Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ian Murdoch a prisoner at HMP Doncaster on 3 April 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 Ian Murdoch died on 3 April 2019, from gallbladder cancer which had spread to other parts of his body, while a prisoner at HMP Doncaster. He was 62 years old. I offer my condolences to Mr Murdoch's family and friends.

The investigation found that Mr Murdoch did not have a secondary health screen when he was remanded to Doncaster, but this had no bearing on his illness. I have previously raised concerns about the omission of such health screens at Doncaster.

I am satisfied that healthcare staff acted quickly to obtain a diagnosis when Mr Murdoch first reported persistent gastric pain. He was challenging to care for and did not always comply with medical advice. However, he received a good standard of care, equivalent to that he could have expected to receive in the community.

I am concerned that in assessing Mr Murdoch's security risk and considering the use of restraints, prison and healthcare staff did not fully take account of how his health and condition had affected his risk of escape in the last weeks of his life. This is also a matter that I have raised with Doncaster before.

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 **November 2019**

Contents

Summary

Events

1. Mr Ian Murdoch (also known as Ian Dempster) was remanded to HMP Doncaster on 27 December 2017. He was later convicted of sexual offences and given an extended sentence of 21 years. A nurse at an initial health screen noted his asthma and lung problems.

2. On 3 July 2018, Mr Murdoch reported persistent stomach pain to healthcare staff. A prison GP examined him the next day and immediately arranged blood tests and a scan, for suspected gallstones. The GP reviewed Mr Murdoch on 11 July and, on the advice of a hospital specialist, prescribed antibiotics.

3. As Mr Murdoch's condition did not improve, he was admitted to hospital on 18 July and his gallbladder was removed on 20 July. On 8 August, Mr Murdoch's specialist wrote to advise that tests had revealed a malignant tumour in Mr Murdoch's gallbladder. The prison GP informed him Mr Murdoch of this on 5 September.

4. Mr Murdoch often refused to cooperate with prison staff and specialists' efforts to assess and treat him. Healthcare staff created care plans and discussed him at weekly multidisciplinary meetings. The prison also appointed a family liaison officer. Mr Murdoch was treated palliatively until his symptoms worsened and he was admitted to hospital on 25 March 2019. Mr Murdoch died on 3 April.

Findings

5. We agree with the clinical reviewer that staff should have completed a secondary health screen, in line with national guidelines on continuity of care. However, this had no bearing on Mr Murdoch's death.

6. There was a delay of four weeks between the prison receiving notification of Mr Murdoch's cancer diagnosis and informing of him of his condition. Although this did not affect the outcome, he should have been told sooner.

7. We are satisfied that Mr Murdoch's care after his diagnosis was at least equivalent to that he could have expected to receive in the community.

8. Mr Murdoch was handcuffed for hospital outpatient appointments and inpatient admissions, until two days before his death. We are concerned that security decisions taken after his diagnosis were not fully justified by his level of risk at the time and that restraints were used inappropriately in the final weeks of his life.

Recommendations

- The Head of Healthcare should ensure that all new prisoners receive secondary health screens.

- The Head of Healthcare should ensure that prisoners are promptly informed of diagnoses made by secondary care services.

- The Director and Head of Healthcare should ensure that all staff who undertake and review risk assessments for prisoners taken to and admitted to hospital understand the legal position on the use of restraints, that assessments fully take in to account a prisoner's health and are based on the actual risk he presents at the time.

The Investigation Process

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

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

11. NHS England commissioned an independent clinical reviewer to review Mr Murdoch's clinical care at the prison.

12. We informed HM Coroner for Doncaster of the investigation. She gave us Mr Murdoch's cause of death. We have sent the coroner a copy of this report.

13. One of the Ombudsman's family liaison officers wrote to Mr Murdoch's brother, his nominated next of kin, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not respond to our letter.

14. The investigation has assessed the main issues involved in Mr Murdoch'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.

15. The initial report was shared with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies and accepted our recommendations. The HMPPS action plan has been annexed to this report.

