Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Roland Jones a prisoner at HMP Stocken on 12 October 2017

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*

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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.

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 Roland Jones died in hospital on 12 October 2017 of lung cancer, while a prisoner at HMP Stocken. He was 58 years old. We offer our condolences to Mr Jones' family and friends.

I am satisfied that the healthcare Mr Jones received at Stocken was equivalent to that which he could have expected to receive in the community. His diagnosis was timely and appropriate.

I am, however, concerned that when Mr Jones attended hospital, restraints were inappropriately used until his last admission. Risk assessments did not take into consideration his health and the risk he posed at the time. The prison also imposed an inappropriate blanket approach to full searching (strip searching) which resulted in Mr Jones refusing to attend at least one appointment.

It is also important that all staff who are involved in applications for compassionate release are aware of the relevant timescales for the paperwork to be completed to avoid any unnecessary delay.

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 **May 2018**

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Summary

Events

1. Mr Roland Jones was serving an indeterminate prison sentence with a minimum tariff of nine years for attempted murder. He had been at HMP Stocken since 2014.

2. On 3 March 2017, a nurse saw Mr Jones, who had been complaining of chest tightness for five to six weeks, along with a cough, which was getting progressively worse. This was the first time Mr Jones reported these symptoms to staff. The nurse discussed a referral for a chest x-ray with a prison GP.

3. A prison GP made an urgent referral for Mr Jones to the ear, nose and throat department, and to the rapid access chest pain clinic at hospital. On 24 March, healthcare staff received the results of his chest x-ray and a fast track referral was made for suspected lung cancer and a brain scan.

4. On 11 April, Mr Jones attended a further appointment at hospital for an ultrasound scan and biopsy tests to get a definitive diagnosis. A letter from the consultant, dated 18 April, confirmed that Mr Jones had advanced small cell lung cancer. He later confirmed that this had spread to Mr Jones' brain. The consultant gave a prognosis of about one year to live, although there was significant scope for variability.

5. On 15 May, Mr Jones started chemotherapy and was given a prognosis of six to nine months to live. He remained on normal location. Healthcare staff regularly reviewed Mr Jones and, from June to August, prison staff made applications for compassionate release and for a move to a prison with 24-hour healthcare.

6. On 2 October, Mr Jones was no longer well enough to continue chemotherapy. A hospital consultant gave him a prognosis of less than 3 months.

7. On 5 October, Mr Jones was taken to Accident and Emergency at hospital due to a suspected accidental overdose. He remained at hospital, where his health deteriorated and, on 12 October, died of lung cancer.

Findings

8. The clinical reviewer considered that the care Mr Jones received was equivalent to that which he could have expected to receive in the community. We are satisfied that there were no delays in his diagnosis and treatment. The prison GP referred him under the 'two week wait', in accordance with NICE guidelines, and a diagnosis was made in a timely manner.

9. Mr Jones was restrained using handcuffs and chains and had to undergo a full search (where all clothing is removed to search for contraband) for all hospital visits prior to 5 October. Both procedures were based on what appears to be an inflexible blanket approach to escorts. Both procedures were inappropriate. Risk assessments failed to take into account his health and condition at the time.

10. Prison staff began the compassionate release process once Mr Jones had received a prognosis of less than three months. There was a delay in the

completion of the paperwork by prison healthcare staff. Although this would not have had an impact on the outcome, as Mr Jones' health declined faster than expected, it is important that all staff are aware of the relevant deadlines and timescales for compassionate release paperwork to be completed.

Recommendations

- **The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints 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 Governor should ensure that full searches on prisoners going on hospital escorts are only undertaken following an appropriate risk assessment, and when there is sufficient intelligence to justify their use.**
- **The Head of Healthcare and Head of OMU should ensure that all reports required for applications for early release on compassionate grounds for prisoners with terminal illnesses are prioritised and completed without delay.**

The Investigation Process

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

12. The investigator obtained copies of relevant extracts from Mr Jones' prison and medical records.

13. NHS England commissioned a clinical reviewer to review Mr Jones' clinical care at the prison.

14. We informed HM Coroner for Rutland and North Leicestershire of the investigation. The doctor at the hospital where Mr Jones died provided Mr Jones' cause of death and we have sent the coroner a copy of this report.

