

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Ward a prisoner at HMP Rye Hill on 27 April 2017

**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*



© Crown copyright 2015

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

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 John Ward died on 27 April 2017 of stomach cancer while a prisoner at HMP Rye Hill. He was 68 years old. I offer my condolences to Mr Ward's family and friends.

Healthcare staff appropriately referred Mr Ward to specialists leading to a swift diagnosis, and he received care in prison equivalent to that which he could have expected to receive in the community. The authorising prison manager appropriately considered the gravity of Mr Ward's condition and its impact on his risk and concluded that staff should not apply restraints during his last admission to hospital. I make no recommendations.

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

November 2017

Contents

Summary	1
The Investigation Process	2
Background Information	3
Findings	4

Summary

Events

1. On 26 August 2016, Mr John Ward was sentenced to two years in prison with eight years extended licence for sexual offences, and was sent to HMP Leicester. He had a medical history of respiratory tract infections and heartburn.
2. Mr Ward was transferred to HMP Rye Hill on 28 October 2016. He did not have any serious health issues and was not interested in stopping smoking.
3. On 2 February 2017, Mr Ward told a prison doctor he had been vomiting and felt he was losing weight. The doctor referred him urgently to see a hospital specialist. Investigations on 8 February revealed he had a cancerous growth in the stomach area, which was confirmed by doctors on 14 February. On 7 March, a hospital specialist told Mr Ward his prognosis was only 'months'.
4. Mr Ward was cared for at Rye Hill on the wing. Staff discussed his diagnosis and prognosis with him, including his resuscitation wishes. His dietary needs were catered for, his pain managed and he was located in a large double cell to himself on the ground floor of the wing. Mr Ward was readmitted to hospital on 24 April. He died on 27 April before an application for a hospice place or early compassionate release was processed. Staff did not apply restraints during his last admission to hospital.

Findings

5. The clinical reviewer was content that the care Mr Ward received was equivalent to that which he could have expected to receive in the community. We are satisfied that the prison appropriately considered release on compassionate grounds. Appropriately, the prison did not apply restraints during his last admission to hospital. We make no recommendations.

The Investigation Process

6. The investigator issued notices to staff and prisoners at HMP Rye Hill informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
7. The investigator obtained copies of relevant extracts from Mr Ward's prison and medical records.
8. NHS England commissioned a clinical reviewer to review Mr Ward's clinical care at the prison.
9. We informed HM Coroner for Northamptonshire of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.
10. The investigation has assessed the main issues involved in Mr Ward'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.
11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HM Prison

12. HMP Rye Hill is run by G4S and it holds more than 600 men convicted of sex offences. G4S Forensic and Medical Services provide primary physical and mental health services, and Northamptonshire Healthcare NHS Foundation Trust (NHFT) provides secondary mental health services. The prison does not have an inpatient facility.

HM Inspectorate of Prisons

13. The most recent inspection of HMP Rye Hill was in August 2015. Inspectors noted that the prison held a complex mix of serious offenders and some frail older men who needed significant levels of care. The inspection found that the quality of healthcare services was the weakest area of the prison. Services had not sufficiently adapted to meet the needs of the new population, when the prison had changed its role to take sex offenders in 2014. There were staff shortages and the available staff were not deployed efficiently. There were long waiting times for most clinics. A small group of regular GPs had run daily clinics since January 2015, which had improved consistency and prisoners' perceptions of service provision. However, prisoners waited up to three weeks for routine GP appointments. Prisoners had good access to pharmacy staff for advice.
14. 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 March 2017, the IMB reported that healthcare provision remained under pressure and was a cause for concern. They found that recruiting and retaining suitable healthcare staff was an ongoing problem. They said the current service needed further investment and improvement if it was to ensure it can give prisoners the same level of care they would receive in the community.

Previous deaths at HMP Rye Hill

15. Mr Ward's is the eighth death from natural causes at Rye Hill since the beginning of 2016. There are no significant similarities with those deaths and Mr Ward's.

Findings

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

16. On 26 August 2016, Mr John Ward was sentenced to two years in prison with eight years extended licence for sexual offences, and was sent to HMP Leicester. Mr Ward committed these offences while released on licence in the community. He had a history of respiratory tract infections and heartburn.
17. A nurse completed Mr Ward's initial health screen at Leicester and noted he was a smoker with no interest in giving up. There were no serious concerns about his physical health, but Mr Ward asked to see the mental health team and they diagnosed depression. A prison GP saw Mr Ward on 9 September and prescribed citalopram (an anti-depressant) and lansoprazole for acid reflux and heartburn.
18. Mr Ward was transferred to Rye Hill on 28 October 2016. A nurse completed the initial health screen and arranged for a doctor to prescribe his medication the same day. The nurse did not note any new concerns.
19. On 5 January 2017, a prison GP saw Mr Ward for a medication review. He noted Mr Ward felt well, did not have any swallowing problems and had not lost any significant weight. He also noted that he discussed Mr Ward's smoking habit and that Mr Ward had said he would struggle to give up even if he had help.
20. On 2 February, the GP saw Mr Ward again. Mr Ward said he had been vomiting, felt he was losing weight, had leg cramps and was more short of breath than usual. The GP provisionally diagnosed indigestion but also made a referral under the NHS pathway, which requires patients with suspected cancer to be seen within two weeks.
21. On 8 February, Mr Ward had a gastroscopy (an internal examination of the stomach with a camera) at hospital. The examination showed that he had a suspected cancerous growth on his pre-pyloric sphincter (the valve at the entry to the stomach). He returned to Rye Hill pending further investigations.
22. After a fall on 11 February, Mr Ward's health deteriorated and he was admitted to hospital the next day for almost a month. On 14 February, Mr Ward had a biopsy and a CT scan (computerised tomography) which confirmed he had adenocarcinoma and secondary pyloric stenosis (the cancer was in his stomach but there was also a blockage to his stomach's entrance). Prison healthcare staff kept in touch with the hospital to check his progress. On 28 February, doctors inserted a stent to relieve the blockage to his stomach.
23. On 7 March, a prison GP saw Mr Ward and wrote to the prison explaining that Mr Ward's condition would not benefit from palliative chemotherapy or radiotherapy unless he gained some weight. He confirmed Mr Ward's condition was terminal and gave him a prognosis of 'months'. Mr Ward was discharged from hospital and was sent back to Rye Hill the next day.

