Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Tony Godfrey a prisoner at HMP Exeter on 11 October 2016

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 Tony Godfrey died on 11 October 2016 of stomach cancer at HMP Exeter. Mr Godfrey was 61 years old. I offer my condolences to his family and friends.

I am concerned that HMP Dartmoor missed opportunities to diagnose Mr Godfrey's cancer earlier. Subsequently, the care Mr Godfrey received at Exeter was very good with evidence of a caring, compassionate and holistic approach to his palliative and end of life care.

However, I am concerned by Exeter's unjustified decision to use restraints when Mr Godfrey went to hospital and by delays in completing a compassionate release application. I have raised similar issues in previous investigations at the prison and am disappointed to have to do so again.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **June 2017**

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Summary

Events

1. Mr Tony Godfrey was convicted of murder in 1993. He was released on licence in March 2004, but recalled to prison five months later. Mr Godfrey spent time at a number of prisons and was transferred to HMP Dartmoor on 20 May 2014.

2. Mr Godfrey had a history of chronic hepatitis C and, in 2005, doctors diagnosed him with a gallbladder polyp (abnormal tissue growth). Doctors recommended surgery to remove his gallbladder but he refused this.

3. Over the next few years, Mr Godfrey complained of abdominal discomfort and received medication to treat it. By February 2012, he reported worsening abdominal pain and healthcare staff performed blood tests and an ultrasound scan, which raised no concerns.

4. Due to the risk of cancer, in 2014, prison healthcare staff referred Mr Godfrey to a specialist regarding his polyp. An ultrasound scan was performed and he remained on the waiting list but the referral did not progress.

5. In early 2016, prison GPs diagnosed Mr Godfrey with gastro-oesophageal reflux disease and irritable bowel syndrome, for which he received appropriate medication.

6. By early April 2016, Mr Godfrey's pain had worsened and a prison GP referred him for another ultrasound scan. The scan showed a mass on his liver so healthcare staff sent him to hospital. Hospital investigations confirmed that he had terminal metastatic stomach cancer and his consultant explained that only palliative care was appropriate. Dartmoor was unable to care for Mr Godfrey's social care needs, so they arranged for him to transfer to HMP Exeter. He moved there on 2 June.

7. Mr Godfrey attended chemotherapy appointments until the end of August, when he refused to attend further sessions. That month, Mr Godfrey moved to the palliative care suite for better management of his symptoms and healthcare staff noted that he used a walking stick.

8. In October, Mr Godfrey's condition seriously deteriorated and a prison GP noted that he was approaching the end of life. On 5 October, carers began 24 hour support for Mr Godfrey's care needs and remained with him until his death on the morning of 11 October.

Findings

9. We are concerned that after he reported worsening abdominal pain and was diagnosed with reflux disease and irritable bowel syndrome, healthcare staff at Dartmoor did not make an urgent cancer referral, in line with NICE guidelines. However, following his diagnosis, we agree with the clinical reviewer that Mr Godfrey received care that was equivalent to that he could have expected to receive in the community and that he received a high standard of medical care at

Exeter, which was delivered within a kindly, caring, compassionate and holistic approach.

10. Given Mr Godfrey's status as a Category D prisoner, his very poor health and his limited mobility, we do not see how Exeter could justify the use of restraints when attending hospital appointments.

11. While at Dartmoor, prison staff appropriately started an application for compassionate release. However, after he transferred to Exeter, that establishment did not respond quickly to requests for information and the process was unnecessarily delayed.

Recommendations

- The Head of Healthcare at HMP Dartmoor should ensure that GPs follow relevant National Institute for Health and Clinical Excellence (NICE) guidelines for suspected cancer and refer patients appropriately.
- The Governor and Head of Healthcare at HMP Exeter 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.
- The Governor at HMP Exeter should ensure that applications for early release on compassionate grounds are progressed without delay.

The Investigation Process

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

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

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

15. We informed HM Coroner for Exeter of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

16. One of the Ombudsman's managers wrote to Mr Godfrey's next of kin to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.

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

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

Background Information

HMP Exeter

19. HMP Exeter is a local prison holding a maximum of 560 men either on remand, convicted or sentenced. The prison serves the courts of the South West. Dorset NHS University Foundation Trust provides health services, including mental health services. The prison has 24 hours healthcare cover. The prison also has a palliative care suite for terminally ill prisoners.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Exeter was in August 2016. Inspectors reported that when a prisoner needed a cell with special adjustments, they had to wait for a cell on the social care unit. They also reported that the palliative care service was inconsistent, as prisoners did not always receive care and medication in a timely way owing to the lack of staff. They also noted that there were not enough social care staff to meet prisoners' needs.