Background Information

HM Doncaster

16. HMP Doncaster is a local prison, operated by Serco, which holds up to 1,145 remanded and sentenced men. Care UK provides physical and mental health services, and substance misuse services. Nurses and a paramedic are available 24 hours a day.

HM Inspectorate of Prisons

17. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Doncaster in July 2017. Inspectors reported that a great deal had been achieved since their inspection two years earlier. Health services had improved significantly since the previous inspection in October 2015 and overall, were reasonably good. There was effective clinical management, with a range of clinics, mandatory staff training and access to professional development. There were no staff shortages and appropriate policies were in place. Patients had access to information and testing on a wide range of conditions and access to external appointments had improved, with rare cancellations. Inspectors considered that the management of prisoners with long-term conditions was particularly good.

Independent Monitoring Board

18. 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. No IMB report has been issued since the reporting year 2015-16.

Previous deaths at HMP Doncaster

19. Mr Murdoch was the tenth prisoner to die at Doncaster since April 2017. Two of these deaths was self-inflicted and eight were from natural causes. Since Mr Murdoch died, there have been three subsequent deaths, all apparently self-inflicted.

20. We have previously raised with Doncaster the issues of the need for secondary health screens; poorly considered risk assessments; and the inappropriate use of restraints.

Findings

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

21. Mr Ian Murdoch was remanded to HMP Doncaster on 27 December 2017, after failing to comply with the conditions of bail. He had served several previous sentences in prison and had last been discharged from Doncaster on 12 October 2017. (Mr Murdoch was later convicted of historic sexual offences and given an extended sentence of 21 years, with a prison term of 18 years and an extended licence period of three years.)

22. At his initial health screen, a nurse recorded that Mr Murdoch had a history of asthma, chronic obstructive pulmonary disease (a group of lung conditions that cause breathing difficulties) and mental health problems. There is no evidence that a secondary health screen was completed. Over the following months, most of Mr Murdoch's contact with healthcare staff was for mental health reviews.

23. On 3 July 2018, Mr Murdoch reported chest and stomach pains that had persisted for several days and had prevented him eating and sleeping. He had taken Gaviscon (an antacid to relieve heartburn and indigestion) with little effect.

24. The next day, a prison GP examined him. The GP suspected gallstones or an ulcer. He prescribed tramadol (an opioid painkiller for moderate to severe pain) and referred Mr Murphy for blood tests and an ultrasound scan, with a plan to review him the following week. (The scan later revealed a fatty liver and inflamed gallbladder, with a gallstone.) Healthcare staff took daily observations and Mr Murdoch told some of them that he had a history of gastric problems and had been treated as an inpatient in the past.

25. After a review on 11 July, the GP discussed Mr Murdoch's symptoms with a specialist at Doncaster Royal Infirmary. He was advised to prescribe antibiotics. He also referred Mr Murdoch for a cholecystectomy (removal of the gallbladder) and wrote to the prison catering manager to request a low-fat diet. At a further review on 18 July, there had been no improvement and Mr Murdoch was still in pain, despite courses of two different antibiotics. The GP therefore arranged for him to be admitted urgently to Doncaster Royal Infirmary.

26. Mr Murdoch's gallbladder was removed on 20 July. Two days later, he discharged himself from hospital, against medical advice. On 8 August, the prison received a letter from Mr Murdoch's consultant, stating that tests on the gallbladder had revealed a malignant tumour. The consultant referred him to the hospital's upper gastrointestinal cancer multidisciplinary team (MDT) and requested blood tests and a CT scan.

27. On 5 September, healthcare administrative staff informed the prison GP that Mr Murdoch had been diagnosed with cancer, but had yet to be told. The GP saw Mr Murdoch that afternoon to break the news. He also advised wing staff that he had received bad news and asked them to keep an eye on him. Mr Murdoch was initially shocked and did not believe the diagnosis.

