Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Daniel Spencer, a prisoner at HMP Gartree, on 23 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 Daniel Spencer, who was 64 years old, died of a chest infection caused by oesophageal cancer on 23 June 2020, while a prisoner at HMP Gartree. We offer our condolences to Mr Spencer's family and friends.

4. Mr Spencer had asthma and diabetes and in February 2020, he was diagnosed with oesophageal cancer. In March, he was told that his condition was terminal and that he would receive palliative care as there was no treatment available. He was offered a place in the prison's healthcare unit but chose to remain on his wing.

5. He needed an operation to help him swallow but refused to have the operation for seven weeks as he was worried about contracting COVID-19 in hospital. The operation was eventually scheduled for 11 June. The day before, Mr Spencer had tested positive for COVID-19 in prison.

6. On 17 June, Mr Spencer was discharged from hospital and returned to Gartree. The following day, he was transferred back to hospital as he was short of breath and felt unwell. He remained in hospital and died there on 23 June.

7. The clinical reviewer was satisfied that Mr Spencer's risk of contracting COVID-19 was appropriately managed in prison.

8. She concluded, however, that the clinical care he received for his cancer was not equivalent to that which he could have expected to receive in the community. The Head of Healthcare will need to consider the recommendations in the clinical review, which we have reflected in the recommendation below.

9. We were concerned that the prison did not initiate family contact when Mr Spencer's condition was thought be terminal and did not appoint a family liaison officer until the day before he died.

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

Recommendations

- The Head of Healthcare should ensure all healthcare staff have the necessary training and supervision to provide timely referral to palliative care services and the skills to deliver palliative care effectively.

- The Governor should ensure that:

    - staff comply with infection control measures, such as use of PPE and handwashing;

- social distancing is maintained wherever physically possible; and
- managers enforce compliance.

- The Governor should ensure that staff notify a prisoner's next of kin as soon as possible when they become seriously ill.

Investigation Process

11. NHS England commissioned an independent clinical reviewer to review Mr Spencer's clinical care at HMP Gartree.

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

13. One of our family liaison officers wrote to Mr Spencer's next of kin, to explain the investigation. She responded with a few questions that are addressed in this report. She will receive a copy of the report.

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

15. Mr Spencer's family received a copy of the draft report. They did not make any comments.

Background Information

HMP Gartree

16. HMP Gartree, which is near Market Harborough in Leicestershire, holds up to 700 men sentenced to life imprisonment and other long sentences. Nottinghamshire Healthcare Foundation Trust provide healthcare services. Nurses are available 24 hours a day.

Previous deaths at Gartree

17. Mr Spencer was the 6th prisoner to die at HMP Gartree since June 2018. Of the previous deaths, two were from natural causes (including one from COVID-19 pneumonia in April 2020) and three were self-inflicted.

COVID-19 (coronavirus)

18. COVID-19 is an infectious disease that affects the lungs and airways. It is mainly spread through droplets when an infected person coughs, or sneezes. The first reported case of COVID-19 in the UK was in February 2020. On 11 March, the World Health Organisation (WHO) declared COVID-19 as a worldwide pandemic.

19. COVID-19 can make anyone seriously ill, but the risk is higher for some people. The clinical reviewer did not consider that Mr Spencer's condition made him particularly vulnerable to COVID-19.

20. To reduce the spread of the virus, the Government introduced voluntary and mandatory actions, such as 'social distancing' and 'lockdown' (on 16 and 23 March, respectively). Public Health England (PHE), HM Prison & Probation

Service (HMPPS) and NHS England worked together to devise measures to contain the outbreak, achieve social distancing, reduce the risk to the most vulnerable in prisons in England and protect the NHS (by reducing the number of people requiring specialist care in community-based hospitals).

Key Events

21. On 6 August 2014, Mr Daniel Spencer was sentenced to life in prison for murder. He was sent to HMP Gartree in August 2018.

22. Mr Spencer had diabetes and asthma and in February 2020, he was diagnosed with oesophageal cancer.

23. After a hospital visit in March, Mr Spencer's consultant said that his cancer had spread and was not curable and that he required palliative care. Mr Spencer said that the consultant had told him that he had eight weeks to live, but the consultant did not record a life expectancy in his letter to the prison GP.

24. As Mr Spencer's condition deteriorated, he was offered a larger cell in the prison's healthcare unit with a hospital bed and social care for support. He told healthcare staff that he preferred to stay on the wing and felt he had the necessary support from his friends.

25. Mr Spencer had increasing difficulty swallowing and needed an operation to insert a stent in his throat. He refused to have the operation for seven weeks because he was worried about contracting COVID-19 in hospital. On 4 June, he was routinely tested for COVID-19. Mr Spencer eventually agreed to have the operation and it went ahead on 11 June. On the same day, the COVID-19 test was returned with a positive result.

