Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Robin Cheesewright a prisoner at HMP Elmley on 20 March 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 Robin Cheesewright died on 20 March 2016 of lung cancer while a prisoner at HMP Elmley. He was 81 years old. I offer my condolences to Mr Cheesewright's family and friends.

I am satisfied that Mr Cheesewright received a generally good standard of care at Elmley. He had long standing lung disease, which prison doctors quickly investigated when he deteriorated. A specialist diagnosed lung cancer which could not be actively treated.

However, while healthcare staff provided a good standard of palliative care for Mr Cheesewright, no one discussed his wishes regarding resuscitation as part of his end of life plans. I am also concerned that a prison manager approved the use of restraints when Mr Cheesewright was taken to hospital in February without properly justified risk assessments, which took into account his health and mobility. This is a matter I have raised with Elmley a number of times.

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 **October 2016**

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Summary

Events

1. In January 2015, Mr Robin Cheesewright was sentenced to fourteen years in prison and sent to HMP Elmley.

2. Mr Cheesewright suffered from chronic obstructive pulmonary disease (COPD) and he used an inhaler to ease his symptoms. Mr Cheesewright's health and mobility were poor and he used a wheelchair to get around. Nurses developed and implemented a care plan to manage his COPD and saw Mr Cheesewright frequently over the next eleven months.

3. In December, staff were concerned that Mr Cheesewright was deteriorating and, following abnormal blood results, a prison GP sent him for a chest X-ray. The results revealed an abnormality on his left lung, so the prison GP referred Mr Cheesewright for a CT scan.

4. The scan revealed a large soft tissue mass in Mr Cheesewright's lung and an abdominal aortic aneurysm (a swelling in the large artery leading from the heart to the abdomen). A respiratory specialist diagnosed a carcinoma (a cancerous growth) in the left lung which could not be actively treated and advised palliative care.

5. Prison nurses created care plans to manage Mr Cheesewright's condition and end of life care. Nurses saw him regularly and the community palliative care team provided advice. However, no one discussed Mr Cheesewright's wishes regarding resuscitation with him.

6. On 20 March, a healthcare assistant found Mr Cheesewright unresponsive in his cell and healthcare staff started resuscitation. A prison GP attended shortly afterwards and confirmed that Mr Cheesewright was dead.

Findings

7. The clinical reviewer found that prison GPs quickly investigated the deterioration in Mr Cheesewright's condition and appropriately sent him to hospital for specialist care. We consider that prison healthcare staff managed Mr Cheesewright's care well and the standard of healthcare was equivalent to that he could have expected to receive in the community. However, no one discussed Mr Cheesewright's wishes regarding resuscitation as part of his end of life plans, which meant it is likely that healthcare staff felt obliged to attempt resuscitation however futile.

8. We are concerned that a prison manager authorised officers restrain Mr Cheesewright when he went to hospital on 4 and 9 February, despite his limited mobility and poor state of health. We do not consider that these decisions were based on carefully appropriately justified risk assessments which should have taken account of Mr Cheesewright's poor health and limited mobility, and how they affected his risk or escape.

Recommendations

- The Head of Healthcare should ensure that end of life care plans include discussions about the prisoner's wishes regarding resuscitation, which should be properly recorded and communicated to all staff.
- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, that assessments take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

The Investigation Process

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

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

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

12. We informed HM Coroner for Mid Kent and Medway of the investigation who sent the results of the post-mortem examination. We have given the coroner a copy of this report.

13. One of the Ombudsman's family liaison officers contacted Mr Cheesewright's son to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He had no specific matters for the investigation to consider.

14. The investigation assessed the main issues involved in Mr Cheesewright'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.

15. Mr Cheesewright's son received a copy of the initial report. He did not raise any further issues, or comment on the factual accuracy of the report.

16. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HM Prison Elmley

17. HMP Elmley is a local prison on the Isle of Sheppey, which serves the courts in Kent and holds more than 1,200 men in five wings, with a mixture of single, double and triple cells. Integrated Care 24 Ltd (IC24) provides primary healthcare services at Elmley. The prison's healthcare centre includes a 29-bed inpatient unit.

HM Inspectorate of Prisons

18. The most recent inspection of Elmley was in November 2015. The Inspectorate reported that health care had improved since the last inspection and was reasonably good. Services were effectively governed and partnerships between providers and the prison worked well. There was an identified lead for older prisoners and the health care support offered to these men was consistent and of good quality. Inspectors observed palliative care pathways which were being used appropriately and sensitively

Independent Monitoring Board

19. 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 October 2015 Elmley's IMB reported that the healthcare outpatients department was efficiently run by helpful and cheerful staff. Long-term chronic disease continued to be monitored by well trained staff.

Previous deaths at HMP Elmley

20. Mr Cheesewright was the fourth prisoner to die of natural causes at HMP Elmley since January 2015. We have raised the issue of the insufficiently justified use of restraints before.

Findings

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

21. On 16 January 2015, Mr Robin Cheesewright was sentenced to fourteen years in prison for sexual offences and sent to HMP Elmley. He was 80 years old at the time and in poor health.

22. Mr Cheesewright had smoked cigarettes for most of his life and had chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases such as chronic bronchitis and emphysema). Doctors prescribed inhalers to ease his breathlessness. Mr Cheesewright's health and mobility were poor and he used a wheelchair to get around. Nurses implemented a care plan to manage his COPD and saw Mr Cheesewright frequently over the next eleven months.

23. On 16 December, a prison GP arranged a full set of blood tests after officers expressed concern that about Mr Cheesewright's physical health and wellbeing. He was in a low mood and increasingly reliant on his prisoner carer (a fellow prisoner who helps with daily living tasks).

