

**Prisons &
Probation**

Ombudsman
Independent Investigations

Investigation into the death of Mr Tomas Wilmot, a prisoner at HMP Onley, on 20 July 2015

**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 Tomas Wilmot died of pancreatic cancer while a prisoner at HMP Onley on 20 July 2015. He was 68 years old. I offer my condolences to Mr Wilmot's family and friends.

Mr Wilmot had a number of chronic health conditions before he arrived in prison. The investigation found healthcare staff managed these well and referred Mr Wilmot to secondary care providers when necessary. After he was diagnosed with pancreatic cancer, healthcare staff implemented appropriate care plans and adapted his cell to make him as comfortable as possible. I am satisfied that Mr Wilmot received a good standard of care at Onley, at least equivalent to that he could have expected to receive in the community. However, the Governor needs to ensure there is appropriate healthcare input into risk assessments to justify the use of restraints for seriously and terminally ill prisoners.

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

April 2016

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Summary

Events

1. On 22 August 2011, Mr Tomas Wilmot was sentenced to nine years in prison for conspiracy to defraud. He had been at HMP Onley since December 2014.
2. Mr Wilmot had a number of health problems including, an irregular heart rate, high blood pressure, type 2 diabetes, gout, lower back pain and sleep apnoea. Healthcare and hospital staff frequently reviewed and managed his conditions.
3. In February 2015, a prison GP referred Mr Wilmot to a gastroenterologist, after he reported stomach problems. The gastroenterologist found no serious problems.
4. On 21 April, the GP reviewed Mr Wilmot who still had stomach problems, including constipation and vomiting. The GP referred him urgently to a specialist. On 7 May, the GP also referred Mr Wilmot urgently for suspected colorectal cancer, after he reported a lump on his penis. He also noted that Mr Wilmot appeared jaundiced. On 13 May, when he was being examined at hospital, Mr Wilmot's blood pressure dropped significantly. The hospital admitted him for tests and a CT scan showed he had pancreatic cancer, which had spread to his liver. No active treatment was possible and doctors estimated he had three to six months to live. On 8 June, the hospital discharged Mr Wilmot and he went back to a specially adapted cell at Onley. Nurses drew up care plans and checked him several times a day.
5. On 10 July, Mr Wilmot's condition worsened and a prison GP sent him to hospital. His condition continued to decline. On 20 July, he died in hospital.

Findings

6. The clinical reviewer concluded that the standard of care Mr Wilmot received at Onley was at least equivalent to that he could have expected to receive in the community. When he reported symptoms, healthcare staff assessed him promptly and ensured he was referred appropriately to hospital specialists. After he was discharged from hospital, he was well cared for with comprehensive care plans. Apart from when he moved off of the ward he was on, Mr Wilmot was not restrained in hospital after 2 June. However, we were concerned that there was no healthcare input into any of the risk assessments to justify the use of restraints, barring a single review on 22 May.

Recommendation

- The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Onley informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
8. NHS England commissioned a clinical reviewer to review Mr Wilmot's clinical care at the prison.
9. The investigator obtained copies of relevant extracts from Mr Wilmot's prison and medical records. He and the clinical reviewer interviewed three members of staff at Onley on 10 September 2015. On 11 September, the investigator interviewed another member of staff by telephone.
10. We informed HM Coroner for Coventry and Warwickshire of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.
11. One of the Ombudsman's family liaison officers contacted Mr Wilmot's son to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He said he was very positive about the sensitivity of the prison's contact with the family, and in particular the chaplain who carried out the role of family liaison officer. However, he was concerned that healthcare staff could have diagnosed his father's condition sooner than 14 May.
12. The investigation has assessed the main issues involved in Mr Wilmot'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.
13. The initial report was shared with the Prison Service. They identified no factual inaccuracies.
14. Mr Wilmot's family received a copy of the initial report. They pointed out some factual inaccuracies and/or omissions. This report has been amended accordingly. Mr Wilmot's family also raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

Background Information

HMP Onley

15. HMP Onley is a resettlement prison serving the Greater London area. It holds approximately 742 adult male prisoners. Northamptonshire Healthcare NHS Foundation Trust provides health services including primary care, mental health and substance misuse services. The prison does not have an inpatient facility but had full time nursing cover. A GP is on duty during normal working hours.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Onley was in June 2012. Inspectors found that healthcare services were very good, with a good range of clinics. Although there was only one GP for general and substance misuse clinics, prisoners had good access to medical services. Inspectors noted there was effective out of hours and emergency medical cover. Links with local palliative care services were very good and had been used well.

Independent Monitoring Board

17. 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 February 2015, the IMB noted that the tendering process for the renewal of the healthcare contract had taken up a significant amount of the healthcare manager's time but noted some good practice, including numerous therapeutic groups.

Previous deaths at HMP Onley

18. Mr Wilmot was the third prisoner at Onley to die from natural causes since 2012. There were no significant similarities with the circumstances of the other deaths.

