Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr William Barber a prisoner at HMP Littlehey on 9 December 2017

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*

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 William Barber died on 9 December 2017 of tongue cancer while a prisoner at HMP Littlehey. He was 67 years old. I offer my condolences to Mr Barber's family and friends.

Mr Barber was originally diagnosed with cancer while at HMP Isle of Wight. Staff there quickly referred Mr Barber to specialists, which enabled them to diagnose and successfully treat his cancer. Following his transfer to HMP Littlehey, the cancer returned and staff there cared for Mr Barber well.

I am satisfied that the care Mr Barber received was equivalent to that which he could have expected to receive in the community, and that the palliative care he received at Littlehey was excellent.

Although it appears that Mr Barber was not restrained during his end of life hospice admissions, I am concerned that Littlehey were unable to provide all the risk assessments to evidence this.

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 **July 2018**

Contents

Summary 1
The Investigation Process 2
Background Information 3
Findings 4

Summary

Events

1. In August 2011, Mr Barber was sentenced to 14 years imprisonment for sexual offences. In March 2016, while at HMP Albany, he was diagnosed with pharyngeal cancer. He was successfully treated in August 2016, and was transferred to HMP Littlehey in October 2016.

2. On 5 April 2017, Mr Barber attended a routine hospital appointment. Specialists identified a tumour on the base of his tongue. Further investigations identified that his cancer had returned, which was confirmed in May 2017.

3. Staff at Littlehey discussed Mr Barber's diagnosis with him and in June 2017, specialists gave him a prognosis of just a few months. Mr Barber decided he did not want any more investigations or treatment.

4. Palliative care nurse specialists were involved in Mr Barber's care. Mr Barber insisted that he wanted to remain on the wing with his friends and he would not consider alternative locations.

5. Mr Barber's condition deteriorated and he was admitted to a hospice on three occasions in October, November and December 2017. He died at a hospice on 9 December 2017.

Findings

6. The clinical reviewer found that the care Mr Barber received at Littlehey was equivalent to that which he could have expected to receive in the community. The palliative care he received at the prison was described as excellent.

7. The prison was unable to provide the investigator with all the risk assessments of Mr Barber's hospital appointments. While the paperwork they did provide demonstrated that they took into account Mr Barber's condition and did not restrain him, it is important that the prison provides all evidence the PPO requests so that we can discharge our remit fully.

Recommendations

- The Governor should ensure that decisions on escort arrangements are fully documented, effectively recorded and securely stored and should ensure that, in line with PSI 58/2010, the Prison and Probation Ombudsman is promptly provided with all requested documents following a death in custody.

The Investigation Process

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

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

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

11. We informed HM Coroner for Milton Keynes of the investigation. A doctor at Mr Barber's hospice provided the coroner with the cause of death. There was no post-mortem examination. We have sent the coroner a copy of this report.

12. The investigator wrote to Mr Barber's son to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not respond to our letter.

13. The investigation has assessed the main issues involved in Mr Barber'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.

14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HM Prison Littlehey

15. HMP Littlehey is a medium security prison in Cambridgeshire, holding approximately 1,200 men. A large proportion of the population have been convicted of sexual offences.

16. Northamptonshire Health Care Foundation NHS Trust provides healthcare services. The prison healthcare centre is open from 7.30am to 5.00pm, Monday to Friday, and from 8.00am to 12.30pm at weekends. A local practice provides GP services, and there is a range of nurse-led clinics. There are no inpatient beds at the prison.

HM Inspectorate of Prisons

17. The last inspection of HMP Littlehey was conducted in March 2015. Inspectors reported that regular GP surgeries had significantly improved patient care. Lifelong medical conditions were identified effectively and there was an appropriate range of clinics, led by specialist nurses. Hospital appointments in the community were rarely cancelled. The risk assessments of prisoners keeping medications in-possession were not always appropriate.

Independent Monitoring Board

18. 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 January 2017, the IMB reported that the prison's working agreement with the local hospice to provide decent and dignified end of life care, was recognised in the local hospital Care Quality Commission report as an outstanding initiative. End of life and audiology clinics had been introduced. The End of Life suite, completed in 2013, continued to be unused due to a lack of funding.

Previous deaths at HMP Littlehey

19. Mr Barber was the tenth prisoner to die of natural causes at HMP Littlehey, since July 2016. There were no significant similarities with the other deaths.