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 most recently published annual report, for the year to December 2015, the IMB reported that it believed that Exeter was a well-run and generally safe establishment and staff made a genuine effort to treat prisoners with dignity and respect. The IMB made special mention of the work of healthcare staff but considered that healthcare resources were inadequate and did not reflect community provision.

Previous deaths at HMP Exeter

22. Mr Godfrey was the seventh prisoner to die from natural causes at HMP Exeter since January 2016. There have been four subsequent deaths. We have consistently found that Exeter has provided good palliative and end of life care. However, we have also made recommendations about the unnecessary use of restraints and problems around compassionate release before.

HMP Dartmoor

23. HMP Dartmoor holds up to 642 adult male prisoners. The prison comprises six residential wings. Dorset Healthcare Unit Foundation Trust provides the prison's healthcare. Healthcare staff are on duty between 7.45am and 5.30pm on weekdays and between 8.15am and 5.15pm at weekends.

HM Inspectorate of Prisons

24. The most recent inspection of HMP Dartmoor was in December 2013. Inspectors found the delivery of health services had improved with a small but well qualified team of healthcare staff delivering a wide range of clinics. Palliative care and end-of-life policies and protocols were available in healthcare.

Independent Monitoring Board

25. 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 September 2016, the IMB reported that the requirements of an ageing prison population increased the interventions needed by healthcare. The IMB remained concerned about the provision of appropriate end of life care.

Previous deaths at HMP Dartmoor

26. Four prisoners have died from natural causes at Dartmoor since January 2015. There were no similarities between the circumstances of Mr Godfrey's death and previous deaths at the prison.

Findings

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

27. Mr Tony Godfrey was convicted of murder on 10 March 1993 and sentenced to life imprisonment. He was released on licence in March 2004 but recalled to prison five months later. He spent time at a number of prisons and he was transferred to HMP Dartmoor on 20 May 2014.

28. Mr Godfrey suffered from numerous medical conditions, including chronic, active hepatitis C, asthma and impaired fasting glycaemia (a type of pre-diabetes). In late 2005, Mr Godfrey began to suffer with abdominal discomfort and, after an ultrasound in February 2006, doctors diagnosed gallbladder polyps (abnormal tissue growth). Doctors recommended surgery to remove his gallbladder but he refused this. A prison GP also diagnosed Mr Godfrey with flatulent dyspepsia and prescribed domperidone to relieve the symptoms.

29. In February 2012, Mr Godfrey reported worsening abdominal pain. Healthcare staff referred Mr Godfrey for blood tests and an abdominal ultrasound, which were normal. There was no evidence that healthcare staff considered further investigative tests.

30. In September 2013, Mr Godfrey again reported abdominal pain and a significant loss of weight. A prison GP suspected that Mr Godfrey had upper gastrointestinal cancer so made an urgent referral under the NHS pathway, which requires patients with suspected cancer to be seen by a specialist within two weeks. A hospital consultant referred Mr Godfrey for a stomach X-ray and diagnosed him with gastroparesis (a chronic condition where the stomach does not empty itself normally).

31. On 29 July 2014, after moving to Dartmoor, a prison GP saw Mr Godfrey, who continued to complain of abdominal pain. He referred Mr Godfrey to a gastroenterologist for consideration for surgery to remove his gallbladder because of the malignancy potential of the polyp. An ultrasound scan was performed at Dartmoor on 31 July. On 9 September, Mr Godfrey's medical record shows he was on the gastroenterologist's waiting list. It is evident that Mr Godfrey remained on the waiting list, because his polyp appeared in later ultrasound scans.

32. On 28 November, Mr Godfrey complained of shortness of breath and a cough. A prison GP diagnosed a possible chest infection and requested a chest X-ray and blood tests, which were normal. She recorded his weight at 66kgs.

33. By 26 May 2015, Mr Godfrey's weight had dropped to 59kgs. A prison GP attributed his weight loss to his hepatitis treatment and prescribed a dietary supplement. After the end of his hepatitis treatment on 8 December, Mr Godfrey still felt tired, but his shortness of breath, appetite and blood tests had all improved. By 22 January 2016, his weight had increased to 64.5kgs.

34. On 18 January, he opted out of an appointment for bowel cancer screening.

35. On 15 March, Mr Godfrey told a prison GP that his abdominal pain had worsened and he was suffering with reflux. The GP made an initial diagnosis of gastro-oesophageal reflux disease (where acid from the stomach leaks into the gullet) and prescribed omeprazole and ranitidine to alleviate the symptoms. After a review two weeks later, an additional diagnosis of irritable bowel syndrome was made.

36. On 7 April, Mr Godfrey's pain had worsened so a prison GP requested an urgent ultrasound scan. After delays at the hospital, the ultrasound took place on 11 May. It showed a large liver mass, which was initially thought to be liver cancer, and he was admitted to hospital as an emergency on 13 May.