Findings

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

19. On 22 August 2011, Mr Tomas Wilmot was sentenced to nine years in prison for conspiracy to defraud. He had been at Onley since 22 December 2014. On 7 April 2015, he received a further sentence of 854 days for non-payment of a confiscation order.
20. Mr Wilmot had poor health before he was sentenced to prison. He suffered from atrial fibrillation, high blood pressure, type 2 diabetes, gout and sleep apnoea, for which he used a machine to help his breathing at night. He suffered lower back pain after spinal surgery in 2004. Prison healthcare and hospital staff reviewed Mr Wilmot's medication and treatment frequently.
21. On 27 February 2015, Mr Wilmot told a prison GP that he was experiencing reflux (where fluid from the stomach moves up into the oesophagus) and felt full after eating only small amounts of food. The GP referred him to the gastroenterology department at hospital. On 10 March, Mr Wilmot had a gastroscopy (where a small camera is used to examine the oesophagus), which found he had a hiatus hernia, but nothing serious.
22. On 19 March, another prison GP reviewed Mr Wilmot who said he had been experiencing constipation and abdominal pain for the previous ten days and had no appetite. The GP scheduled a further review two weeks later but Mr Wilmot transferred to HMP Wandsworth for a court appearance, before this could take place.
23. On 14 April, a GP at Wandsworth reviewed Mr Wilmot, who explained he had suffered constipation for a prolonged period and had lost weight quickly. The GP considered referring Mr Wilmot under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks. However, Mr Wilmot refused to be referred as he thought that would mean he would have to stay at Wandsworth for a diagnosis and any treatment and he wanted to go back to Onley. The clinical reviewer noted that it was not clear from the records why the GP considered a two week referral was appropriate as Mr Wilmot did not meet the criteria for this at the time.
24. On 17 April, Mr Wilmot went back to Onley. A GP reviewed him four days later and noted that he had continued to lose weight and was constipated. He did not consider that Mr Wilmot met the criteria for a two-week cancer referral, but was concerned about his symptoms and asked the hospital colorectal department to review him urgently.
25. On 7 May, a GP reviewed Mr Wilmot, who was worried about a lump on his penis. The GP was concerned this could be a sign of colorectal cancer and made an urgent suspected cancer referral to the hospital urology department. During the review, he also noted that Mr Wilmot appeared jaundiced. On 13 May, a consultant urologist examined him and noted he would need a biopsy to make an accurate diagnosis. While he was at the hospital, Mr Wilmot's blood pressure dropped dramatically. The hospital admitted him for tests.

26. Later that day, a CT scan showed that Mr Wilmot had a pancreatic tumour and liver metastasis (the spread of a cancer from one organ to another). No active treatment was possible. On 14 May, hospital doctors informed Mr Wilmot of the diagnosis and told him that he had between three and six months to live. A GP, a nurse and members of the chaplaincy team visited Mr Wilmot in hospital to support him.
27. The clinical reviewer noted that the National Institute for Health and Care Excellence (NICE) issued new guidance for referrals for suspected cancer in June 2015. When doctors reviewed Mr Wilmot in April, the guidance on referrals meant that he did not meet the criteria for a two-week suspected cancer referral. Despite this, on 21 April, a GP arranged an urgent referral, as he was concerned about Mr Wilmot's symptoms. Before the hospital made the appointment, the GP saw Mr Wilmot again in May and, because of new symptoms, made an urgent referral for suspected cancer.
28. The clinical reviewer noted that, in the early stages, a tumour in the pancreas does not cause any symptoms, which can make it difficult to diagnose. One of the significant symptoms of pancreatic cancer is lower back pain, but that would not have been a new symptom for Mr Wilmot as he had suffered from such pain for some years. The clinical reviewer considered that prison doctors referred Mr Wilmot to relevant specialists in a timely way. We are satisfied that there was no undue delay in Mr Wilmot's diagnosis and that prison healthcare staff supported him well after his diagnosis.

Mr Wilmot's clinical care

29. On 18 May, the healthcare team organised a multidisciplinary team meeting with representatives from all areas of the prison that would be involved in his care. As Mr Wilmot was in hospital, he was unable to attend but his views were sought and taken into consideration. The meeting discussed his diagnosis and prognosis, and noted that a GP and a nurse had visited him in hospital. Another nurse and a prison chaplain visited Mr Wilmot the next day and told what the meeting had discussed. Multidisciplinary team meetings continued regularly until Mr Wilmot's death and consulted him appropriately.
30. After Mr Wilmot returned to the prison on 8 June, healthcare staff monitored him frequently and dispensed his medication. He had access to pain relief at all times. During the night, his pain relief medication was kept in a locked cupboard in his cell and officers opened the cupboard whenever he needed it.
31. On 10 July, a locum GP reviewed Mr Wilmot and noted that Mr Wilmot's condition had significantly worsened; his abdomen had become swollen and painful, and he had been experiencing vomiting and diarrhoea. The GP sent him to University Hospital by emergency ambulance.
32. Mr Wilmot's condition continued to deteriorate in hospital and he died on the morning of 20 July.
33. After he was discharged from hospital in June, Mr Wilmot received a good standard of care at the prison. Healthcare staff monitored him every day and dispensed his medication as required. The prison gave him a well-considered,

