Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Robert Chubb a prisoner at HMP Exeter on 5 October 2015

A report by the Prisons and Probation Ombudsman
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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.

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 Chubb died on 5 October 2015, of inflammation of the kidney and cancer of the intestine, while a prisoner at HMP Exeter. He was 84 years old. I offer my condolences to Mr Chubb's family and friends.

Mr Chubb had suffered from a number of chronic health conditions before he arrived in prison including ongoing problems with a tumour in his bowel, which was eventually diagnosed as malignant. I am satisfied that Mr Chubb received a good standard of care in prison throughout his illness. In particular, Mr Chubb received caring and respectful end of life care at Exeter, and I commend the staff of the prison as I have done in previous investigations.

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 **May 2016**

Contents

Summary

Events

1. On 12 June 2014, Mr Robert Chubb was sentenced to eight years in prison for historic sexual offences and was sent to HMP Bristol. He was 82 and had a number of health problems, including high blood pressure, an irregular heartbeat and stomach, bladder and bowel problems caused by an unspecified tumour. In February 2014, Mr Chubb had refused surgery to remove the tumour and the surgeon planned to review him six months later. He used a wheeled walking frame.

2. When he arrived at Bristol, Mr Chubb told a nurse he suffered from diverticular disease (an abnormality in the bowel or intestine) and had a follow-up hospital appointment in July.

3. On 27 June, Mr Chubb transferred to HMP Dartmoor. In July, the prison received a letter from the hospital cancelling Mr Chubb's follow-up appointment. GPs reviewed Mr Chubb frequently, and referred him to hospital for tests several times. In February 2015, a GP made an urgent referral for suspected cancer. In April 2015, hospital doctors discovered a large mass in Mr Chubb's pelvis, but could not take a biopsy because of its position.

4. Mr Chubb's health deteriorated and, on 29 May 2015, he was transferred to HMP Exeter, which was better able to provide the level of care he needed. On 20 July, after further tests, the hospital confirmed Mr Chubb had cancer but doctors considered that, because of Mr Chubb's poor physical condition and age, active treatment was not possible. Mr Chubb moved to the prison's palliative care suite on 22 July and his condition steadily declined. He died at the prison on 5 October.

Findings

5. The clinical reviewer considered it likely that Mr Chubb's ongoing stomach problems before he went to prison were the result of an undiagnosed cancerous tumour but an earlier referral to hospital specialists would not have affected the eventual outcome. When Mr Chubb reported symptoms, healthcare staff assessed him promptly and referred him appropriately to hospital specialists. We are satisfied that Mr Chubb received a good standard of care in prison, at least equivalent to that he could have expected to receive in the community. We make no recommendations.

The Investigation Process

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

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

8. The investigator obtained copies of relevant extracts from Mr Chubb's prison and medical records. He and the clinical reviewer interviewed three members of staff at Exeter on 8 December 2015.

9. We informed HM Coroner for Exeter and Greater Devon of the investigation who gave us the post-mortem report. We have sent the coroner a copy of this report.

10. One of the Ombudsman's family liaison officers wrote to Mr Chubb's brother-in-law (who was acting for Mr Chubb's sister, his next of kin) to explain the investigation. He was very positive about the care Mr Chubb had received in prison and had no specific matters for the investigation to consider.

11. The investigation has assessed the main issues involved in Mr Chubb'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.

12. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

13. Mr Chubb's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

Background Information

HMP Exeter

14. HMP Exeter is a local prison holding 565 men. Dorset Healthcare University NHS Foundation Trust provides health services. There are 10 cells on F Wing for prisoners who need social care and one cell for end of life palliative care. The wing has facilities for visiting relatives.

HM Inspectorate of Prisons

15. The most recent inspection of Exeter was in August 2013. Inspectors reported that care for prisoners on F Wing with complex social care needs and disabilities was impressive. There were 24-hour health services and a wide range of clinics, including for chronic diseases. Two nurses led the care of older prisoners. Palliative care was supported through an excellent new suite, which had been created for the care of terminally ill prisoners.

Independent Monitoring Board

16. 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 most recently published annual report for the year to December 2014, the IMB said the health services at Exeter were generally good and they noted the effectiveness of the palliative care suite. Healthcare assistants and prison officers worked together in teams to deliver palliative care and the prison kitchen was able to meet special dietary requirements.

Previous deaths at HMP Exeter

17. Mr Chubb was the fourth person to die from natural causes at Exeter since January 2014. We have found that Exeter has consistently provided good end of life care. There were no significant similarities with the circumstances of the other deaths.

Findings

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

18. On 12 June 2014, Mr Robert Chubb was sentenced to eight years in prison for sexual offences and was sent to HMP Bristol. He was 82, and in poor health, with high blood pressure, atrial fibrillation (intermittent irregular heartbeat) and mild aortic stenosis (a blockage of a valve in the heart). He used a wheeled walking frame.

