Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Vincent Parry a prisoner at HMP Doncaster on 6 August 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*

Summary

1. 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.
2. This office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Vincent Parry, who was 73 years old, died of carcinomatosis caused by transitional cell carcinoma of the ureter (a condition in in which cancer forms in the ureter and spreads widely throughout the body) on 6 August 2019 at HMP Doncaster. We offer our condolences to Mr Parry's family and friends.
4. The clinical reviewer concluded that the clinical care that Mr Parry received after his cancer diagnosis was of a reasonable standard and equivalent to that which he could have expected to receive in the community. She has made three recommendations about clinical issues, including second reception screenings, following National Institute for Health and Care Excellence (NICE) guidance about malnutrition and recording end of life care plans.
5. We did not find any non-clinical issues of concern.

Recommendations

- **The Head of Healthcare should ensure that NICE guidance is followed when patients show signs of malnutrition.**

- **The Head of Healthcare should ensure that End of Life Care Plans are attached to records and explicit for all to see.**

Investigation Process

1. Spectrum commissioned an independent clinical reviewer to review Mr Parry's clinical care at HMP Doncaster.

2. The PPO has investigated non-clinical issues, including Mr Parry's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

3. Our family liaison officer wrote to Mr Parry's next of kin to explain the investigation and to ask whether he had any matters he wanted to be considered during the investigation. He did not respond to our letter.

4. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous Deaths at Doncaster

5. There have been six deaths from natural causes and seven non-natural deaths at HMP Doncaster since August 2017 years. Since Mr Parry died, there have been two more deaths from natural causes and two more deaths from non-natural causes.

6. We previously raised with Doncaster the need for secondary health screens in November 2018 and again in November 2019. Since Mr Parry died, staff at Doncaster have assured us that action has been taken to ensure that all new prisoners will receive secondary health screens. Therefore, we do not repeat this recommendation.

Key Events

7. On 21 December 1992, Mr Vincent Parry was sentenced to life imprisonment for sexual offences.

8. On 20 August 2002, Mr Parry transferred to HMP Wakefield. In 2016, he was diagnosed with bladder cancer and treated.

9. On 21 December 2018, Mr Parry transferred to HMP Doncaster. His history of cancer was noted and he continued to be monitored for any reoccurrences by the Urological Team at hospital.

10. Between 25 May and 1 June 2019, Mr Parry was admitted to hospital due to vomiting and a general deterioration in his physical health. While in hospital, Mr Parry was diagnosed with a malignant left ureteric lesion (cancer that begins in the cells that line the inside of the tubes (ureters) that connect the kidneys to the bladder) with liver metastases.

11. On 1 July, Mr Parry was admitted to hospital due to vomiting. During his admission, the cancer was found to have spread to Mr Parry's bones and he was given a prognosis of between three to six months to live.

12. While in hospital, Mr Parry signed A Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) form and a plan was made for him to have palliative treatment. Mr Parry returned to Doncaster on 12 July.

13. Mr Parry was admitted to hospital again between 15 to 26 July, where he was treated for the progression of his cancer. An outpatient's appointment was arranged with the Palliative Care Team on 30 July, which he attended, and his painkillers were increased.

14. Mr Parry died on 6 August 2018 at 3.18pm.

15. The Coroner concluded in the post-mortem that Mr Parry died from carcinomatosis caused by transitional cell carcinoma of the ureter.

Clinical Findings

16. The clinical reviewer concluded that the care Mr Parry received was of a reasonable standard and equivalent to that he could have expected to receive in the community. However, the clinical reviewer found that after Mr Parry had a first health screening, he did not have a second health screening within 7 days. The clinical reviewer also identified that healthcare staff did not follow National Institute for Health and Care Excellence (NICE) guidance when Mr Parry showed signs that he was malnourished, and that there was no evidence to show that healthcare staff discussed with Mr Parry his preferred place of death. Therefore, the clinical reviewer has made recommendations about second reception screenings, following malnutrition guidance and recording end of life care plans.

Sarah Stolworthy **March 2020**

Assistant Ombudsman