

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Graham Cummins a resident at The Crescent Approved Premises on 26 March 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*



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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.

Mr Cummins died on 26 March 2017, of rectal cancer that had spread to other organs while a resident at The Crescent Approved Premises. He was 68 years old. I offer my condolences to those who knew him.

Mr Cummins was diagnosed with terminal cancer at HMP Stafford before being released on license to The Crescent Approved Premises. Staff offered Mr Cummins appropriate support and managed his care needs effectively. We are satisfied that the care he received was equivalent to that which he could have expected to receive in the community.

Although staff appropriately addressed allegations of bullying there should be a policy setting out instructions for the management of bullying.

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

**Richard Pickering**  
**Deputy Prisons and Probation Ombudsman**

**June 2018**

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# Summary

## Events

1. On 24 May 2012, Mr Cummins was remanded into custody and was sent to HMP Parc. On 6 July 2012, he was sentenced to 12 years in prison for sexual offences. Mr Cummins was transferred to HMP Stafford where he remained until he was released into the community on 22 November 2016. Mr Cummins had a history of medical conditions including high blood pressure and diabetes.
2. In March 2015, while at HMP Stafford Mr Cummins saw a prison GP to discuss changes in his bowel habits. The prison GP prescribed him a laxative and referred him for a blood test. The blood test results indicated that he might have cancer and the prison GP urgently referred him to a colorectal specialist.
3. In May, a CT scan confirmed that Mr Cummins had bowel cancer, which had spread to the liver and lungs. He had emergency surgery to remove the tumour and part of his bowel. In July, Mr Cummins told a prison nurse that the chemotherapy had not worked and his cancer had spread.
4. On 22 November, Mr Cummins was released from HMP Stafford. He was required to live at The Crescent Approved Premises (AP, formerly known as probation or bail hostels). Staff arranged for Mr Cummins to attend a local GP surgery that afternoon.
5. In December, Mr Cummins reported to staff that another resident had threatened to conduct an internet search on him and three other residents. He also believed that other residents were taking his personal items and in March 2016, staff saw Mr Cummins arguing with another resident. He said that other residents had been calling him names in relation to his offence. As a result, staff closely monitored Mr Cummins and the other residents.
6. On 16 March, A multi-disciplinary meeting was held with Mr Cummins. The AP manager expressed concerns about whether The Crescent was suitable accommodation for Mr Cummins. It was agreed that he should be moved to a hospice.
7. On 19 March, Mr Cummins was taken to hospital where he remained until his death on 26 March 2017.

## Findings

8. We agree with the clinical reviewer that the care Mr Cummins received was equivalent to that which he could have expected to receive in the community.
9. National policy requires each Approved Premises to have a written policy in place to deal with bullying. Mr Cummins raised concerns to staff about other residents. Mr Cummins did not tell staff that he thought he was being bullied but staff believed that this was what Mr Cummins concerns and the actions of the other residents amounted to. Staff appropriately monitored his interaction with other residents. Although we are satisfied that staff appropriately managed the

alleged bullying incidents, The Crescent does not have a written local policy on bullying.

## **Recommendation**

- The Approved Premise Manager should implement a local policy which requires all information indicating bullying and intimidation to be fully coordinated and investigated; that alleged perpetrators are appropriately challenged; and that apparent victims are effectively supported and protected.

## The Investigation Process

10. The investigator issued notices to staff and residents at The Crescent Approved Premises 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 Cummins's prison and medical records.
12. NHS England commissioned a clinical reviewer to review Mr Cummins's clinical care at The Crescent Approved Premises.
13. We informed HM Coroner for Teesside 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 Cummins's wife to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.
15. The investigation has assessed the main issues involved in Mr Cummins's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, and liaison with his family.
16. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

# Background Information

## The Crescent Approved Premises

17. Approved Premises (formerly known as probation and bail hostels) accommodate offenders released from prison on licence and those directed to live there by the courts as a condition of bail. Its purpose is to provide an enhanced level of residential supervision in the community, as well as a supportive and structured environment. Residents are responsible for their own healthcare and are expected to register with a GP.
18. The National Probation Service manages The Crescent Approved Premises, Middlesbrough. It has 20 single rooms, including a ground floor room with en-suite facilities. The accommodation is catered and there is a communal area for eating and socialising. Each resident has a key worker to oversee their progress and well-being and see that they adhere to their individual licence conditions and the premises' rules. Staff are on duty at The Crescent 24 hours a day.