15. One of the Ombudsman's family liaison officers contacted Mr Jones' next of kin - his sister and his daughter - to explain the investigation and to ask whether they had any matters they wanted the investigation to consider. The family had the following concerns:

    - the compassionate release process;
    - the suitability of HMP Stocken to provide the healthcare Mr Jones needed;
    - the use of restraints and risk assessments; and
    - the lack of communication between HMP Stocken and the family.

16. Mr Jones' family received a copy of the initial report. They pointed out some a factual inaccuracy. This report has been amended accordingly. Mr Jones' 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.

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

18. 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

HMP Stocken

19. HMP Stocken is a medium security prison in Rutland which holds up to 842 men. Healthcare is provided by Care UK, and mental health services are sub-contracted to Northamptonshire Foundation NHS Trust. GP provision is provided by two permanently-employed GPs who provide ten GP sessions per week.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Stocken was conducted in July 2015. Inspectors reported that health services were good, particularly in identifying and supporting prisoners with complex health needs. Waiting times for GP, nurse and dental service appointments were acceptable but prisoners waited too long for most other health services.

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 April 2017, the IMB reported that healthcare at HMP Stocken had recently changed contractor to Care UK. Waiting lists for dental and optician treatment had reduced although “Did Not Attends” remained too high. The number of hospital appointments cancelled due to lack of escorts was being addressed.

Previous deaths at HMP Stocken

22. Mr Jones was the fourth prisoner to die from natural causes at Stocken since January 2015. In investigations into the earlier deaths, in December 2015 and February 2016, we also made recommendations about the proper consideration of risk assessments.

Findings

Diagnosis of Mr Jones' terminal illness and informing him of his condition

23. Mr Roland Jones had been at HMP Stocken since November 2011, other than for a month spent at HMP Grendon in 2014. He had a history of generally good health.

24. On 3 March 2017, Mr Jones presented to healthcare at Stocken with tightness in his chest, a persistent cough and shortness of breath on exertion. He said the cough had been getting progressively worse over the past five to six weeks. There is no record that he had previously complained about these symptoms.

25. On 9 March, Mr Jones saw the prison GP and was referred for an urgent x-ray under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks. On 24 March, the results of the x-ray were faxed to the prison. They showed a dense mass in the right lung which might be cancer. He explained the results to Mr Jones, who agreed to have further tests.

26. On 11 April, Mr Jones had a lung biopsy at hospital. On 19 April, a hospital consultant confirmed that Mr Jones had advanced small cell lung cancer with further evidence of cancer in the brain.

27. We agree with the clinical reviewer that healthcare staff appropriately referred Mr Jones for urgent investigative tests when he presented with chest pain and a persistent cough. His diagnosis was timely and he was informed of his prognosis without delay.

Mr Jones' clinical care

28. On 24 April, Mr Jones attended an oncology appointment. Hospital staff told him he would start chemotherapy the next day and they gave him a MacMillan cancer charity information leaflet. At his follow-up appointment on 25 April, a hospital consultant told Mr Jones that his prognosis was up to a maximum of a year, with treatment.

29. On 5 May, Mr Jones said he did not want anyone to resuscitate him if his heart or breathing stopped. He signed a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) order to that effect. On 23 May, after discussions with relatives, Mr Jones decided to withdraw the order.

30. On 25 May, Mr Jones was admitted to hospital after a routine blood test showed that he had neutropenia (a low level of white blood cells). He was discharged to Stocken on 30 May with several medications for oral thrush, methicillin-resistant staphylococcus aureus (MRSA) and high blood sugar.

31. On 22 June, Mr Jones refused to attend his appointment at the hospital for a computerised tomography (CT) scan (which produces detailed images of structures inside the body, including the internal organs, blood vessels and bones). The reason was unknown.

32. On 3 July, Mr Jones refused to attend his chemotherapy appointment. The next day, he told a nurse, he had refused because he felt that his head was the main problem, not his chest. He also requested an x-ray of his head so that the hospital consultant could compare it with the last one. It is not documented whether she did anything with this information, although Mr Jones had another appointment booked for a brain x-ray at the end of the month.

