Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Alan Damon a prisoner at HMP Rye Hill on 27 January 2019

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 Alan Damon died in hospital of pneumonia on 27 January 2019, while a prisoner at HMP Rye Hill. He was 60 years old. I offer my condolences to Mr Damon's family and friends.

Mr Damon was diagnosed with incurable throat cancer in October 2017. I am satisfied that, when Mr Damon reported pain in his ear and throat, healthcare staff at Rye Hill had referred him promptly to hospital specialists under the two-week suspected cancer pathway, leading to a swift diagnosis. I am also satisfied that the healthcare Mr Damon received at Rye Hill was equivalent to that which he could have expected to receive in the community.

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

Sue McAllister, CB
Prisons and Probation Ombudsman **June 2019**

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Summary

Events

1. Mr Damon was serving a 14-year prison sentence for sexual offences and had been at HMP Rye Hill since 19 October 2015. He did not have any long-term health issues and he was not taking any medication.

2. On 5 July 2017, Mr Damon complained of pain in his ear and was treated for impacted ear wax. On 23 August, after complaining of continuing pain in his ear and throat, he was referred to hospital specialists under the two-week suspected cancer pathway. On 5 October 2017, after some testing and a biopsy, Mr Damon was diagnosed with incurable throat cancer and told he had a life expectancy of about six months.

3. Mr Damon had two rounds of radiotherapy in November 2017, to reduce the size of his tumour, which were successful. After this, the management of his cancer was palliative (that is, designed to make him as comfortable as possible).

4. On 2 January 2019, Mr Damon collapsed in his cell. He was taken to hospital by emergency ambulance, and was treated for pneumonia. Initially, Mr Damon's health improved and he was fitted with a feeding tube.

5. On 23 January, the prison, healthcare staff and the hospital began to plan for his discharge. However, on 25 January, Mr Damon's health suddenly deteriorated due to an infection.

6. At 1.35am, on 27 January, Mr Damon died in St Cross hospital.

7. There was no post mortem. The coroner confirmed the cause of death as 1a aspiration pneumonia; 1b left oropharyngeal squamous cell carcinoma, and, 1c, left internal jugular thrombosis (that is, pneumonia with underlying throat cancer and a blood clot in the jugular vein).

Findings

8. The clinical reviewer found that the care Mr Damon received was equivalent to that that which he could have expected to receive in the community. He was referred to hospital specialists promptly under the two-week suspected cancer pathway. After his diagnosis, his physical and mental wellbeing were well supported by healthcare staff and prompt action was taken to address and manage his pain. A specialist GP working at Rye Hill managed Mr Damon's palliative care which ensured continuity.

9. We are satisfied that the prison appropriately considered Mr Damon's release on compassionate grounds.

10. The prison did not apply restraints during Mr Damon's last admission to hospital.

11. We make no recommendations.

The Investigation Process

12. 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.

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

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

15. We informed HM Coroner for Warwickshire of the investigation. The coroner gave us the cause of death. We have sent the coroner a copy of this report.

16. One of the Ombudsman's family liaison officers contacted Mr Damon's daughter, to explain the investigation and to ask if she had any matters they wanted the investigation to consider. Mr Damon's daughter wanted to know if there were any missed opportunities to diagnose Mr Damon's cancer, and whether healthcare staff and prison staff properly monitored him. We have addressed those questions in this report.

17. The investigation has assessed the main issues involved in Mr Damon'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.

Background Information

HMP Rye Hill

18. HMP Rye Hill is managed by G4S and holds over 600 men convicted of sex offences. G4S Health provide primary, physical and mental health services. The prison does not have an inpatient facility.

HM Inspectorate of Prisons

19. 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. Inspectors found that after Rye Hill changed its role to take sex offenders in 2014, services had not sufficiently adapted to meet the needs of the new population. They noted that a small group of regular GPs had run daily clinics since January 2015, which had improved the consistency of service and prisoners' perceptions of that service.

20. Healthcare discharge arrangements to ensure continuity of care on transfer and release were appropriate. The demand for palliative care had increased. Prisoners with such needs received weekly reviews with a designated GP and most had appropriate care plans. A formal pathway and relationships with local palliative care services and hospices were being developed.

Independent Monitoring Board

21. 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 31 March 2018, the IMB noted that a number of major changes had been introduced to improve healthcare provision, including the appointment of a new clinical lead and new practice manager who were implementing initiatives to make more efficient use of healthcare resources. The Board noted that the number of terminally ill prisoners and number of bed watches was high, but that it was unlikely the trend would improve given the prison's population.

Previous deaths at HMP Ryehill

22. Mr Damon is the ninth prisoner to die from natural cause at Rye Hill in the last two years. There are no similarities with those deaths.

Findings

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

23. Mr Damon was serving a 14-year prison sentence for sexual offences and had been at HMP Rye Hill since 19 October 2015. He did not have any long-term health issues and he was not taking any medication.

24. On 5 July 2017, Mr Damon complained to healthcare staff of pain in his left ear. He was prescribed antibiotics, irrigation and ear drops.

25. On 23 August, a prison GP examined Mr Damon. He noted that Mr Damon had had ear pain and a hoarse voice for the last three months. The GP found no abnormality in Mr Damon's ear but his throat was red. He made an urgent referral to the Head and Neck Department at George Eliot Hospital under the NHS pathway, which requires patients with suspected cancer to be seen by a specialist within two weeks.

