2018 he went to hospital where he remained until he died on 5 February.

Findings

7. We are concerned that after Mr Shepherd had an abnormal chest X-ray, healthcare staff at Stafford did not make an urgent cancer referral in line with NICE guidelines.

8. We found that staff did not put a formal palliative care plan in place following Mr Shepherd's terminal diagnosis. We are also concerned that his pain relief medication was delayed due to discussions about how healthcare staff should administer controlled pain relief medication outside of commissioned hours.

9. We agree with the clinical reviewer that Mr Shepherd's care was not equivalent to that which he could have expected to receive in the community.

Recommendations

- The Head of Healthcare at HMP Stafford should ensure that GPs follow relevant National Institute for Health and Clinical Excellence (NICE) guidelines for suspected cancer and refer patients appropriately.

- The Head of Healthcare should ensure that an effective palliative care plan is implemented for all prisoners who are terminally ill and that this ensures access to appropriate levels of pain relief at all times.

The Investigation Process

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

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

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

13. We informed HM Coroner for South Staffordshire District of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.

14. The investigator wrote to Mr Shepherd's next of kin, his stepson, to explain the investigation and to ask if he had any matters he wanted the investigation to consider but received no response. We understand that Mr Shepherd's stepson died shortly after Mr Shepherd.

15. The investigation has assessed the main issues involved in Mr Shepherd'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.

16. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Stafford

17. HMP Stafford is a medium security prison for adult sex offenders, which can hold around 750 prisoners across seven wings. Care UK provides healthcare services. Nurses are on duty daily between 7.30am and 5.30pm and there is a weekday GP service, with on-call GPs outside these hours.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Stafford was conducted in February 2016. Inspectors found that health provision was not consistently meeting the needs of the ageing population. Governance was reasonable overall, with effective working between providers and the prison. The range of primary care services was appropriate and access to nurses and GPs was good. There was a very high need for hospital appointments and at times over a quarter of appointments were cancelled or rescheduled because there were not enough escort staff. Prisoners over 65 and those with mobility problems were not routinely handcuffed for external hospital appointments except when a specific risk had been identified.

Independent Monitoring Board

19. 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 their latest annual report, for the year to 30 April 2017, the IMB reported that healthcare had improved substantially since its last report, with a reduction in waiting lists for internal services, and fewer cancelled escorts for external appointments. The waiting time for GP appointments was comparable to that in the community.

Previous deaths at HMP Stafford

20. Mr Shepherd was the thirteenth prisoner to die at Stafford since 1 January 2015, which is not remarkable, given the prison's population. All were from natural causes. In two previous investigations, we found there had been a delay in the prisoners' cancer diagnoses, as in Mr Shepherd's case. There have been two deaths since, one from natural causes and one awaiting classification.

Findings

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

21. Mr Robert Shepherd was serving a 10-year sentence for sexual offences. He was sent to prison in November 2014 and had been at HMP Stafford since 4 January 2016. He was in poor physical health and had a history of ischaemic heart disease, stroke and chronic kidney disease. In November 2014 at HMP Hewell, he had a malignant mole removed from his cheek.

22. On Mr Shepherd's arrival at Stafford, a prison nurse carried out his initial health screen. She noted his history of cancer and heart disease and his prescribed medication. Mr Shepherd was a long-term smoker and declined help to stop. The nurse also noted Mr Shepherd's history of exposure to asbestos.

23. On 11 March 2016, Mr Shepherd complained of a persistent cough. A prison GP made an urgent referral to a chest specialist under the NHS pathway that requires patients with suspected cancer to be seen by a specialist within two weeks. On 17 March, Mr Shepherd had a chest X-ray at County Hospital, Stafford. The results were received on 28 April and showed no abnormalities. On 16 June, a follow-up X-ray showed Mr Shepherd's lungs were normal and clear.

24. On 30 May, a prison GP made an urgent referral to a dermatology specialist under the NHS pathway that requires patients with suspected cancer to be seen by a specialist within two weeks. Mr Shepherd had a benign lesion removed from his right cheek. Hospital specialists continued to monitor Mr Shepherd while he was at Stafford.

25. On 11 January 2017, Mr Shepherd started smoking cessation therapy and a prison GP prescribed nicotine cartridges and an inhalation device.