33. Mr Jones continued to refuse chemotherapy until he had had a head scan, and as a result, had only had two cycles of chemotherapy. Mr Jones was taking dexamethasone (a steroid), for his headaches but was still getting headaches intermittently.

34. On 12 July, a clinical practitioner reviewed Mr Jones' headaches as they were now waking him at night. The clinical practitioner suggested an increase in his dose of dexamethasone and discussed the side effects. The dose was increased.

35. On 17 July, Mr Jones refused to attend an oncology appointment at hospital and, on 24 July, refused to go to a further oncology appointment. He said he was fed up with staff insisting he was strip-searched before leaving prison. Staff explained that the appointment was to discuss his brain scan but Mr Jones said that he knew what it would reveal. An appointment was made with the prison GP to discuss future treatment and care options.

36. On 3 August, a letter received from the hospital specialist noted that Mr Jones had had an excellent response to the first two cycles of chemotherapy in his chest and that the scan of his brain was unremarkable. The prison GP discussed this with Mr Jones, who was pleased with the outcome and agreed to continue further treatment.

37. On 24 August, Mr Jones attended his chemotherapy appointment although he had missed two appointments earlier in the week due to his tiredness and shortness of breath. He had also failed to take his medication for two days because of tiredness. It is not documented that his medication was brought to him during these two days or that he made anyone aware that he had not taken any medication prior to this. Mr Jones was subsequently admitted to hospital.

38. On 1 September, a nurse spoke to the hospital nurse looking after Mr Jones, as he was being discharged. She asked whether a social services assessment had been carried out. The nurse said that Mr Jones was self-caring with his washing, dressing and mobility while in hospital so this was not required.

39. On 8 September, the family liaison officer held a cancer care review with Mr Jones. He said he felt much better than the previous week and felt steadier when walking. Mr Jones said that he wanted to be transferred to another prison closer to home and asked when this might be possible. It was discussed that he would move when he had finished his course of treatment.

40. On 2 October, Mr Jones went to the medication hatch and told a nurse that he had not been able to eat for two weeks, felt weak and had increased headaches, and nose bleeds. He also mentioned that he had fallen three times and felt the

chemotherapy was making him feel worse. She advised him to discuss this at his hospital appointment later that day.

41. Later that morning, Mr Jones' attended an appointment with, the oncology consultant. She said that Mr Jones was not well enough to have any more chemotherapy and arranged for him to have an urgent CT scan. She also noted that Mr Jones' platelet count was very low, the cause of which might be a chest infection or disease progression. She said that Mr Jones' dexamethasone could be doubled to help the headaches and she would see him in two to three weeks.

42. On 05 October, wing staff noticed at 08:15am that Mr Jones was sitting in his chair and had been incontinent of urine. Mr Jones said he had a cough and had not been able to walk unaided for a number of days. He also said he had a severe headache and had been taking paracetamol throughout the night. Wing staff checked his bin and it appeared that he might have taken up to 24 paracetamol, although Mr Jones did not think he had taken that many. Wing staff immediately called an ambulance and paramedics took Mr Jones to hospital, where he was admitted for a potential accidental paracetamol overdose.

43. A blood test showed that Mr Jones had not taken the suspected overdose. On 6 October, the hospital palliative care team and an oncologist reviewed Mr Jones and implemented a further DNACPR order.

44. On 12 October, a nurse spoke to a hospital oncology nurse at the hospital who said that Mr Jones was on the Personalised Care Plan for palliative patients and was not expected to live longer than a few days. However, Mr Jones' condition deteriorated quickly and he died in hospital later that day.

45. We agree with the clinical reviewer that Mr Jones' clinical care at HMP Stocken was equivalent to that he could have expected to receive in the community. Mr Jones was able to access outpatient appointments and received the treatment prescribed by his consultants. There were appropriate care plans put in place and consideration was given to his wishes.

Mr Jones' location

46. When Mr Jones arrived at Stocken, he lived on normal location. However, after his diagnosis, and as his condition progressed, on 5 September he moved to a disabled cell where he had more room, his own shower, handrails for easy accessibility and additional cell bells located around the cell. The cell was left open for the majority of the day, allowing friends to visit, or for Mr Jones to visit friends elsewhere. Staff would also check on Mr Jones at random times throughout the day. Mr Jones received much of his care on the wing.

