

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Malcolm Donaldson a prisoner at HMP Garth on 29 June 2019

A report by the Prisons and Probation Ombudsman

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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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. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Malcolm Donaldson, who was 78 years old, died of aspiration pneumonia caused by squamous cell oral cancer (mouth cancer) on 29 June 2019 at hospital, while a prisoner at HMP Garth. He also had cell lymphoproliferative disorder (a blood disorder) and frailty, which contributed to, but did not cause his death. We offer our condolences to Mr Donaldson's next of kin and friends.
4. The clinical reviewer concluded that the clinical care that Mr Donaldson received was of a satisfactory standard and equivalent to that which he could have expected to receive in the community. She has made two recommendations about clinical issues.
5. We did not find any non-clinical issues of concern.

Recommendations

- The Head of Healthcare should ensure that when a prisoner returns from hospital, the prisoner promptly receives appropriate medication recommended in the hospital discharge report.
- The Head of Healthcare should ensure that prisoners at risk of falls have an appropriate risk assessment in line with NICE guidelines and the assessment is recorded and acted on.

Investigation Process

6. NHS England commissioned an independent clinical reviewer, to review Mr Donaldson's clinical care at HMP Garth. The clinical review is attached to this report as Annex 1.
7. The PPO has investigated the non-clinical issues in Mr Donaldson's care, including his location, the security arrangements for his hospital escorts, liaison with his next of kin and whether compassionate release was considered.
8. Our family liaison officer wrote to Mr Donaldson's next of kin, to explain the investigation. They asked:
 - Was there a log for next of kin contact? (When Mr Donaldson's next of kin rang the prison, she found it difficult to discuss her father's care with staff.)
 - When necessary, had Mr Donaldson had access to specialist care?

- As his cancer had not spread, had he died because of an inability to eat due to the pain of eating causing malnutrition and weakness which, in turn, caused him to develop aspiration pneumonia?
 - If this was the case, then was his death caused by substandard care, and not his cancer or blood disorder?
9. We asked the clinical reviewer to address the questions regarding Mr Donaldson's clinical care in her report. We have addressed the question of family contact in this report.
10. Mr Donaldson's next of kin received a copy of the initial report. They raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.
11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Previous deaths at Garth

12. There have been nine deaths at HMP Garth in the two years before Mr Donaldson's death. Three of these were from natural causes. There are no similarities between our findings in the investigation of Mr Donaldson's death and the other deaths.

Key Events

13. Mr Malcolm Donaldson was serving eleven years in prison for serious sexual offences. He transferred to HMP Garth on 16 June 2015.
14. In December 2018, hospital doctors diagnosed Mr Donaldson with oral cancer. He was admitted for treatment and investigations. He had radiotherapy. Blood tests showed that he had low haemoglobin levels of 51 (The normal range is 130-180). In hospital he had a blood transfusion and the hospital consultant haematologist prescribed medication to help rectify his blood count.
15. Mr Donaldson was in contact with his next of kin and they were aware of his diagnosis. When Mr Donaldson went to hospital for his radiotherapy treatment, he could maintain contact with his next of kin.
16. The prison family liaison log noted that prison staff contacted Mr Donaldson's family on 8 March 2019. Mr Donaldson's next of kin said that she was the point of contact for any prison issues, and another next of kin for any medical issues.
17. On 21 June, hospital doctors recommended that the prison should contact Mr Donaldson's next of kin as he was very poorly but not considered to be at the end of life. Prison staff spoke to Mr Donaldson and he said he was happy for staff to contact his next of kin when they were unable to contact his other next of kin. The prison appointed a prison manager, to contact the next of kin and she

left a telephone message for Mr Donaldson's next of kin to contact her. The prison manager spoke to Mr Donaldson's next of kin on 24 June and arranged for her to visit him in hospital.

18. On 28 June, hospital staff told prison staff that Mr Donaldson was deteriorating and his next of kin should be contacted to discuss end of life care with them. Prison staff contacted his next of kin and she said that she would contact the hospital.
19. The family liaison log confirmed that after his diagnosis, Mr Donaldson maintained frequent contact with his next of kin. The log also noted that when hospital staff told prison staff to contact Mr Donaldson's next of kin, this was completed immediately. Prison records do not note any issues with next of kin contacting the prison to discuss Mr Donaldson's condition. There is only a note that hospital staff had initially refused to discuss his medical condition with his next of kin. As the actions of hospital staff are not within the remit of this investigation, we are unable to comment.
20. The possibility of compassionate release was not discussed as Mr Donaldson did not have a terminal diagnosis. In these circumstances, we consider that it was reasonable that staff did not apply for him to be considered for early release on compassionate grounds.
21. Mr Donaldson died in hospital on 29 June 2019 with next of kin present.
22. There was no post-mortem examination as the coroner accepted the cause of death provided by the hospital. The hospital doctor recorded the cause of death as aspiration pneumonia, caused by squamous cell oral cancer, with cell lymphoproliferative disorder and frailty as contributory factors.

Sarah Stolworthy

January 2020

Acting Assistant Ombudsman

Annex 1

Clinical Review into the death of Mr Malcolm Donaldson

Annex 2 HMPPS action plan