26. On 16 March, Mr Shepherd had a chest X-ray with normal results after he complained of wheezing and a tight chest.

27. On 20 July, a prison nurse saw Mr Shepherd for a routine blood pressure check. Mr Shepherd said he had a poor appetite, loose stools and unexplained weight loss. The nurse made a referral to a GP. A prison GP saw Mr Shepherd the next day to review his prescribed medication but did not discuss his weight loss.

28. On 3 August, Mr Shepherd complained of swelling in his tongue and neck and feeling short of breath. A prison nurse called an emergency ambulance and Mr Shepherd was taken to County Hospital where he had a chest X-ray. He returned to Stafford the same day.

29. On 8 August, an accident and emergency doctor wrote to the prison and said Mr Shepherd's X-ray had revealed a pleural effusion (a build-up of fluid between the linings of the lung) on Mr Shepherd's right lung. The hospital doctor advised an urgent referral to the respiratory clinic.

30. The same day, a prison GP asked a healthcare administrator to contact the respiratory clinic about Mr Shepherd's appointment. There is no evidence that this took place. On 22 August, a prison GP made a routine referral to the respiratory clinic.

31. On 12 September, a hospital respiratory specialist saw Mr Shepherd. The specialist told Mr Shepherd he may be suffering from lung cancer and he would need to investigate this. On 28 September, the respiratory clinic cancelled Mr Shepherd's outpatients appointment due to the clinic being overbooked.

32. On 9 October, a cardiothoracic consultant saw Mr Shepherd at Royal Stoke Hospital and said he would need fluid drained from his lungs to confirm his diagnosis. This took place on 19 October.

33. On 13 November, the cardiothoracic consultant told Mr Shepherd he had lung cancer. On 29 November, Mr Shepherd had an appointment with a consultant clinical oncologist. The oncologist told Mr Shepherd that his condition could not be treated and he would receive palliative care.

34. National Institute for Health and Care Excellence (NICE) guidelines state that healthcare professionals should make a fast track cancer referral for all patients with chest signs consistent with lung cancer or pleural disease.

35. In Mr Shepherd's case, a hospital doctor advised an urgent referral to the respiratory clinic but prison GPs did not make a fast track referral. A respiratory consultant did not see Mr Shepherd until six weeks after his abnormal chest X-ray.

36. While the failure to make an urgent referral may not have impacted on Mr Shepherd's prognosis, we share the clinical reviewer's concern that prison GPs did not make an urgent referral for further investigation into Mr Shepherd's abnormal chest signs. We make the following recommendation:

    The Head of Healthcare at HMP Stafford should ensure that GPs follow relevant National Institute for Health and Clinical Excellence (NICE) guidelines for suspected cancer and refer patients appropriately.

37. We also direct the attention of Head of Healthcare to further comments and recommendations that are contained in the clinical review, which are not repeated here.

Mr Shepherd's clinical care

38. On 23 November, a prison GP contacted the Head of Healthcare, the Deputy Head of Healthcare and the Gold Standards Framework (GSF) lead to ensure that Mr Shepherd's palliative care needs were met. The GSF is a model that enables good practice to be available to all people nearing the end of their lives, irrespective of diagnosis. It provides a framework for a planned system of care in consultation with the patient and family and promotes better coordination and collaboration between healthcare professionals. The tool helps to optimise out-of-hours care and can prevent crises and inappropriate hospital admissions.

39. On 30 November, a prison nurse created a pain relief care plan to ensure Mr Shepherd remained comfortable and pain free. There is no record that Mr Shepherd was placed on a palliative care register or that staff created a formal palliative care plan.

40. On 1 December, Mr Shepherd told a prison GP he did not wish to be resuscitated if his heart or breathing stopped. He signed an order to that effect on 6 December.

41. On 11 December, a prison nurse made a social care referral after Mr Shepherd fell over in the shower. The nurse noted that Mr Shepherd needed support with his hygiene and social care.

42. On 19 December, a prison officer visited Mr Shepherd in his cell and told healthcare that Mr Shepherd was complaining of extreme pain. A healthcare administrator told the prison officer that healthcare staff were in a meeting and would see Mr Shepherd when they were free. There was no evidence that healthcare staff saw Mr Shepherd that day.