47. As Mr Jones' condition deteriorated, prison staff discussed moving him to another prison which would be able to provide 24-hour healthcare.

48. On 8 September, the family liaison officer spoke to Mr Jones about potentially moving to HMP Highdown, which had 24-hour healthcare, and might have suited his needs better. However, the transfer did not happen due to lack of space at Highdown.

49. On 6 October, while Mr Jones was an inpatient at hospital, the palliative care team and oncologist discussed the possibility of discharging him to a hospice, in case Stocken could not meet his care needs. Mr Jones' condition deteriorated quickly and he remained in hospital until his death on 12 October 2017.

50. We are satisfied that Mr Jones' location was appropriate at all times and staff at Stocken clearly reviewed his location as his condition changed. Although Mr Jones was not able to move to a prison with 24-hour healthcare or to the hospice, there is no evidence to suggest that this had a detrimental effect on him or his condition.

Restraints, security and escorts

51. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has 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 of 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 risk to the public in the event of an escape) 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.

52. Mr Jones went to hospital on a number of occasions following his diagnosis. The escort risk assessments provided by the prison indicated that he presented a medium risk of escape and harm to others. His risk assessments recommended that officers restrain Mr Jones with single handcuffs and an escort chain. (This is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.) Prison healthcare staff did not contribute to any risk assessments or indicate any objections to the use of restraints. The generic risk assessment was reviewed each time Mr Jones went to hospital but the level of restraint was not reviewed in light of his deteriorating physical presentation and ability to mobilise. As Mr Jones' condition worsened, he could no longer walk long distances.

53. On 5 October, the last visit to hospital prior to his death, Mr Jones was unable to mobilise independently. However, the risk assessment still recommended that escort staff use single handcuffs. Healthcare staff, again, did not make any changes or comment about the actual risk that Mr Jones now posed.

54. The risk assessment appears to have been based primarily on Mr Jones' offence, with little consideration of how his health affected the level of risk he posed at the time, as the 2007 High Court judgment requires. Prison staff told us that there was no security intelligence available because the security server (Mercury) was unavailable, however, there is no evidence that alternative investigations were made about Mr Jones' behaviour over the previous three months.

55. Whenever restraints are used, the risk assessments must accurately reflect the risk posed at that time to ensure proportionality and to maintain human dignity. We are not satisfied that the prison appropriately considered Mr Jones' level of

risk or clearly justified the use of restraints as his condition deteriorated. Although it is the Governor's responsibility to ensure that the risk assessment process is properly managed, the Head of Healthcare also needs to make sure that healthcare staff fully understand the requirements of the High Court judgement. We make the following recommendation:

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

56. Mr Jones was full searched every time he went out on an escorted visit to hospital. Prison Service Instruction (PSI) 07/2016, *Searching of the person*, does not require the prison to perform a full search of a prisoner going to hospital on escort automatically. Instead, it states that each prison must carry out risk assessments to assess the security risks of each escort and to put in place appropriate screening as a response. There is no evidence to suggest that Mr Jones posed a significant risk while on escort. On the contrary, as time went on there was a decrease in his level of risk due to the decline in his health and mobility.

57. On 24 July, Mr Jones refused to attend a hospital consultation as he stated that he was fed up with staff insisting on strip searching him before leaving the prison. The investigator discussed this with the Head of Security and Intelligence at Stocken who stated that all prisoners have to have a full search on discharge from the prison in accordance with their Local Security Strategy Guidelines. These guidelines do not reflect the provisions of PSI 07/2016.

58. Full searches are demeaning and can be unpleasant for both staff and prisoners. It is vital that any full searches conducted on prisoners going on hospital escorts are supported by a risk assessment that accurately reflects any security concerns and the risks posed. There is no evidence that this happened for any of Mr Jones' escorts and, consequently, he missed a hospital consultation. This might have been avoided if a risk assessment had been done to establish the real and current risk that Mr Jones posed, rather than a blanket rule for all prisoners. There is also no evidence to suggest that healthcare was consulted to give advice on whether a full search was necessary and appropriate given Mr Jones' physical disposition in the latter stages of his condition and during treatment. We make the following recommendation:

The Governor should ensure that full searches on prisoners going on hospital escorts are only undertaken following an appropriate risk assessment, and when there is sufficient intelligence to justify their use.