28. National Institute for Health and Clinical Excellence (NICE) guidelines NG57 and PSO 3050 *Continuity of Healthcare for Prisoners* state that prisons should ensure continuity of care for newly-arrived prisoners, including carrying out a secondary health assessment. This enables healthcare staff to explore the prisoner's medical history and state of health in greater depth than at the initial health screen. We note it had only been two and a half months since Mr Murdoch's previous release from prison and that staff thought he was only there temporarily. However, we share the clinical reviewer's concern that Mr Murdoch did not receive a secondary health screen after he was sentenced, particularly as he later disclosed a history of gastric problems. We make the following recommendation:

The Head of Healthcare should ensure that all new prisoners receive secondary health screens.

29. There was a gap of four weeks between the prison receiving Mr Murdoch's cancer diagnosis and healthcare staff communicating it to him and no reason for the delay was recorded. Although this does not appear to have affected the outcome, we consider it important that patients receive significant medical information without delay. We make the following recommendation:

The Head of Healthcare should ensure that prisoners are promptly informed of diagnoses made by secondary care services.

Mr Murdoch's clinical care

30. Mr Murdoch did not attend an appointment with the prison GP on 11 September and refused to have the necessary blood tests and CT scan. He went to an appointment with the hospital consultant on 2 October, where he rejected any further investigations or interventions, unless it was in Scotland. Mr Murdoch also refused to see the consultant for future appointments, as he had convinced himself that the development of his cancer had been due to medical negligence. The consultant asked the prison to try to persuade Mr Murdoch to agree to the tests (and subsequently arranged for Mr Murdoch to see specialists at alternative hospitals). After a discussion with the prison GP on 10 October, Mr Murdoch agreed to the blood tests and scan.

31. Healthcare staff created a cancer care plan and monitored Mr Murdoch's condition at a weekly MDT meeting. Mr Murdoch remained uncooperative and aggressive, often rejecting reviews or medication, but he was considered to have the mental capacity to refuse treatment.

32. On 21 December, the hospital consultant wrote to the prison to advise that the CT scan had shown liver lesions and he had referred Mr Murdoch to the Sheffield MDT and to a colorectal cancer specialist at Doncaster Royal Infirmary. (Mr Murdoch refused to see the colorectal cancer specialist on 25 January.)

33. On 3 January 2019, the multidisciplinary team diagnosed that Mr Murdoch's cancer had spread to his liver. In view of his refusal to engage with doctors at Doncaster Royal Infirmary, on 9 January, the consultant referred him to a consultant oncologist at Weston Park Hospital, Sheffield.

34. The prison GP regularly went to see Mr Murdoch in his cell and adjusted his medication in response to his increasing symptoms. Healthcare staff conducted risk assessments and allowed Mr Murdoch to keep some medications in his cell.

35. Mr Murdoch's pain worsened and he was admitted to Bassetlaw Hospital, Nottinghamshire on 7 February. A palliative care specialist assessed him and discussed palliative chemotherapy. In discussion with the specialist, Mr Murdoch agreed to active treatment, but did not want to be resuscitated if his heart or breathing stopped. A *Do Not Attempt Resuscitation* order was put in place that day.

36. Prison healthcare staff planned to visit the hospital to discuss discharge arrangements. However, Mr Murdoch discharged himself on 10 February, against medical advice and signed a waiver.

37. The next day, Mr Murdoch refused to attend an urgent appointment with a prison GP to review his care plan and pain relief, in line with the advice in the hospital discharge letter. He declined examinations and observations by healthcare staff during the following days, but said that a named prison GP (who had taken over from his previous GP) could check on him occasionally, as the previous GP had done. A member of healthcare staff advised Mr Murdoch to attend his GP appointments, so that his medication and overall health could be reviewed, but he continued to deliberately miss healthcare appointments. The MDT discussed Mr Murdoch regularly.

38. Mr Murdoch's condition deteriorated, with several symptoms. Due to widespread abdominal pain and vomiting, he agreed to see a prison GP on 13 February and was diagnosed with ascites (an abnormal build-up of fluid in the stomach which can cause other symptoms, such as abdominal discomfort and shortness of breath). The GP referred him urgently to Weston Park Hospital for a procedure to drain fluid, noting there was already an outstanding routine referral. She also prescribed co-codamol for pain relief, as Mr Murdoch felt that doctors who prescribed morphine were trying to kill him. A social care plan was created and contact was offered twice a day, but Mr Murdoch often refused this.