19. In 2013, Mr Chubb had developed a colo-urethral fistula (an abnormal connection between the colon and urethra). In August, a colonoscopy (an examination using a thin flexible camera) suggested he had a malignant bowel tumour. In September, Mr Chubb had surgery to bypass the tumour and to provide a colostomy. The tumour was not removed but biopsies taken at the time indicated it was not malignant. In November, tests indicated an impassable blockage in Mr Chubb's bowel. In January 2014, Mr Chubb had a CT scan, which showed the tumour had shrunk. In February 2014, a surgeon noted it was not clear whether the blockage was malignant (cancerous) or diverticular (caused by an abnormality of the bowel or intestine) and offered Mr Chubb surgery to remove it, but he refused. The surgeon planned to review him six months later.

20. At an initial health screen at Bristol, a nurse noted Mr Chubb's medical conditions. Mr Chubb told the nurse that he had a follow up appointment for diverticulitis at Southmead Hospital, Bristol scheduled for 30 July 2014. On 17 June, a healthcare administrator noted the appointment in Mr Chubb's prison medical record.

21. On 27 June, Mr Chubb transferred to HMP Dartmoor. A nurse assessed him and arranged for his to have a ground floor cell due to his limited mobility.

22. On 11 July, the prison received a letter from hospital (which had originally been addressed to Mr Chubb's community GP) indicating that the follow up appointment for 30 July had been cancelled. On 15 July, a prison GP reviewed Mr Chubb, who said his bowel tumour was caused by diverticular disease, and was not malignant. He said he had had a CT scan in January (before he went to prison) but was not aware of the results. He thought he was due a further CT scan. The GP asked for further information from Southmead Hospital.

23. On 12 August, the GP requested a CT scan at another hospital based on information from the first hospital that Mr Chubb was due a three-month review scan of his chest and abdomen. Healthcare staff continued to monitor Mr Chubb frequently. On 3 September, Mr Chubb reported blood in his urine. A blood test for prostate cancer was normal and he was prescribed antibiotics for an infection.

24. On 6 October, Mr Chubb had a CT scan of his chest and abdomen. The results were marked normal although his right kidney was duplex (where a kidney forms in two parts).

25. On 25 October, Mr Chubb had blood in his urine again. An out of hours doctor prescribed an antibiotic and advised that a prison GP should review him in two or three days. The out of hours GP suggested that if symptoms persisted, the

prison GP might need to consider an urgent referral for suspected cancer. On 28 October, the GP reviewed Mr Chubb. As there was no evidence of blood in his urine and his condition had improved, the GP decided not to make a referral. On 12 November, Mr Chubb again noticed blood in his urine. A urine test confirmed Mr Chubb had a urinary infection and the GP prescribed antibiotics.

26. On 17 December, a prison GP reviewed Mr Chubb, who said that he had been experiencing bleeding from his anus. She referred him to the colorectal department at hospital.

27. On 3 February 2015, Mr Chubb again noticed blood in his urine. A prison GP prescribed antibiotics and a urine sample taken on 6 February was clear. A further urine test on 13 February, indicated traces of blood. On 17 February, another prison GP reviewed Mr Chubb and was concerned about the recurring blood in his urine. Blood tests were normal but the GP made an urgent referral under the NHS pathway, which requires patients with suspected cancer to be seen by a specialist within two weeks.

28. On 25 February, Mr Chubb had an X-ray and ultrasound scan at hospital. A urologist reviewed the results and found that Mr Chubb had a cyst on the upper part of the right kidney and swelling of the left kidney. He referred him for a CT scan and a flexible sigmoidoscopy (a flexible camera inserted into the rectum, which takes samples of tissue for testing).

29. On 15 April, test results showed Mr Chubb had a 25-30cm mass in the left side of his pelvis involving the bladder and colon. Due to the position, it was difficult for doctors to obtain tissue samples (biopsies) so it was still not clear if the mass was benign or malignant. On 29 April, a specialist colorectal registrar at hospital explained to Mr Chubb that they would need to repeat the tests, but there was a strong possibility that the mass was malignant. On 6 May, further tests did not lead to a definitive diagnosis.

30. On 14 May, a consultant colorectal surgeon said that the mass was probably malignant, although they did not have biopsies to confirm this. The next day, another consultant colorectal surgeon noted that if Mr Chubb had cancer, it would be inoperable because of his age and physical condition. He requested biopsies from Mr Chubb's pelvic wall to try to get a definitive diagnosis.

31. On 27 May, the clinical lead GP for prisons in Devon reviewed Mr Chubb at Dartmoor. They discussed his medical conditions and that it looked likely he had cancer. Mr Chubb told her he understood how ill he was and he did not want anyone to attempt resuscitation if his heart or breathing stopped. She said that Dartmoor could not provide the palliative care he needed and Mr Chubb agreed to transfer to HMP Exeter.

32. On 29 May, Mr Chubb moved to Exeter. Healthcare staff implemented a care plan to ensure he had appropriate care, including pain relief and that his fluid intake was managed.