balanced diet. Care plans were comprehensive and healthcare staff followed them fully. Mr Wilmot had access to pain relief at all times. Regular multidisciplinary team meetings ensured that a wide range of services including health, social care, prison facilities and estates, were well coordinated to meet Mr Wilmot's needs. A lot of thought was given to Mr Wilmot's comfort and support. We are satisfied that Mr Wilmot received a high standard of care at Onley.

Mr Wilmot's location

34. When Mr Wilmot returned to Onley on 8 June, the prison had prepared a double-sized cell for him, with a hospital bed and a shower seat. Mr Wilmot used a walking frame and the prison installed grab rails and an emergency call button. Staff and prisoners had cleaned and decorated the cell, provided new bedding, new pyjamas and washed and sorted all his clothes. Mr Wilmot remained in this cell until his final admission to hospital on 10 July.
35. On 11 June, an occupational therapist assessed Mr Wilmot. She suggested that he would benefit from a raised toilet seat and an armchair capable of raising his legs, both of which the prison provided. On 19 June, Mr Wilmot was given a wheelchair, as he became less able to mobilise.
36. We are satisfied Mr Wilmot was appropriately located throughout his illness, and that Onley made commendable efforts to ensure his comfort and welfare.

Restraints, security and escorts

37. The Prison Service has a duty to protect the public when escorting prisoners outside prison and a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.
38. When Mr Wilmot went to hospital on 13 May, he was assessed as a low risk to the public and of escape, and a low risk of hostage taking. This was a routine day outpatient appointment and a manager decided that officers should use handcuffs to restrain Mr Wilmot on the journey and an escort chain when hospital staff were examining him. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.)
39. No one reviewed the risk assessment when Mr Wilmot was admitted to hospital and was diagnosed with incurable pancreatic cancer. He was restrained by an escort chain. On 22 May, over a week after his diagnosis, a prison manager decided he should continue to be restrained. There is no evidence of any healthcare assessment in any reviews after 22 May.
40. On 2 June, the prison manager again reviewed the risk assessment and noted that Mr Wilmot's condition and level of mobility had deteriorated. He decided that

the escort chain should be removed unless Mr Wilmot moved off of the ward into other areas of the hospital. He returned to Onley on 8 June. Restraints were not used when Mr Wilmot went back to hospital on 10 July.

41. The prison manager told us that he considered Mr Wilmot was in reasonable physical condition after his admission into hospital on 13 May. He said that initially there had been some concerns that as Mr Wilmot had been found guilty of a crime involving a significant amount of money, he might have had the resources to organise an escape. However, this was not reflected in the risk assessment at the time.
42. While the decisions reached may have been reasonable, we are concerned that there is no evidence of any healthcare input into any of the risk assessments commenting on how Mr Wilmot's medical condition and mobility affected his risk of escape, barring a review on 22 May, as the 2007 judgment requires. It also took too long to review the risk assessment after his original admission to hospital. We make the following recommendation:

The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

Liaison with Mr Wilmot's family

43. On 14 May, a member of the chaplaincy team, accompanied by a Macmillan nurse, visited Mr Wilmot in hospital to discuss his diagnosis and to offer him support.
44. They asked Mr Wilmot who they should contact to break the news of his condition. He told the chaplain that he had spoken to members of his family himself and informed them of his diagnosis. She arranged for Mr Wilmot's family to visit him in hospital.
45. On 21 May, the prison asked an officer to act as the prison's family liaison officer. The family liaison officer kept in contact with Mr Wilmot's family by email, telephone and in person at the hospital.
46. On 17 July, the Macmillan nurse based at the prison met Mr Wilmot's family at the hospital to offer them support and advice about what to expect as his condition declined.
47. The family liaison officer kept in contact with Mr Wilmot's son after his death and members of the Onley chaplaincy team conducted the funeral service at his family's request. Prison representatives attended. The prison contributed to the costs of the funeral, in line with national instructions.
48. Mr Wilmot's family were very positive about the communication and support they received from the family liaison officer and we are satisfied that there was very good family liaison.

Compassionate release

49. Prisoners can be released 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.
50. The minutes of a multidisciplinary meeting on 8 July 2015, show that an application for release on compassionate grounds was made on Mr Wilmot's behalf. As part of the process, a report was required from the hospital consultant outlining Mr Wilmot's prognosis. Despite repeated requests, healthcare staff did not receive the report until 15 July.
51. The prison submitted the application for approval that day, but Mr Wilmot died before a decision was reached. We consider that the prison appropriately considered compassionate release and did their best to progress this.

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