43. On 20 December, a prison nurse completed Mr Shepherd's social care assessment. There is no evidence that nurses created a care plan to manage Mr Shepherd's physical or social care needs.

44. The next day, Mr Shepherd complained of feeling unwell. A prison nurse contacted a Macmillan nurse at Katherine House Hospice who advised morphine sulphate and Oramorph (liquid morphine) for pain. The nurse noted that healthcare staff did not have access to controlled pain relief medication after 5.30pm during the week and 6pm at the weekend. A prison GP prescribed Mr Shepherd pain relief medication as advised.

45. That same day, a multidisciplinary team meeting (MDT) took place to discuss Mr Shepherd's access to controlled pain relief medication. Prison managers agreed to allow Mr Shepherd to have Oramorph in his cell. A prison GP informed the MDT that he intended to report the prison healthcare department to the Care Quality Commission (CQC-the independent regulator of all health and social care services in England) regarding the availability of Oramorph outside of commissioned hours. There is no evidence in Mr Shepherd's clinical record that the prison GP contacted the CQC.

46. On 22 December, nurses gave Mr Shepherd morphine sulphate for pain relief. On 4 January 2018, nurses gave Mr Shepherd Oramorph to keep in his cell to enable healthcare staff to administer it outside of commissioned hours. This was 15 days after Mr Shepherd complained of pain and nurses received advice from Katherine House Hospice.

47. A further MDT took place on 16 January to discuss Mr Shepherd's palliative care. On 19 January, Mr Shepherd's condition deteriorated and he complained of increased pain. A prison nurse arranged an emergency ambulance to take Mr Shepherd to County Hospital. Mr Shepherd's condition continued to decline and he died in hospital at 11.25pm on 5 February.

48. The clinical reviewer commented that Mr Shepherd was a frail, elderly man who already had significant health problems when he was diagnosed with lung cancer.

The clinical reviewer considered that Mr Shepherd did not have appropriate palliative, cancer and complex care plans and that his palliative care was limited.

49. We are concerned that Mr Shepherd's pain relief medication was delayed due to discussions about how healthcare staff should administer controlled pain relief medication outside of commissioned hours. We note the clinical reviewer's comments that NHS England should consider commissioning 24-hour healthcare at Stafford due to the increase in the elderly population in prisons. Prison GP prescribed Mr Shepherd Oramorph on 21 December, but he was not able to start taking it until 4 January 2018. After healthcare and prison staff agreed to allow Mr Shepherd Oramorph in possession, a further delay occurred waiting for the medication to arrive at the prison. We make the following recommendation:

The Head of Healthcare should ensure that an effective palliative care plan is implemented for all prisoners who are terminally ill and that this ensures access to appropriate levels of pain relief at all times.

Mr Shepherd's location

50. Staff nursed Mr Shepherd in his cell at Stafford. He was initially located on C wing but when his condition deteriorated in December 2017, he was moved to the care suite on F wing. On 29 December 2017, healthcare staff made a referral to Katherine House Hospice but there were no beds available. On 19 January 2018, Mr Shepherd was moved to County Hospital, Stafford where he remained until his death on 5 February. We are satisfied that Mr Shepherd's location was appropriate.

Restraints, security and escorts

51. 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.

52. Staff carried out thorough risk assessments and following his diagnosis, did not restrain Mr Shepherd.

Liaison with Mr Shepherd's family

53. On 1 December, the prison appointed a prison officer as Mr Shepherd's family liaison officer (FLO). The same day, at Mr Shepherd's request, the FLO contacted Mr Shepherd's stepson, introduced herself and explained Mr Shepherd's condition. The FLO maintained regular contact, providing information about Mr Shepherd's condition. Mr Shepherd's step-son asked to be told about Mr Shepherd's death by telephone. At 9am on 6 February, the FLO telephoned Mr Shepherd's stepson and told him Mr Shepherd had died.

54. Mr Shepherd's funeral was held on 1 March 2018. The prison arranged and contributed to the 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. On 5 December 2017, a prison GP completed the medical part of the compassionate release application, indicating that Mr Shepherd had a life expectancy of a few months. The Governor considered the completed application on 12 December, but did not support compassionate release. His reasons included the nature of Mr Shepherd's offending and the lack of suitable accommodation and financial support.

57. We are satisfied that Stafford appropriately considered early release.

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