24. The clinical reviewer found that Mr Ward's symptoms were appropriately referred to specialists and that his care up to and including diagnosis was equivalent to that which he could have expected to receive in the community.

Mr Ward's clinical care

25. On his return to Rye Hill on 8 March, Mr Ward was discharged to the wing, as the prison does not have inpatient facilities. The next day a nurse discussed meal options with him (including a build up drink called Fortisip), medication and injections. Mr Ward saw a prison GP the next day who prescribed enoxaparin (an anticoagulant, preventing clots), adcal (a calcium supplement), clopidogrel (reduces risk of heart disease and stroke), and omeprazole (reduces stomach acid).
26. On 23 March, a prison GP discussed Mr Ward's prognosis with him and Mr Ward understood that his life expectancy might be very limited. From 31 March, Mr Ward reported he had experienced more symptoms for a couple of days. He had pain when passing urine and generally in his abdomen. Prison healthcare staff were waiting for a decision from the hospital about palliative chemotherapy, but this was dependant on his condition and if he could withstand it.
27. On 13 April, Mr Ward had a hospital appointment with a doctor. The doctor concluded that Mr Ward's tumour was probably bleeding and clopidogrel should be stopped. The doctor also wanted Mr Ward to have a blood transfusion, an iron infusion and some fluid drained in the future (an appointment notice was sent for 22 June). The doctor said that he expected Mr Ward had only a 'few months' left to live.
28. On 17 April, a prison GP saw Mr Ward because the nurses had told him Mr Ward seemed particularly unwell. The GP noted he was managing his pain (with tramadol and paracetamol) but appeared frail and was resistant to the idea of a hospital admission. He preferred to try to eat more and have blood tests to assess his progress. The GP noted that he would monitor Mr Ward's need for an admission. He also discussed 'A Do Not Attempt Cardiopulmonary Resuscitation' order DNACPR) with Mr Ward (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 Ward completed and signed a DNACPR form.
29. On 18 April, a prison GP saw Mr Ward because the nurses were unable to take blood for tests. He noted Mr Ward was very thin and frail and that he was waiting for the results of previous blood tests and noted he would chase them. Mr Ward continued to deteriorate before the doctor received his test results.
30. On 24 April, Mr Ward had an oncology appointment. On the same day, a prison GP referred Mr Ward to a hospice for end of life care, but when Mr Ward got to hospital for his appointment the staff decided to admit him. He continued to decline and a doctor declared that he had died at 3.53am on 27 April.
31. We are satisfied that the care Mr Ward received at Rye Hill was equivalent to that which he could have expected to receive in the community. Prison healthcare

staff discussed his condition and prognosis with him, managed his pain appropriately, arranged build up drinks and tended to his everyday care needs.

Mr Ward's location

32. HMP Rye Hill does not have an inpatient unit. Mr Ward was cared for in a large double cell on a normal wing on the ground floor. When Mr Ward's condition deteriorated, a prison GP appropriately referred him to a hospice for end of life care. Mr Ward died in hospital before the hospice referral was processed.
33. We are satisfied that Mr Ward was appropriately located throughout his illness.

Restraints, security and escorts

34. 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.
35. Mr Ward's final admission to hospital was on 24 April. Having considered the gravity of his illness, the authorising prison manager confirmed that Mr Ward should not have any restraints applied. Two escorting officers accompanied Mr Ward.
36. We are satisfied that the risk assessment process properly considered the extent to which Mr Ward's health impinged on his risks, and he was not restrained.

Liaison with Mr Ward's family

37. Mr Ward did not have any known family or friends that he wanted staff to contact. His prison Probation Officer confirmed this with him and made a note of Mr Ward's decision in the compassionate release application.
38. Mr Ward's funeral was held on 2 June 2017 and a prison manager attended. The prison covered the costs of the funeral in line with national policy.

Compassionate release

39. 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.
40. We are satisfied that the prison managed this process satisfactorily. Although difficult to predict, a doctor was vague about how long Mr Ward might have left to live. In March, the doctor said Mr Ward had 'months' to live, and in mid-April 'a few months'. Staff started the compassionate release documentation when the hospital admitted Mr Ward on 24 April. The doctor, Probation Service and the Director all supported his early release but they were waiting for a hospice bed to become available. Mr Ward died before a bed was confirmed or the application processed.

**Prisons &
Probation**

Ombudsman
Independent Investigations