Prisons &
Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen Dawes, a prisoner at HMP Frankland, on 18 June 2020

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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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 Stephen Dawes died on 18 June 2020 of prostate cancer, while a prisoner at HMP Frankland. Mr Dawes was 66 years old. I offer my condolences to Mr Dawes' family and friends.

4. Mr Dawes was first admitted to hospital on 18 January 2016 with urinary retention and referred for further investigations. He was eventually diagnosed with prostate cancer in October that year. Mr Dawes was treated with hormone therapy but this was unsuccessful and his cancer later spread to his pelvis.

5. The clinical reviewer found that the standard of care at HMP Frankland was variable. There were examples of good practice and opportunities for improvement. She found that hospital treatment plans were not always implemented as requested. The clinical reviewer concluded that the clinical care Mr Dawes received at HMP Frankland was not equivalent to that he could have expected to receive in the community. She made four recommendations, which the Head of Healthcare will need to address:

   - The Head of Healthcare should ensure that prisoners receive medication in line with their treatment plan.
   - The Head of Healthcare should ensure abnormal test results are followed up without delay.
   - The Head of Healthcare should develop a protocol with secondary health providers to ensure that prisoners are given test results promptly by the most appropriate person.
   - The Head of Healthcare should ensure that care plans and risk assessments are initiated in a timely manner.

6. We found no non-clinical issues of concern.

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

The Investigation Process

7. NHS England commissioned an independent clinical reviewer, to review Mr Dawes' clinical care at HMP Frankland.

8. The PPO investigator has investigated non-clinical issues, including Mr Dawes' location, the security arrangements for his hospital escorts, and whether compassionate release was considered.

9. 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 HMP Frankland

10. Mr Dawes was the tenth prisoner to die at HMP Frankland since June 2018. All ten deaths were from natural causes, one of which was also due to prostate cancer. There are similarities between our findings in the investigation into Mr Dawes' death and another death that occurred in May of this year. Both investigations found delays in referring the prisoner to hospital for cancer-related care.

Key Events

11. Mr Stephen Dawes was sentenced to life imprisonment for arson on 14 August 1989, and sent to HMP Frankland.

12. Mr Dawes was first admitted to hospital in January 2016, where he was diagnosed with an acute kidney injury. A hospital doctor sent an urgent referral for a urology review, which took place in March. The doctor carrying out the review found a suspicious swollen gland, and further testing indicated likely prostate cancer. Mr Dawes was eventually diagnosed with prostate cancer in October.

13. On 15 November, Mr Dawes discussed treatment options with the hospital and decided to have hormone injections every six months, which he started in January 2017. There were occasions when this injection was delayed beyond the recommended timescales. Mr Dawes was told that he would not be referred back to hospital unless his PSA (prostate-specific antigen) levels rose above 20, which could indicate a worsening of his condition.

14. An X-ray of Mr Dawes' pelvis in April 2019 showed a lesion on his pubic bone. Mr Dawes did not want an MRI scan to investigate this further.

15. On 29 April, Mr Dawes' PSA level was recorded as 21.4. The prison GP did not refer him back to the hospital's urology department for review, as instructed. Mr Dawes complained of blood in his urine on 25 June, but would not provide a sample for testing.

16. On 12 July, a healthcare administrator asked the prison GP about Mr Dawes' raised PSA and the blood in his urine. On 16 July, a prison GP referred Mr

Dawes back to hospital. He went for further hospital tests in September, which were not conclusive.

17. Mr Dawes was taken to hospital for an MRI scan on 1 October. He was restrained by an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). A prison risk assessment found Mr Dawes to be a low risk to the public. Healthcare staff contributed information about his medical condition to inform the assessment of his risk.

18. The MRI scan results showed that Mr Dawes' cancer had spread to his pelvis. There was a significant delay in discussing these results with Mr Dawes. A prison GP emailed the scan results to the Mr Dawes' hospital consultant on 9 October, asking him to explain the diagnosis. The consultant did not respond and the prison GP did not speak to Mr Dawes about his diagnosis until 16 December.

19. On 7 April 2020, Mr Dawes told the prison GP that if his condition deteriorated, he did not want to be resuscitated and signed an order to that effect.

20. On 9 April, prison staff noted that Mr Dawes had become more reliant on support from other prisoners on the wing. Mr Dawes was admitted to the prison's inpatient unit.

21. On 23 April, Mr Dawes told the prison's family liaison officer that there was no one he wanted to be contacted after his death.

22. Mr Dawes was discussed at a prison multidisciplinary meeting on 19 May. He was now bedbound and taking morphine for breakthrough pain. He could still eat and drink, but spent most of the day asleep. A Macmillan nurse met Mr Dawes to discuss early release from prison on compassionate grounds and his end of life wishes. Mr Dawes said he was happy to stay at Frankland receiving end of life care, and did not want to be considered for early release.

23. On 16 June, healthcare staff confirmed that Mr Dawes was in his last days of life. It was difficult for him to swallow tablets, so healthcare staff used a syringe driver to deliver pain relief.

24. A nurse checked Mr Dawes at around 5.54am on 18 June. He appeared comfortable but his breathing was laboured. At 9.00am, a nurse found Mr Dawes unresponsive in his bed and not breathing. Healthcare staff respected his wish not to be resuscitated. Mr Dawes' death was confirmed at 9.25am.

25. The coroner accepted the cause of death provided by a prison doctor and a post-mortem examination was not carried out. The doctor gave Mr Dawes' cause of death as 1a) Metastatic Adenocarcinoma of the Prostate Gland, secondary prostate cancer.

Karen Johnson **February 2020**
Assistant Ombudsman

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