24. On 24 December, a prison GP reviewed Mr Cheesewright's blood test results. He noted that Mr Cheesewright was anaemic and prescribed iron tablets; he also arranged a chest X-ray.

25. On 5 January, the X-ray results revealed an enlarged left hilum (the root of the lung where the bronchi, arteries, veins and nerves enter and exit the lung) on Mr Cheesewright's left lung. A prison GP referred Mr Cheesewright for a CT scan at hospital.

26. On 4 February 2016, the CT scan revealed a large soft tissue mass in his left lung and an abdominal aortic aneurysm (a swelling in the large artery leading from the heart to the abdomen).

27. On 9 February, a respiratory specialist saw Mr Cheesewright to discuss the results and diagnosed a carcinoma of the left lung, which was not suitable for active treatment. The specialist advised palliative care. The next day a prison nurse saw Mr Cheesewright and he said he knew he had cancer. He declined a GP appointment to discuss this further.

28. We are satisfied that prison GPs quickly investigated the deterioration in Mr Cheesewright's condition and arranged appropriate investigations and referral to a specialist. The clinical reviewer commented that it is often difficult to differentiate between the deterioration expected in COPD and the development of a second smoking related medical condition such as lung cancer, so the investigations and referral were appropriate. Hospital doctors quickly diagnosed lung cancer and advised palliative care.

Mr Cheesewright's clinical care

29. After Mr Cheesewright's diagnosis, the prison held a multi-disciplinary meeting to plan his care. Prison nurses sought advice from the community palliative team and created an end of life care plan to manage his pain relief and his daily living needs. Over the next six weeks nurses saw Mr Cheesewright every day. He was reluctant to take any pain relief medication, but agreed to ask for pain relief if he experienced any discomfort.

30. At 9.36am on 20 March 2016, a healthcare assistant found Mr Cheesewright unresponsive in his cell and radioed for an emergency ambulance; the prison's control room requested one immediately.

31. A prison nurse and the healthcare assistant started cardiopulmonary resuscitation and gave Mr Cheesewright oxygen but he did not respond. A prison GP arrived shortly after and at 9.56am he recorded that Mr Cheesewright had died.

32. The clinical reviewer concluded that Mr Cheesewright's care and treatment prison was equivalent to that he could have expected to receive in the community and his palliative care was good. However, he was concerned the no-one had discussed Mr Cheesewright's wishes regarding resuscitation with him, despite his terminal diagnosis which meant it was likely that healthcare staff felt obliged to attempt resuscitation, however futile. Such discussions should take place and be recorded as part of planning end of life care. We make the following recommendation:

    The Head of Healthcare should ensure that end of life care plans include discussions about the prisoner's wishes regarding resuscitation, which should be properly recorded and communicated to all staff.

Mr Cheesewright's location

33. Throughout his time at Elmley, Mr Cheesewright lived in a single cell on the ground floor of the vulnerable prisoner unit. The prison arranged for a prisoner carer to give him extra support. On 13 February, as Mr Cheesewright's condition deteriorated, nurses advised him to move to the inpatient unit. However, he said he had a good relationship with his carer and wished to remain on the wing. There were good care plans in place ensuring that healthcare staff saw Mr Cheesewright regularly in his cell. We are satisfied that Mr Cheesewright was appropriately located throughout his illness.

Restraints, security and escorts

34. 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.

35. Mr Cheesewright was unable to walk long distances and used a wheelchair. The risk assessments completed before he went to hospital on 4 and 9 February indicated that he was a low risk in respect of all areas, including risk of escape and to the public. The medical section of the form stated there was no objection to the use of restraints, but noted that he was very poorly. (On 30 January, a nurse had written in his medical record that he was motionless, hardly communicating, shaking, dehydrated and confused.) On both days a prison manager authorised officers to use an escort chain (an escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer) because Mr Cheesewright used a wheelchair. Officers removed the escort chain for a short period on 4 February while Mr Cheesewright had a CT scan.

36. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances. Mr Cheesewright had very limited mobility and was further incapacitated by breathlessness from his lung condition. It appears that the decision to restrain him was based on the nature of his offence rather on his actual risk at the time. We do not consider that prison managers appropriately considered how Mr Cheesewright's health and mobility at the time affected his risk, in line with the court judgment. This is a matter we have raised frequently with Elmley in previous cases. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

Liaison with Mr Cheesewright's family

37. On 10 February, the prison appointed a chaplain as the family liaison officer. The chaplain explained his role to Mr Cheesewright and Mr Cheesewright told him he did not want his son, his nominated next of kin, informed about his condition.

38. The records show that staff had several discussions with Mr Cheesewright about contacting his family, but Mr Cheesewright was adamant he did not want his son to know about his condition.

39. After Mr Cheesewright died on 20 March, the chaplain visited Mr Cheesewright's son at home to inform him of his death and offer his condolences and support.

40. Mr Cheesewright's funeral was on 11 April. The prison contributed to the costs in line with national policy.

Compassionate release

41. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.

42. On 10 February, the prison started an application for compassionate release and requested a letter from Mr Cheesewright's hospital consultant to support the application. On 29 February, the prison contacted Mr Cheesewright's consultant again; he said he would provide the letter shortly.

43. On 3 March, the prison contacted the Public Protection Casework Section (PPCS) of the National Offender Management Service (NOMS) who advised the prison to obtain an assessment of Mr Cheesewright's current condition from the community palliative care team. On 11 March, a community palliative care team leader assessed Mr Cheesewright. Sadly, Mr Cheesewright died before the consultant's letter or palliative assessment arrived. We are satisfied that the prison began the process of compassionate release appropriately.

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