26. When he was discharged back to Gartree on 17 June, Mr Spencer agreed to social care support and a hospital bed in the prison's healthcare unit. He was required to self-isolate because he had tested positive for COVID-19 and was cared for in line with HMPPS's COVID-19 guidelines.

27. The following day, staff recorded that Mr Spencer was angry as he struggled to come to terms with his condition. He was also upset that he had to self-isolate.

28. Later that day, Mr Spencer was transferred back to hospital as he was feeling unwell and short of breath. On 22 June, the prison was informed that Mr Spencer's condition had deteriorated and that his prognosis was not good. The prison appointed a family liaison officer to support Mr Spencer and his family.

29. On 23 June, bed watch officers contacted the prison and notified them that Mr Spencer had died at 11.35pm. Mr Spencer's family were present.

30. The coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave the cause of death as pneumonia caused by oesophageal cancer. Mr Spencer also had diabetes, which did not cause, but contributed to his death.

Findings

Clinical Findings

31. The clinical reviewer concluded that the clinical care Mr Spencer received for his cancer was not equivalent to that which he could have expected to receive in the community. She was particularly concerned that Mr Spencer was not referred to palliative care specialists and she concluded that palliative care services would possibly have enhanced Mr Spencer's care and symptom control.

32. The Head of Healthcare will need to consider the recommendations in the clinical review, which we have reflected in the recommendation below:

    The Head of Healthcare should ensure all healthcare staff have the necessary training and supervision to provide timely referral to palliative care services and the skills to deliver palliative care effectively.

Management of Mr Spencer's risk of infection from COVID-19

33. HM Inspectorate of Prisons carried out a scrutiny visit of HMP Gartree in September 2020. They reported that at the beginning of the COVID pandemic in March 2020, the prison had set up a COVID-19 command post to ensure that the relevant procedures were implemented in accordance with national prison guidance. There were procedures on entry to the prison to ensure social distancing and facilitate sanitising hands and keys. Signage and markers throughout the prison emphasised the importance of social distancing, but inspectors found that this was difficult to maintain in some areas of the prison because of physical restrictions, or the arrangements were not enforced. One prisoner had died of a COVID-related illness in April 2020, but there had been few cases in the last six months.

34. Inspectors reported that the prison was well prepared to manage positive cases of COVID-19 but, given the static population and the low rate of cases, there was no dedicated reverse cohort unit (RCU), prisoner isolation unit (PIU) or shielding unit. Instead, new arrivals were located in the induction unit alongside other settled prisoners and were only quarantined if they came from a prison or area with an outbreak. Inspectors reported that they were told the prison had appropriate procedures to manage any prisoners who required isolation without compromising safety or the regime, but that they were not able to test this because there were no prisoners shielding for medical reasons and none with symptoms at the time of their visit.

35. As Mr Spencer had not left Gartree since March, we assume he contracted COVID-19 in the prison.

36. The clinical reviewer said that, although Mr Spencer was suffering from cancer, he was not on active treatment such as chemotherapy which would have made him more vulnerable if he were to become infected with the virus, and he did not therefore fall into the 'extremely clinically vulnerable' group who need to be shielded. She was satisfied that he was appropriately managed on his wing before his admission to hospital in June.

37. We make the following recommendation:

The Governor should ensure that:

- **staff comply with infection control measures, such as use of PPE and handwashing;**
- **social distancing is maintained wherever physically possible; and**
- **managers enforce compliance.**

Compassionate release

38. Although Mr Spencer said that the hospital consultant had told him in March that he had only eight weeks to live, the consultant did not provide a prognosis in his correspondence with the prison GP. We recognise that, as there was no prognosis, the prison could not apply for Mr Spencer's early release on compassionate grounds. However, as prison healthcare staff were aware that Mr Spencer had a terminal diagnosis, we consider that they should have been more proactive in seeking a prognosis so the possibility of compassionate release could have been considered.

Non-clinical Findings

Liaison with Mr Spencer's next of kin

39. Prison Rule 22 says that when a prisoner becomes seriously ill, the Governor should at once inform the prisoner's next of kin. This is reflected in Prison Service Instruction (PSI) 64/2011, which governs safer custody and requires prisons to contact families of prisoners who are seriously ill. We are concerned that the prison did not appoint a family liaison officer until the day before Mr Spencer died, despite his serious and deteriorating condition.

The Governor should ensure that staff notify a prisoner's next of kin as soon as possible when they become seriously ill.

Sue McAllister CB
Prisons and Probation Ombudsman **October 2021**