26. Mr Damon had his first appointment at the Head and Neck Department on 6 September. On 5 October, after some testing and a biopsy, Mr Damon was diagnosed with throat cancer. He was told by the consultant at the hospital that the cancer was inoperable and incurable.

27. On 12 October, Mr Damon had a follow up appointment with the consultant to discuss treatment options. The consultant told Mr Damon that he was most likely to have a life expectancy of six months, and Mr Damon decided that he wanted to have a course of radiotherapy to try to prolong his life.

28. Mr Damon was given support to deal with his diagnosis by healthcare staff at the prison, and had regular appointments with the mental health team to support his wellbeing during his diagnosis and treatment.

29. The clinical reviewer is satisfied that healthcare staff appropriately investigated Mr Damon's symptoms, referred him promptly to hospital specialist under the two-week suspected cancer pathway and discussed his diagnosis with him.

Mr Damon's clinical care

30. On 1 November 2017, Mr Damon started a seven-day course of radiotherapy. After a short break, he had a second course of radiotherapy which ended on 28 November.

31. On 20 November, Mr Damon said he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect.

32. Mr Damon's cancer treatment was due to be reviewed by the consultant at University Hospital on 1 February 2018. However, this appointment was changed by the hospital, and Mr Damon was reviewed on 8 March 2018. The consultant told Mr Damon that the radiotherapy had reduced the size of the tumour, but this was the limit of the treatment and his care would now be palliative (that is, designed to make him comfortable and to manage his pain).

33. For the next few months, Mr Damon's cancer was managed using pain relief, dietary changes and monitoring the progression of his tumour.

34. On 12 June 2018, Mr Damon was transferred to hospital after becoming unwell. He was treated with intravenous antibiotics for a urinary infection and thrombosis. On 19 June, Mr Damon was discharged from hospital and was transferred back to Rye Hill.

35. On 20 July, Mr Damon reported increasing pain. Healthcare staff took advice from the palliative care team. Mr Damon's pain relief medication was increased and he was prescribed oromorph (liquid morphine).

36. Mr Damon's care over the next few months focused on monitoring and adapting his pain medication to make him as comfortable as possible.

37. On 31 December 2018, Mr Damon reported feeling anxious. Healthcare staff spoke to the Macmillan team. They considered that the anxiety was likely to be pain related and 300mgs of gabapentin was added to his pain regime.

38. At 4.20pm, on 2 January 2019, a prisoner approached an officer and told her that Mr Damon had collapsed in his cell. The officer went to Mr Damon's cell straight away and found him sitting on his bed, semi-conscious. The officer called an emergency code blue (which indicates that a prisoner is unconscious or has breathing problems) over the radio. The control room called an ambulance straight away.

39. A prison GP and nurse went to the cell. Mr Damon told them that he had a severe headache extending into his neck. They monitored Mr Damon until the paramedics arrived. According to the control room log, the paramedics arrived at the prison at 4.54pm, and arrived at Mr Damon's cell at 5pm. Mr Damon was taken to hospital by emergency ambulance.

40. On 3 January, healthcare staff contacted the hospital and they were told that Mr Damon was being treated for pneumonia, and he was waiting for a head and neck CT scan.

41. Initially, Mr Damon's health improved and he was fitted with a feeding tube. On 23 January, the prison, healthcare staff and the hospital began to plan for his discharge. However, on 25 January, Mr Damon's health suddenly declined due to an infection.

42. At 1.35am, on 27 January, it was confirmed that Mr Damon had died.

43. The clinical reviewer is satisfied that healthcare staff at Rye Hill acted promptly to manage Mr Damon's pain and that his healthcare was equivalent to that he could have expected in the community.

Mr Damon's location

44. Mr Damon was located on the same wing, in the same cell, throughout his illness. He could care for himself and was among prisoners and staff who knew him.

45. There is no indication that Mr Damon's location was not suitable and his care was managed well. We are satisfied that Mr Damon was appropriately located throughout his illness.

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 Damon was not restrained when he was taken to hospital on 2 January. He remained unrestrained until his death on 27 January. We consider that this was appropriate.

Liaison with Mr Damon's family

48. On 17 October 2017, shortly after his cancer diagnosis, a Family Liaison Officer (FLO) was appointed to support Mr Damon and his daughter who was named as the next of kin. On 13 June 2018, FLO duties were taken over by another officer. This officer maintained regular contact with Mr Damon's daughter.

49. On 2 January 2019, when Mr Damon went to hospital, the FLO was on leave so Mr Damon's daughter was informed he was in hospital by another member of staff. On 3 January, the FLO called Mr Damon's daughter and offered support and advice. Mr Damon's family was able to visit him regularly in hospital.

50. On 25 January, when Mr Damon's health deteriorated suddenly, the FLO contacted his daughter to inform her of Mr Damon's decline in health. Mr Damon's daughter was then able to visit him.

51. When Mr Damon died on 27 January, the FLO contacted his daughter and son by phone. The FLO continued to support the family with the funeral arrangements and with getting Mr Damon's property back.

52. Mr Damon's funeral was held on 26 February 2019. The FLO and prison chaplain attended. The prison contributed to the cost of the funeral in line with national instructions.

Compassionate release

53. 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.

54. In November and December 2018, Mr Damon was considered for compassionate release. Both applications were refused. Mr Damon presented a high risk of harm to children, his risk had not reduced during his time in prison and his life expectancy at the time was six to 12 months. Although there is no set time, three

months or less is typically considered an appropriate period for compassionate release to be considered.

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

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