Findings

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

20. On 3 August 2011, Mr Barber was sentenced to 14 years imprisonment for sexual offences and was sent to HMP Gloucester. He was subsequently transferred to HMP Isle of Wight.

21. On 13 January 2016, Mr Barber saw a prison GP at Isle of Wight and told him he had had a sore throat for approximately two months. The GP examined Mr Barber and prescribed paracetemol. He noted that he would review him again if the problem persisted.

22. On 4 February, Mr Barber saw a prison GP and told him his throat was still sore and he could feel a lump in it. The GP examined Mr Barber and noted that he could not feel any 'nodes or masses', but he made an urgent referral under the NHS pathway, which requires patients with suspected cancer to be seen by a specialist within two weeks.

23. On 29 February, a specialist at the hospital examined Mr Barber using an endoscope and found a tumour in his throat. (An endoscope is an instrument with a camera enabling investigation of internal structures.) A biopsy of the tumour taken on 21 March 2016 led to a diagnosis of 'inoperable squamous cell carcinoma of the pharynx'. Mr Barber started a course of chemotherapy and radiotherapy on 23 March 2016, and was transferred to HMP Winchester during the course of his treatment.

24. On 19 August 2016, specialists confirmed that Mr Barber had been successfully treated. On 4 October 2016, he was transferred to HMP Littlehey.

25. Mr Barber had regular follow up appointments with no sign of the cancer returning. On 5 April 2017, Mr Barber attended a routine review appointment at the hospital. Specialists identified a tumour on the base of his tongue. A follow-up CT (computerised tomography) scan on 11 April, identified that the cancer might have spread locally. A biopsy taken on 4 May, indicated it was very likely that the cancer had returned. This was confirmed by further scans and by the hospital in a letter on 26 May 2017.

26. We are satisfied that staff at Albany promptly diagnosed Mr Barber's cancer in 2016, and Littlehey appropriately managed the return of Mr Barber's cancer in 2017.

27. We make no recommendations.

Mr Barber's clinical care

28. On 27 May, a nurse saw Mr Barber to discuss his diagnosis. On 28 May, she created a palliative care plan covering pain management, personal care and end of life care planning. She discussed resuscitation options with Mr Barber, and he decided to wait until the outcome of his scan results before making a final decision.

29. On 14 June, Mr Barber attended hospital along with the nurse to discuss his case with an Ear Nose and Throat specialist. The specialist told him he had cancer in the lymph nodes in his neck but a biopsy would be needed to confirm if it was also on his tongue. An oncologist told Mr Barber that his prognosis was months rather than years. Mr Barber said he did not want any treatment or further investigations.

30. On 16 June, hospital specialists met to discuss Mr Barber's case. They concluded that they could not offer any curative treatment but would like to do another biopsy in case Mr Barber had an additional tumour. Again, Mr Barber said he did not want any further investigations or treatment.

31. On 17 June, Mr Barber told the nurse that he did not want to be resuscitated in the event of cardiac or respiratory arrest. On 19 June, Mr Barber signed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order (which means that, in the event of cardiac or respiratory arrest, no attempt at resuscitation will be made). All other appropriate treatment and care would continue to be provided.

32. Palliative care nurse specialists, a palliative care consultant and other members of the prison nursing team regularly saw Mr Barber. His pain was controlled with buprenorphine patches, gabapentin and oromorph and attempts were made to control his weight loss with nutritional drinks and high calorie snacks.

33. On 17 August, a palliative care consultant noted that Mr Barber had nerve damage caused by his tumour. She prescribed dexamethasone (a type of steroid with a range of uses including the ability to decrease local swelling).

34. Mr Barber continued to deteriorate and in the early hours of 6 October 2017, he was admitted to a hospice. He was in pain, shivering and mildly confused. Prison healthcare staff maintained contact with the hospice for the duration of his stay.

35. On 10 October, Mr Barber was discharged from the hospice and was returned to Littlehey and was located in his original cell. (He had a supply of liquid morphine in his cell.) Mr Barber was in good spirits but within a few weeks his condition deteriorated again. His ankles and feet were very swollen and nurses were having difficulty stalling his bed sores. On 27 November, Mr Barber was transferred to the hospice again and prison healthcare staff maintained contact with the hospice staff. Mr Barber was discharged from the hospice and was returned to Littlehey on 30 November. He confirmed that he wished to stay on the wing, and near his friends.