Liaison with Mr Jones' family

59. On 26 April, after Mr Jones' diagnosis, HMP Stocken appointed the Activities Hub Manager as a family liaison officer. She met Mr Jones' brother and sister at the prison on 7 May. She introduced herself and offered support. Mr Jones was also present and she was able to discuss any concerns with him and his brother and sister. She remained in regular contact with Mr Jones' sister and facilitated

arrangements for Mr Jones to visit his mother shortly before she died in May 2017.

60. On 27 July, after Mr Jones' application for compassionate release was rejected, the family liaison officer explained the process to Mr Jones' sister to ensure that she understood how it worked.

61. The family raised concerns about a lack of communication from the Governor at Stocken in response to emails from the family. There were some delays in responding in the Governor's absence. However, we are satisfied that the family liaison officer was always available as the family's main point of contact and would follow up any concerns from the family.

62. After Mr Jones' death, the family liaison officer attended the hospital to offer support to Mr Jones' family, and continued to offer on-going support to the family afterwards. Mr Jones' funeral was held on 10 November. The prison offered a financial contribution in line with national policy.

63. We are satisfied that there was appropriate liaison with Mr Jones' family. The prison appointed a family liaison officer promptly after Mr Jones' diagnosis and she provided a good level of support to his family.

Compassionate release

64. Release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months, can be permanently released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. The criteria for early release for indeterminate sentenced prisoners are set out in *Prison Service Order (PSO) 4700*. Among the criteria is that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of Her Majesty's Prison and Probation Service (HMPPS).

65. On 25 April 2017, a prison GP noted that Mr Jones had a prognosis of up to one year left to live. On the 10 May, the hospital oncologist said that his prognosis was six to nine months.

66. The prison submitted a compassionate release application to PPCS on 7 July 2017. However, Mr Jones' offender supervisor was notified on the phone by PPCS that this application had been rejected as his prognosis did not meet the threshold of less than three months.

67. On 31 August, the hospital oncologist rang the healthcare department with an update. Mr Jones was having assessments in hospital about the most suitable arrangements for his palliative care. The administrative / clinical support officer, said that the healthcare staff would consider plans once the hospital had completed its assessments. The options were either a prison transfer or compassionate release if Mr Jones' prognosis was less than three months.

68. On 5 September, Mr Jones' offender supervisor forwarded a compassionate release form to healthcare and asked them to complete it as soon as possible. She said healthcare replied stating that they were aware that his previous application had been rejected. She explained that as Mr Jones was terminally ill, there were frequent reviews.

69. On 28 September, a hospital oncology consultant sent a letter to prison healthcare confirming that Mr Jones' prognosis was less than three months. The following day, the prison GP signed off the medical form for compassionate release. On 1 October, Mr Jones' offender supervisor asked a prison manager, to assist in obtaining the completed compassionate release form from healthcare. On 2 October, a Practice Healthcare Administrator emailed her to say that she will drop the form in the internal post. On 6 October, the compassionate release form was completed and forwarded to PPCS.

70. On 12 October, a nurse spoke to a hospital oncology nurse for an update. Mr Jones' prognosis was now only a few days. She asked the hospital to confirm this in writing so she could update his current compassionate release paperwork. Hospital staff said a hospital doctor had already sent a letter.

71. PPCS did not grant Mr Jones' compassionate release until the day after his death.

72. Prison staff appropriately kept Mr Jones' condition under review and reconsidered the compassionate release application when his prognosis changed to meet the appropriate threshold. However, it took a week - from 29 September to 6 October - for all relevant information to be obtained to evidence Mr Jones' poor prognosis. There was a delay in obtaining information from healthcare. We consider that Prison and healthcare staff should have been more proactive in obtaining and completing the section in the paperwork with the latest information about Mr Jones' prognosis. We therefore recommend:

    The Head of Healthcare and Head of OMU should ensure that all reports required for applications for early release on compassionate grounds for prisoners with terminal illnesses are prioritised and completed without delay.

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