Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Daniel, a prisoner at HMP Doncaster, on 9 December 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 | 020 7633 4100
F | 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*

© Crown copyright 2022

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 Michael Daniel died in Doncaster Royal Infirmary on 9 December 2020 of lung cancer while a prisoner at HMP Doncaster. Mr Daniel was 68 years old. I offer my condolences to Mr Daniel's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Daniel received at HMP Doncaster was of a good standard and mostly equivalent to that which he could have expected to receive in the community. She made two recommendations about ensuring that staff adhere to the guidance when making a two week wait referral for suspected cancer and ensuring that falls risk assessments are completed promptly.

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

Recommendations

- The Head of Healthcare and Prison GP services should ensure that the NG12-suspected cancer, recognition and referral guidance is adhered to when considering a 2 week wait referral.

- The Head of Healthcare should ensure that healthcare staff complete a falls risk assessment promptly if a prisoner is known to be at risk of falls and ensure that the assessment is recorded on SystmOne and is accessible for all professionals.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Daniel's clinical care at HMP Doncaster.

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

8. The PPO family liaison officer wrote to Mr Daniel's next of kin, his brother, to explain the investigation. He did not respond to our letter.

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

Previous deaths at HMP Doncaster

10. Mr Daniel was the 17th prisoner to die at Doncaster since December 2018. Of the previous deaths, eight were self-inflicted, six from natural causes, one was a drug related death and one is awaiting classification from the Coroner. Since Mr Daniel's death, there have been eight deaths; two self-inflicted deaths, five natural causes deaths and one is awaiting classification from the Coroner.

11. There are no similarities between our findings in the investigation into Mr Daniel's death and our investigation findings for the previous deaths.

Key Events

12. Mr Michael Daniel was serving a 10-year sentence for sexual offences and had been at HMP Doncaster since 26 September 2017. He had a history of back pain and leg ulcers.

13. On 23 January 2018, Mr Daniel told a nurse that he had swollen ankles, tingling and felt breathless. The nurse referred him for a chest X-ray, blood tests, an echocardiogram (ECG) and a review with the prison GP. The test results indicated that there was a lung abnormality which needed further investigation because it could have been an indication of cancer. The prison GP completed a review and made another referral for the X-ray to be repeated (within three weeks when the in-house X-ray facility was available), with another GP review in five weeks. He did not make a two week wait referral (which requires anyone suspected of cancer be referred to clinic specialists under the NHS pathway within two weeks) as he should have done.

14. The X-ray was repeated on 29 March and the prison GP reviewed the results on 11 April. He discussed the results with Mr Daniel on 18 April and made an urgent two week wait referral to specialists.

15. Mr Daniel was diagnosed with adenocarcinoma of the right lung in June and treated with chemotherapy in July and radiotherapy in December. He had hospital check-ups which indicated his cancer remained unchanged.

2020

16. On 4 January, Mr Daniel was told that the cancer was active. He had chemotherapy again in February but in March he was diagnosed with left-sided pneumonia.

17. On 25 March, Mr Daniel was advised to self-isolate and shield for 12 weeks due to the COVID-19 pandemic and being at high risk of contracting the virus. He isolated in his cell.

18. On 6 June, Mr Daniel was admitted to hospital and was treated for excess build-up of fluid on his lungs. He told hospital staff that he did not want anyone to resuscitate him if his heart or breathing stopped and signed a do not attempt cardiopulmonary resuscitation (DNACPR) order to that effect.

19. Prison healthcare staff remained in regular contact with the hospital about Mr Daniel's progress. On 16 June, the hospital informed prison healthcare staff that Mr Daniel's health was deteriorating, and he was being cared for under the end of life pathway.

20. On 25 June, Mr Daniel's health improved, and he was discharged from hospital and returned to Doncaster. Healthcare staff were made aware of the DNACPR order that was in place for Mr Daniel. He continued to be reviewed regularly by healthcare staff.

21. On 31 July, a nurse witnessed Mr Daniel fall in his cell. The nurse assessed him and noted no injuries or cause for concern. The nurse did not complete a falls risk assessment.

22. Over the months that followed, Mr Daniel continued to receive healthcare support and regular reviews.

23. On 7 October, Mr Daniel decided that he no longer wanted to shield. Healthcare staff advised him of all the risks of not doing so and gave him advice about how to protect himself.

24. On 6 November, Mr Daniel had some blood tests, and the results were abnormal. It was also noted that his health had continued to deteriorate. Mr Daniel developed left side weakness. Hospital specialists diagnosed cerebral metastases as the tumours had spread to his brain.

25. Mr Daniel had a COVID-19 test on 27 November and on 3 December. Both test results were negative.

26. Mr Daniel received palliative care from 4 December, and, on 9 December, Mr Daniel died in Doncaster Royal Infirmary.

Post-mortem report

27. The Coroner concluded that Mr Daniel died of disseminated lung carcinoma (lung cancer that had spread from the lung) and infective endocarditis (an infection in the heart).

Lisa Burrell
Assistant Ombudsman **June 2021**

Prisons & Probation

Ombudsman

Independent Investigations

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