36. A nurse was aware of the importance of caring for Mr Barber's bed sores and made a referral to the tissue viability service. The nurse specialists at the service were on leave but the nurse lodged her concerns and noted ways to ensure Mr Barber was appropriately cared for in the meantime.

37. On 1 December, a nurse discussed the possibility of an open-door policy at night with a prison manager (security governor). This would have enabled staff to easily check Mr Barber had not fallen. Although the prison manager recognised that it would be the 'decent' thing to do, he concluded that the prison could not facilitate this because there was only one member of staff on duty at night on that

wing. Mr Barber refused offers to relocate him to a more appropriate part of the prison or to a prison with inpatient beds. He accepted that there was no overnight care on his wing.

38. On 7 December, a nurse and a prison GP noted that Mr Barber had fallen in the night, seemed confused and could no longer be cared for safely at Littlehey. Mr Barber was transferred to a hospice on 8 December. He died on 9 December at 12.27pm.

39. We are satisfied that the care Mr Barber received at Littlehey was equivalent to that which he could have expected to receive in the community. The clinical reviewer describes the palliative care delivered by the multidisciplinary palliative team as excellent.

40. We make no recommendation.

Mr Barber's location

41. For the duration of his illness, Mr Barber insisted that he wished to remain near his friends and did not want to move from the wing.

42. Mr Barber was located on 'I' wing, which is a wing for elderly prisoners. Staff offered Mr Barber accommodation on 'A' wing where there was a larger cell with a hospital bed, aids and extra nursing support. He declined this on every occasion, including on those occasions where the hospice discharged him from their care.

43. On 30 November, a nurse discussed the possibility of a move to HMP Bedford where there was an inpatient facility, but Mr Barber also declined this offer. He also refused her offer of a social care assessment to see if he needed any physical aids or extra assistance with washing and dressing.

44. It was important to Mr Barber that he be near his friends. Staff made Mr Barber aware of the benefits of a move, but it was his wish to stay where he was. The standard of care Mr Barber received on I wing (as far as could be delivered) was good, staff offered him alternative locations and he did not resist hospice care when it was absolutely necessary.

45. We make no recommendation.

Restraints, security and escorts

46. 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.

47. Mr Barber was not restrained during his first and last admission to the hospice between 5 October 2017 and 10 October 2017 or 8 to 9 December because of his ill health and reduced mobility. However, staff could not provide the investigator with the records for the admission between 27 and 30 November.

We are therefore unable to conclude with certainty that all decisions on escort arrangements were appropriate.

48. Prison Service Instruction (PSI) 58/2010 contains a mandatory instruction that "when the PPO is carrying out investigations or enquiries that staff comply with requests for information and assistance". We make the following recommendation:

The Governor should ensure that decisions on escort arrangements are fully documented, effectively recorded and securely stored and should ensure that, in line with PSI 58/2010, the Prison and Probation Ombudsman is promptly provided with all requested documents following a death in custody.

Liaison with Mr Barber's family

49. The prison appointed a family liaison officer on 8 November 2016, shortly after Mr Barber transferred to Littlehey. When Mr Barber's cancer returned, the family liaison officer contacted his son and kept him updated about Mr Barber's condition. He told Mr Barber's son when Mr Barber deteriorated on 9 December and attended the hospice to meet him when Mr Barber had died. He offered the family advice and support over the following weeks.

50. Mr Barber's funeral was held on 4 January. The prison contributed to funeral costs in line with national policy.

51. We are satisfied that the prison's liaison with Mr Barber's family was satisfactory.

Compassionate release

52. 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.

53. When specialists told Mr Barber his cancer had returned, he refused any further clinical investigations. It was therefore impossible for the prison to get a prognosis to satisfy the compassionate release criteria. The prison applied for compassionate release on 26 July 2017, at Mr Barber's request (although staff documented that he frequently changed his mind about this issue). On 8 August 2017, the Secretary of State for Justice refused the application, citing a lack of a clear prognosis, the gravity of Mr Barber's offending and risk of reoffending as reasons for refusing early release. The prison did not make any further applications.

54. We are satisfied that the prison appropriately considered compassionate release.

Prisons & Probation Ombudsman
Independent Investigations

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