## Previous deaths at The Crescent Approved Premises

19. Mr Cummins's death was the first at The Crescent Approved Premises.

# Findings

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

20. On 24 May 2012, Mr Cummins was remanded into custody and was sent to HMP Parc. On 6 July 2012, he was sentenced to 12 years in prison for sexual offences. Mr Cummins was transferred to HMP Stafford where he remained until his release on 22 November 2016. He had a history of medical conditions including high blood pressure and diabetes.
21. On 24 March 2015, at HMP Stafford, Mr Cummins saw a prison GP and told him that there had been a change in his bowel habits. Because there was no blood in his stools and he had not lost any weight, he prescribed macragol (a laxative) and referred him for a blood test.
22. On 1 April, a prison GP reviewed Mr Cummins's blood test results. He found that his Carcinoembryonic Antigen (CEA) level was above the normal range. He made an urgent referral to a colorectal specialist under the NHS pathway, which requires patients with suspected cancer to be seen by a specialist within two weeks.
23. On 6 May, a nurse saw Mr Cummins after a colonoscopy procedure. He told her that he had been diagnosed with bowel cancer. He said that he did not want any support from staff. Two days later Mr Cummins had a CT scan (computerized tomography scan combines a series of x-ray images taken at different angles and uses computer processing to provide more detailed images than traditional X-ray).
24. On 20 May, Mr Cummins saw a consultant at a hospital. The consultant told him the CT scan had confirmed that he had cancer, which had spread to the liver, and there were suspicious nodules found in his chest. He advised emergency surgery to remove the tumour and a section of the bowel. Prison staff escorted Mr Cummins to hospital for surgery on 22 May. He returned to HMP Stafford seven days later.
25. On 9 June, a prison GP saw Mr Cummins to discuss his diagnosis. He recorded that Mr Cummins had secondary growths on his liver and lungs and would have further treatment. He reviewed Mr Cummins again on 23 June and recorded that Mr Cummins needed more chemotherapy (the treatment of cancer using cytotoxic and other drugs).
26. On 16 January 2016, a nurse saw Mr Cummins after he returned from a hospital appointment. He told her that the chemotherapy had not worked and the cancer had spread. He said that the hospital consultant had given him a prognosis of six to eighteen months. She informed wing staff and reviewed him again later that day.
27. We agree with the clinical reviewer who was satisfied that Mr Cummins received a good standard of care at Stafford following diagnosis, which was equivalent to the care he could have expected to receive in the community. The quality of

nursing and medical care during the palliative stages of his illness at Stafford was of a good standard.

### **Mr Cummins's clinical care**

28. On 6 July, a nurse recorded that they would stop chemotherapy for Mr Cummins, as it had not worked. She went with another nurse to speak to him about ending his treatment and to offer him support.
29. On 24 August, a nurse attended a multi-disciplinary team (MDT) meeting to discuss Mr Cummins's palliative care. They discussed his release and referral to services in the community. Stafford continued to hold regular MDT meetings to discuss his palliative care needs and future release. There is no record that a representative from the Offender Manager Unit (OMU) attended these meetings.
30. On 9 November, a nurse saw Mr Cummins after he returned from his oncology appointment. He told her that the hospital consultant wanted him to start palliative chemotherapy. Because Mr Cummins was due to be released within the next two weeks, the hospital consultant decided not to start the course of medication. Instead, he referred him to a hospital close to the AP.
31. On 21 November, a nurse spoke to the governor about Mr Cummins's release. The governor said that Mr Cummins's family liaison officer had concerns about his health and release arrangements. The Head of Healthcare confirmed that there were no concerns about his clinical condition. The same day, a probation officer sent an email to an offender supervisor stating that a taxi would take Mr Cummins from Middlesbrough police station to The Crescent AP. He also told the offender supervisor that if Mr Cummins was too ill then the AP would not be suitable for him and he should be transferred to a hospice.
32. On 22 November, Mr Cummins was released from Stafford. He was required to reside at The Crescent Approved Premises, Middlesbrough. The next day, AP staff arranged an appointment for Mr Cummins at the medical centre for that afternoon. Mr Cummins told her that he was able to travel to the surgery on his own.
33. On 6 December, Mr Cummins told his key worker that he did not feel well. He went to the local accident and emergency department by taxi. When he returned, he told her that he was advised to rest but would speak to his consultant later in the week and would request the support of a Macmillan nurse.
34. The probation officer saw Mr Cummins on 15 February. He noted that Mr Cummins looked unwell but said that he felt ok. Mr Cummins said that the chemotherapy was not working. Six days later a staff member recorded that Mr Cummins went to hospital because he was suffering from pain. When Mr Cummins returned from hospital, he said that he was told to contact his GP and take some pain relief.
35. On 22 February, Mr Cummins went to see his GP who advised him to return to hospital. The hospital admitted Mr Cummins and he remained there until 9 March. Staff contacted the hospital on a daily basis for updates on his condition.