37. Hospital investigations confirmed that Mr Godfrey had gastric cancer, which was widespread throughout his body but had not reached his brain. A consultant oncologist told Mr Godfrey on 24 May that his condition was not curable and outlined the palliative treatment appropriate for him. Mr Godfrey also signed a Treatment Escalation Plan and Resuscitation Decision Record (TEP) indicating that he wanted to be resuscitated in the event that his heart or breathing stopped.

38. In line with National Institute for Health and Care Excellence (NICE) guidelines, healthcare professionals should make a fast track cancer referral for all patients with unexplained worsening of dyspepsia (discomfort in the upper abdomen) and a history of chronic inflammation of the stomach lining, changes in the lining of the intestine or of peptic ulcer surgery. In Mr Godfrey's case there was past medical history of all of these conditions, but a fast track referral was not made until 7 April. We agree with the clinical reviewer that Dartmoor's failure to make a referral in March 2016 caused a delay in diagnosing Mr Godfrey's gastric cancer. We make the following recommendation:

    The Head of Healthcare at HMP Dartmoor should ensure that GPs follow relevant National Institute for Health and Clinical Excellence (NICE) guidelines for suspected cancer and refer patients appropriately.

39. We also direct the attention of Heads of Healthcare at both Dartmoor and HMP Exeter to comments and recommendations that are contained in the clinical review, but are not repeated here.

Mr Godfrey's clinical care

40. On 26 May, Mr Godfrey's tumour was found to be larger than previously thought, so hospital staff brought forward chemotherapy treatment to 31 May. Eight further doses between mid-June and early November 2016 were planned.

41. Mr Godfrey remained in hospital until 2 June and although he was mobile and self-caring following his cancer diagnosis, Dartmoor could not give him appropriate care. They arranged for Mr Godfrey to transfer to Exeter, where palliative care was available. Prior to Mr Godfrey's discharge from hospital, comprehensive plans were made to handover care from the local hospital to another hospital and for appropriate treatment to be available for him at the prison. These plans included input from the hospital's palliative care and liver teams. Appointments were made for eight chemotherapy cycles.

42. Three days after arriving at Exeter, a nurse created pain management, medication management and cancer care plans for Mr Godfrey.

43. On 7 June, a prison GP reviewed Mr Godfrey's medication and diet. She reviewed and updated his care plans on 16 June, 25 July and 13 August.

44. A specialist palliative care nurse from Hospiscare (a local adult hospice charity) reviewed Mr Godfrey's care on 20 July and recommended adjustments to his medication, which a prison GP implemented the following day. Thereafter, she reviewed Mr Godfrey regularly until the week before his death.

45. Mr Godfrey attended chemotherapy appointments on 22 June, 13 July and 3 August and was reviewed by a consultant on each occasion. For the appointment on 3 August, a prison GP noted that Mr Godfrey used a walking stick. Mr Godfrey cancelled his appointment for 31 August because he felt unwell and signed a disclaimer to that effect. The prison cancelled the rescheduled appointment for 7 September because they did not receive sufficient notice of the treatment. The appointment was re-booked for 13 September, though Mr Godfrey cancelled it as he felt the chemotherapy was not working. He signed a disclaimer refusing to attend further chemotherapy sessions.

46. Over the last weeks of his life, Mr Godfrey remained mobile while his health continued to deteriorate. Healthcare staff regularly reviewed and monitored him, ensuring he was comfortable and as pain free as was possible.

47. At 10.53am on 5 October, a prison GP noted that Mr Godfrey was approaching the end of his life. She explained this to him and amended his TEP to show that he was not for resuscitation. Following this review, healthcare staff placed Mr Godfrey under 15 minute observations, arranged 24 hour carers to support his care needs and ordered a syringe driver to deliver regular pain relief.

48. Mr Godfrey's condition continued to decline and he died at 10.10am on 11 October with a carer and nursing staff present. A prison GP certified his death at 10.40am.

49. A post-mortem concluded that Mr Godfrey died from metastatic gastric carcinoma (stomach cancer that had spread to other parts of the body).

50. We agree with the clinical reviewer that after his diagnosis, the care that Mr Godfrey received at Exeter was equivalent to that he could have expected in a community setting. We agree that there was evidence of a caring, compassionate and holistic approach to his palliative and end of life care.

Mr Godfrey's location

51. Mr Godfrey was transferred to Exeter as Dartmoor was unable to care properly for him and no bed was available at the palliative care facility at HMP Leyhill, which would have befitted his category D security status (the lowest category of prisoner and those who are reasonably trusted not to try to escape).

52. On arrival at Exeter, Mr Godfrey occupied a room in a wing that caters specifically for men with social care needs. As his condition worsened, he moved into Exeter's palliative care suite on 24 August for better management of

his symptoms. He remained there until he died. Prison healthcare staff sought a hospice placement for Mr Godfrey but he preferred to remain at the prison.

