Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Alan Scorfield, a prisoner at HMP Whatton, on 17 November 2020

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 020 7633 4141

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 Alan Scorfield, who was 60 years old, died of cancer on 17 November 2020 at HMP Whatton. We offer our condolences to Mr Scorfield’s family and friends.

4. The clinical reviewer concluded that the clinical care Mr Scorfield received was equivalent to that which he could have expected to receive in the community. The clinical reviewer commented on the good standard of palliative and end of life care at HMP Whatton.

5. We did not find any non-clinical issues of concern.

Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Scorfield’s clinical care at HMP Whatton.

7. The PPO has investigated the non-clinical issues in Mr Scorfield’s care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

8. One of our family liaison officers wrote to Mr Scorfield’s next of kin to explain the investigation. We did not receive a response.

9. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies.

Previous deaths at Whatton

10. Mr Scorfield was the 12th prisoner to die at HMP Whatton since November 2018. All the deaths were from natural causes, including three prisoners who died from cancer.

Key Events

11. On 4 April 2011, Mr Alan Scorfield was given an indeterminate sentence in prison for sexual offences. He was sent to HMP Whatton on 10 May 2018.

12. Mr Scorfield had high blood pressure which was regularly monitored by prison healthcare. Between January 2019 and January 2020, Mr Scorfield spoke to healthcare staff three times about his weight loss. Healthcare staff examined Mr Scorfield but did not find anything of concern and his Body Mass Index (BMI) remained within the normal range.

13. On 28 August, Mr Scorfield visited the prison GP with neck pain. The GP examined his neck and did not find any abnormal growth, so concluded that the pain was muscular and prescribed pain relief.

14. On 25 September, Mr Scorfield went back to the same prison GP, saying he still had pain in the side of his head and he had lost weight. The GP examined him, but still could not find any abnormalities, so ordered some blood tests. The results came back abnormal.

15. Mr Scorfield forgot to go to his follow-up appointment on 14 October, but he told a nurse the next day that he had found a lump on the side of his neck. The nurse made another appointment with the GP.

16. At the GP appointment on 20 October, the GP recorded that Mr Scorfield had lost more weight, had a lump on the side of his neck and his voice had changed. The GP referred him for urgent investigation for possible cancer and explained the seriousness of the situation to Mr Scorfield.

17. On 2 November, Mr Scorfield went to hospital, where it was suspected that he had throat cancer at an advanced stage. (The diagnosis was confirmed on 11 November, although the primary site was never found.)

18. On 4 November, Mr Scorfield was placed on a palliative care plan and was regularly monitored at the prison through multi-disciplinary complex case meetings. Mr Scorfield's condition was not treatable. In line with his wishes, he stayed on a residential wing, supported by carers.

19. On 12 November, Whatton assigned a family liaison officer (FLO) and contacted Mr Scorfield's next of kin to tell them that Mr Scorfield was unwell. The prison facilitated calls between Mr Scorfield and his sister every day before he died.

20. On 17 November, staff found Mr Scorfield in his cell with no signs of life. They did not attempt to resuscitate him as he had signed an order not to be resuscitated.

21. The FLO stayed in contact with Mr Scorfield's sister after his death to arrange his funeral and to collect his belongings.

22. The post-mortem examination confirmed that Mr Scorfield died of cancer, however the primary site of the tumour was not clear.

Karen Johnson **July 2021**
Assistant Ombudsman