33. On 2 July, Mr Chubb had a biopsy of his pelvic wall. On 16 July, a multidisciplinary meeting reviewed his care plan and ensured healthcare and

prison staff were aware of Mr Chubb's care needs. Healthcare staff referred Mr Chubb to the palliative care team.

34. On 20 July, doctors at the hospital reported that the biopsy had confirmed Mr Chubb had cancer of the bowel, and that surgery was not an option. They said Mr Chubb's condition would continue to deteriorate rapidly, and he had a prognosis of weeks, or at best, a few months.

35. The clinical reviewer noted that it was almost certain the intestinal problems Mr Chubb experienced in 2013, before his went to prison, were related to the highly malignant tumour that eventually led to his death. He did not consider that any earlier diagnosis would have changed the outcome. We are satisfied that healthcare staff referred Mr Chubb to relevant specialists promptly when indicated and prison healthcare staff kept him informed and supported him well.

Mr Chubb's clinical care

36. On 21 July, the clinical lead GP saw Mr Chubb and discussed the confirmed diagnosis. She explained that palliative treatment was the only option and he agreed to speak to a palliative care nurse. The next day, Mr Chubb was moved to the palliative care suite at Exeter (an area specifically designed and equipped for end of life care). There were regular multidisciplinary meetings to discuss Mr Chubb's ongoing needs. She and other healthcare staff regularly reviewed and supported him. On 27 August, she noted he was increasingly frail and was taking longer to swallow his medication.

37. On 28 September, the clinical lead GP recorded that Mr Chubb's condition had deteriorated to the point he was unable to swallow. Healthcare staff gave him nutritional supplements and used a syringe driver (a small pump that gives pain relief medication continuously under the skin). Despite his frailty and poor physical condition, she noted Mr Chubb was in good spirits.

38. At 1.47am on 5 October, two officers checked Mr Chubb and saw that he was not breathing. One officer radioed for assistance and a few minutes later a nurse and a custodial manager arrived. In line with Mr Chubb's wishes, they did not attempt resuscitation. An out of hours GP later recorded Mr Chubb's death.

39. After a post-mortem, the coroner gave the cause of death as severe bilateral acute pyclonephritis with pyonephrosis (both forms of kidney infection); and locally advanced carcinoma of the sigmoid colon (cancer of the intestine closest to the rectum) with bladder involvement.

40. We are satisfied that Mr Chubb received a good standard of care at Exeter. Healthcare staff saw Mr Chubb every day, and there were good care plans to ensure his pain and nutrition were managed effectively. Regular multidisciplinary team meetings involved a wide range of services to meet his needs.

Mr Chubb's location

41. At Dartmoor, Mr Chubb lived in a ground floor single cell because of his limited mobility. As his condition deteriorated, he moved to Exeter, which was better able to deliver the increasing level of care that Mr Chubb needed.

42. On 22 July, Mr Chubb's condition had deteriorated to the extent that healthcare staff at Exeter moved him to the prison's palliative care suite. It had a hospital bed and all the medical equipment needed to deliver palliative care. The door was left open at all times to allow healthcare staff unrestricted access. We are satisfied Mr Chubb was appropriately located throughout his illness, and that Exeter made commendable efforts to ensure his comfort and welfare.

Restraints, security and escorts

43. When prisoners have to travel outside prison, a risk assessment determines the nature and level of any 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. The level of restraints used should be necessary in the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes account of factors such as the prisoner's health and mobility.

44. Mr Chubb deteriorated rapidly from May 2015. After the clinical lead GP reviewed Mr Chubb on 27 May, she ensured the healthcare and security staff were aware that his serious condition meant that he was not a risk of escape and should not be restrained. We are satisfied that this was a proportionate and humane approach.

Liaison with Mr Chubb's family

45. Mr Chubb had not been in contact with his family for a number of years and initially did not want them informed of his illness. When he moved to the palliative care suite at Exeter, the prison asked a custodial manager to act as the prison's family liaison officer. With Mr Chubb's agreement, she rang his sister. Her husband took the call, as his wife was in a nursing home. He agreed to act as a family contact.

46. The custodial manager explained about Mr Chubb's illness and remained in weekly contact with his brother-in-law to keep him updated on his condition. When Mr Chubb died, she rang his brother-in-law, as they had agreed should happen, to inform him and offer support.

47. Mr Chubb's funeral was on 13 October. The prison contributed to the cost in line with national policy.

48. Mr Chubb's brother–in-law was very positive about the care Mr Chubb had received from the prison and the communication and support from the custodial manager. We are satisfied that there was 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. On 21 July, the clinical lead GP discussed the possibility of compassionate release with Mr Chubb. He told her he did not want to apply for compassionate release. She discussed this with him again a number of times, but he was clear about his decision.

51. We are satisfied that the possibility of compassionate release was raised with Mr Chubb appropriately, who chose to apply.

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