36. On 8 March, the probation officer spoke to a nurse at the hospital. He told her that Mr Cummins could not return to The Crescent with oramorph (opiate based pain relief), as it would make him vulnerable to other residents. He said that the AP could not cater for his health needs and the nurse agreed to refer him to the social care team.
37. The probation officer spoke to the hospital on 9 March. The hospital informed him that Mr Cummins's needs were not great enough for intervention by adult social care as he was still able to live independently. The hospital referred him to a hospice who would see him weekly.
38. On 13 March, his key worker saw Mr Cummins. She had concerns about his health and thought he was struggling. He told her that he had fallen on the stairs while walking into The Crescent. She reminded him that staff were there to support him and that if he had any health concerns they would ensure he was taken to hospital. A member of staff also recorded concerns about whether the AP was appropriate accommodation for Mr Cummins. She recorded that although the Macmillan nurse and Offender Manager were concerned with his discharge; staff at the hospital assessed him and found him to have enough capacity and mobility to manage.
39. On 16 March, the probation officer, the AP manager, Macmillan nurses and Mr Cummins attended a meeting. The probation officer explained to Macmillan why The Crescent was no longer suitable for Mr Cummins. Macmillan agreed and referred him for residential care. A hospice accepted Mr Cummins and called the AP manager to arrange his transfer.
40. On 19 March, Mr Cummins was taken to hospital where he remained until his death on 26 March 2017.
41. On release, staff quickly referred Mr Cummins to the community GP at a medical centre. The liaison with services for continuity of care for Mr Cummins was appropriately managed. A suitable hospice was also identified for his end of life care. We are satisfied that Mr Cummins received the appropriate care while at The Crescent AP and are satisfied that he received appropriate care in the community.

## **Bullying**

42. On 10 December, a member of staff at the AP recorded that Mr Cummins reported to staff that another resident had threatened to conduct an internet search on him and three other residents. There is no record that staff took any action following Mr Cummins's complaint. A member of staff checked on Mr Cummins at 23.00pm and he said he was ok.
43. Mr Cummins spoke to his key worker on 1 February 2017. He told her that some of his personal items had gone missing and asked if staff could address this at the next residents' meeting. There is no evidence that staff raised this at the residents meeting.
44. On 10 March, Mr Cummins saw a member of staff. He was shouting that he believed other residents were taking his personal items. She tried to calm him down and told him that the residents he was accusing had not been in the area.

Three days later, staff saw Mr Cummins arguing with another resident. Mr Cummins said that other residents had been calling him names in relation to his offence. Staff advised him to ignore the comments and to tell them if it happened again so that they could deal with it. As a result, staff monitored Mr Cummins and his interaction with the other residents.

45. PSI-31-2014 sets out the expectations of an AP when dealing with bullying. It states "Residents may be vulnerable for a number of reasons, such as age (including both elderly and juvenile offenders); illness & infirmity, including mental health; substance misuse or dependency; bullying; ethnic origin; belief; disability; sexual orientation; and pattern of offending. Approved premises are required to have strategies for managing vulnerable offenders that cover all of these reasons." Each AP should have their own written policy, which details how they should manage bullying in the residence. The Crescent has a strategy for the prevention of bullying but it does not provide instructions on what staff should do if they suspect it is happening.
45. Mr Cummins expressed concerns to staff about being threatened and bullied and that other residents were taking his personal belongings. The Crescent AP manager said that staff addressed his concerns through key worker sessions, monitored him via CCTV and accompanied him across the AP grounds. Staff also supervised meal times and communal areas. The AP manager said that other residents expressed concerns about Mr Cummins and said that he was in fact bullying other residents, but they did not submit a formal complaint.
46. Although the AP appropriately addressed and monitored Mr Cummins's concerns about bullying effectively, given the policy requirement we would have expected The Crescent AP to have a written local policy in place, which provides guidance to staff on how they should manage and deal with bullying incidents. We make the following recommendation:

**The Approved Premise Manager should ensure that a policy is implemented which requires all AP staff and residents to act with dignity and respect. There should be a robust process for ensuring there is a clear audit trail for any information indicating bullying and intimidation to be fully investigated and the victim appropriately supported.**

#### **Mr Cummins's location**

47. We agree with the clinical reviewer that although Mr Cummins had a terminal diagnosis at the time of his release his condition was not critical. HMP Stafford appropriately liaised with Middlesbrough Probation Service to facilitate Mr Cummins's transfer to The Crescent AP.

#### **Liaison with Mr Cummins's family**

48. Mr Cummins contacted his family while he was in hospital. They visited him before he died on 24 March but decided not to have further contact.
49. Mr Cummins's funeral was held on 7 April 2017. The National Probation Service contributed to the cost, in line with national policy.

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