39. After a review on 20 March, a prison GP prescribed a steroid medication to reduce inflammation; an opioid patch for pain relief; and a nutritional supplement due to Mr Murphy's reduced appetite.

40. On 25 March, Mr Murdoch was admitted to Rotherham Hospital as his symptoms had worsened due to ascites. Healthcare staff contacted the hospital daily for updates. Mr Murdoch remained in hospital and died on 3 April 2019.

41. The Coroner confirmed that the cause of Mr Murdoch's death was metastatic adenocarcinoma of the gallbladder (gallbladder cancer that had started within the lining of the gallbladder and spread to other areas of the body).

42. Mr Murdoch was a challenging patient who often refused to comply with medical advice and treatment. Healthcare staff reviewed him frequently and liaised promptly and effectively with hospital specialists to manage his condition. Staff tried to accommodate his wishes throughout and any delays in assessments and managing Mr Murdoch's pain were due to his refusal to cooperate. We agree

with the clinical reviewer that Mr Murdoch's care at Doncaster was of a good standard and at least equivalent to that which he could have expected in the community.

Mr Murdoch's location

43. Towards the end of June 2018, Mr Murdoch was relocated from a residential wing to the upper healthcare centre, known as 'the Loft' as he felt under threat from other prisoners. The unit accommodates up to 14 prisoners with social care needs. Mr Murdoch's symptoms started at around the time of this move, but he later moved back to a residential house block.

44. A few days after his cancer diagnosis, Mr Murdoch requested a transfer to a Scottish prison (under a UK Prisoner Transfer Agreement) as he felt he would benefit from the support of his family. Between September and November 2018, he had further discussions about this with prison staff. However, when his offender supervisor prepared the paperwork on 5 November, Mr Murdoch had changed his mind and declined to sign, as he believed it to be a ruse to move him to Scotland to face further charges.

45. After he discharged himself from hospital in February 2019, staff tried several times to persuade Mr Murdoch to move back to the Loft, as the controlled medication he was taking could not be dispensed on the house block, but he refused. He eventually agreed to move to the Loft on 12 March and remained there until his final admission to hospital.

46. We are satisfied that Mr Murdoch's accommodation was suited to his needs and that staff respected his wishes to remain on a standard residential unit for as long as possible. Healthcare staff promptly arranged for him to be admitted to hospital when he developed symptoms that they could not adequately manage in prison.

Restraints, security and escorts

47. 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.

48. 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 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.

49. Mr Murdoch was a category B prisoner. He was also a large man (6 foot 5 inches tall).

50. The security risk assessment for an inpatient admission to hospital, on 7 February 2019, indicated that Mr Murdoch was a medium risk on the following

factors – risk to the public; escape potential; risk of hostage taking; and likelihood of outside assistance. It also noted that he had a history of violence and had often been abusive to staff. The tick box medical assessment by the prison GP indicated that restraints would not need to be removed for treatment. He added that an escort chain would be required for a CT scan and that Mr Murdoch had a fear of needles and was verbally aggressive. (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.) Mr Murdoch was escorted by two prison officers and double handcuffed, with the addition of an escort chain "due to large wrists." (Double cuffing is the standard level of restraint for a category B prisoner in good health - when the prisoner's hands are handcuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs.)

51. A security risk assessment for an outpatient hospital appointment, on 5 March, was almost identical to the previous one on 7 February. The medical section, completed by a nurse, stated that Mr Murdoch would need a wheelchair once at the hospital. He was again double handcuffed.

52. The medical comments on the risk assessment for Mr Murdoch's final hospital admission on 25 March were completed by a prison paramedic. It was noted that Mr Murdoch would require a wheelchair at hospital and that he had widespread cancer that had caused increased breathlessness. The level of risk on each risk factor was the same as in previous risk assessments. It was noted that Mr Murdoch could be disruptive and non-compliant in prison, but there had been no issues during his last escort to hospital and there was no risk to hospital staff. The form also indicated that there was no history of violence. The decision was that Mr Murdoch should be single cuffed "due to infirmity and treatment needs". The handcuffs were removed on 1 April, two days before Mr Murdoch's death.

53. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances. Although Mr Murdoch was a challenging prisoner, who was often very verbally aggressive and threatening to staff, there is no record of physical aggression. Mr Murdoch had been the victim of three serious assaults in 2017 and 2018, with no evidence of being a perpetrator. Although there were complaints of him bullying and threatening other prisoners in the Loft and also on the standard wing (most recently on 8 February), there is no evidence that this took a physical form.

54. Mr Murdoch's risk assessments appeared to be somewhat generic and influenced by his security category, offences and verbal aggression, with little consideration of how his personal circumstances and state of health had impacted on this risk, as the High Court judgement requires.

55. Given his size and verbally aggressive behaviour (which may have caused staff to fear possible physical aggression), and the fact that he was in denial about how ill he was, we consider that restraints may have been reasonable when he went to hospital on 7 February.

56. However, we are concerned that his assessed risk of escape did not change as his health deteriorated after this, even though he was suffering increased breathlessness and needed to use a wheelchair by March 2019. We also note

that the use of restraints is an ineffective and inappropriate method of trying to manage verbal abuse.

57. We are not satisfied that staff appropriately assessed Mr Murdoch's risk in the last weeks of his life, an issue that we have raised in previous investigations at Doncaster. We repeat the following recommendation:

The Director and Head of Healthcare should ensure that all staff who undertake and review risk assessments for prisoners taken to and admitted to hospital understand the legal position on the use of restraints, that assessments fully take in to account a prisoner's health and are based on the actual risk he presents at the time.

Liaison with Mr Murdoch's family

58. On 6 February 2019, the prison assigned an administration support officer as Mr Murdoch's family liaison officer (FLO). The FLO introduced herself to Mr Murdoch on 11 February, but he told her to leave. A few days later, he asked to see her and apologised, explaining that he was struggling to come to terms with his diagnosis. The FLO and a member of the chaplaincy visited Mr Murdoch in hospital after he was admitted in March.

59. Mr Murdoch had lost contact with everyone in his family except his mother. However, she was seriously ill in hospital and several attempts to contact her were unsuccessful. The prison had contact details for his brother, but Mr Murdoch had asked staff not to contact him, as they were estranged. At Mr Murdoch's request, the FLO and the prison's chaplaincy department tried to trace his eldest son, through the Salvation Army. The FLO also tried to get in touch with Mr Murdoch's ex-wife, who was listed as his next of kin in his prison records, without success.

60. On 30 March, when it became clear that Mr Murdoch only had a short time to live, the FLO took the decision to telephone his brother, as his only contactable family member. He was grateful for the call and said that he held lasting power of attorney for their mother. Mr Murdoch's brother later contacted the FLO for an update and they discussed funeral arrangements. They agreed that the prison would hold a memorial service, organise Mr Murdoch's cremation and ask the funeral director to send the ashes to his brother. His brother also intended to arrange a service. The FLO informed Mr Murdoch's brother of his death, within ten minutes.

61. The prison arranged and paid for Mr Murdoch's cremation, which was held on 16 April. As agreed, his ashes were sent to his family.

62. We are satisfied that the prison appointed a family liaison officer at an appropriate stage of Mr Murdoch's illness and that there was effective liaison during his illness and after his death.

Compassionate release

63. 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.

64. At a mental health review, on 30 January, it was noted that although Mr Murdoch's condition was likely to be terminal, there had been no confirmation of life expectancy, or plan of treatment from a hospital consultant. On 7 February, an entry in the medical records noted that the deputy head of healthcare intended to set up a multidisciplinary case conference to discuss issues such as the possibility of compassionate release.

65. We note that Mr Murdoch's failure to fully engage with healthcare staff and hospital specialists meant that a prognosis of life expectancy was not available. (When he was last admitted to hospital, he was still awaiting an appointment with an oncologist at Weston Park.) We are satisfied that staff at Doncaster were mindful of the possibility of applying for early release on Mr Murdoch's behalf but, realistically, could not make a credible application.

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