53. We are satisfied that Mr Godfrey's accommodation was appropriate to his needs.

Restraints, security and escorts

54. 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 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.

55. During an offender care meeting on 8 June, a prison GP recommended that Mr Godfrey should not be restrained when escorted outside the prison because he was receiving palliative care. Also, upon arrival at Exeter, he was a category D prisoner for whom restraints should not be necessary.

56. However, six days later, a prison GP raised no objection on the risk assessment in regards to restraints being used on Mr Godfrey for an escort to the hospital on 22 June. No reason is evident for her change of opinion.

57. In the same risk assessment, a custodial manager noted that Mr Godfrey presented a normal level of risk (as opposed to medium or high). He recommended that a minimum of two officers accompany Mr Godfrey though he made no mention on restraints. The Head of Security authorised two officers to accompany Mr Godfrey and restrain him with double handcuffs (double cuffing is 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). There is no indication that these instructions were not carried out.

58. In a risk assessment for a hospital visit on 3 August, a prison GP noted that Mr Godfrey used a walking stick but again raised no concerns about the use of restraints. A custodial manager noted that Mr Godfrey was a category D prisoner, used a walking stick and that his risk levels had not changed. The Head of Security used this information and authorised two officers to accompany Mr Godfrey and restrain him with an escort chain. He recommended the same level of restraint for a hospital visit on 10 August.

59. By choice, Mr Godfrey did not attend hospital appointments after 24 August.

60. Although we note that the level of restraint was reviewed and decreased, we are concerned at what appear to be inconsistent views on the need for restraint expressed by a prison GP. We do not understand why double cuffs were used on a category D prisoner who was seriously ill and had limited mobility. Double cuffs are usually used when moving category A or category B prisoners in good health. When double cuffs are used for lower category prisoners, the Prison

Service requires that reasons should be recorded in writing. There was no evidence to support this decision. We have raised the issue of the unjustified use of restraints, including the use of double handcuffs, with the prison before. We make the following recommendation:

The Governor and Head of Healthcare at HMP Exeter 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.

Liaison with Mr Godfrey's family

61. Mr Godfrey named a friend as his next of kin. Following his terminal diagnosis and discharge from hospital to Exeter on 2 June, the Head of Security sanctioned a supervised telephone call for him to her to discuss the diagnosis. After this, the prison appointed an officer as a family liaison officer and she spoke with Mr Godfrey's next of kin. A prison chaplain also spoke with Mr Godfrey's next of kin and agreed that in the event of his death a telephone call would be made to break the news of his death.

62. On the morning of Mr Godfrey's death, the chaplain telephoned his next of kin to break the news of his death and to offer support. Following this call, the officer kept in contact with Mr Godfrey's next of kin and helped to arrange the funeral.

63. Mr Godfrey's funeral, which the prison arranged and paid for in line with national policy, was held on 14 November.

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 determinate sentenced prisoners are set out in Prison Service Order (PSO) 6000. 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 the National Offender Management Service (NOMS).

65. In anticipation of a terminal diagnosis, on 20 May, the nurse manager at Dartmoor asked Mr Godfrey's hospital doctor to complete part of an application for compassionate release. A hospital doctor completed it on 21 May and sent it to the prison the following day. He did not offer a definitive prognosis, though he told the Deputy Healthcare Manager at Dartmoor that Mr Godfrey was not expected to survive beyond six months.

66. The Governor supported Mr Godfrey's compassionate release and Dartmoor sent the relevant documents to PPCS on 6 June.

67. The same day, PPCS emailed a copy of the application to Exeter asking whether the application was supported at Exeter, for a release plan for Mr Godfrey and the Governor's view on the proposed release. PPCS chased up this information a month later and Mr Godfrey's offender supervisor at Exeter and a probation officer at Dartmoor responded by 8 July.

68. PPCS decided that Mr Godfrey should not be released because he had no suitable address and did not meet the criteria for either an approved premises run by the National Probation Service or, at that stage because he was mobile, a hospice place. By the time Mr Godfrey's condition had declined to an extent that he was suitable for a hospice, Mr Godfrey preferred to end his life at Exeter.

69. While we appreciate that PPCS refused Mr Godfrey's application for compassionate release, we consider that there were long delays at Exeter in progressing the application after the proactive work at Dartmoor. It is apparent that there was confusion between Dartmoor and Exeter as to where responsibility lay for addressing Mr Godfrey's accommodation needs and that these unwarranted delays were detrimental to his emotional state during his last weeks of life. We make the following recommendation:

The Governor at HMP Exeter should ensure that applications for early release on compassionate grounds are progressed without delay.

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