

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr John Mitcheson, a prisoner at HMP Doncaster, on 1 October 2021**

**A report by the Prisons and Probation Ombudsman**



## 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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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.

The Ombudsman's 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 John Mitcheson died on 1 October 2021 of sepsis (a life threatening reaction to an infection), urinary tract infection, diabetes mellitus, ischaemic heart disease and cerebrovascular disease (refers to a group of conditions, diseases, and disorders that affect the blood vessels and blood supply to the brain) while a prisoner at HMP Doncaster. He was 68 years old. I offer my condolences to Mr Mitcheson's family and friends.

The clinical reviewer concluded that the healthcare Mr Mitcheson received at Doncaster was of a good standard and was more than equivalent to that which he would have expected to receive in the wider community.

However, she was concerned that documentation in respect of Mr Mitcheson's care choices was not evident in his medical records.

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

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

**May 2022**

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# Summary

## Events

1. On 5 March 2021, Mr John Mitcheson was sentenced to sixteen months in prison charged with possession of indecent images of children. He was sent to HMP Doncaster.
2. Mr Mitcheson had a number of pre-existing medical conditions namely type 2 diabetes, neuropathy in his hands and feet, a diabetic wound to his right heel (an open wound or sore caused by diabetes), atrial fibrillation (an irregular increased heart rate) and he was incontinent of urine. He required a Zimmer frame to help him move around and a wheelchair for longer distances. He was also a heavy smoker, but despite repeated attempts, he refused smoking cessation advice.
3. He was regularly reviewed by healthcare staff and care plans were implemented to manage his care. He was also prescribed medications for his various conditions.
4. On 13 May, a prison nurse reviewed Mr Mitcheson after he reported feeling unwell. Following her review, she was concerned he may have developed sepsis (blood poisoning) so sent him to DRI by taxi for review. Following a review by hospital staff, he was diagnosed with sepsis, possibly caused by a chest infection or the diabetic wound on his foot. He was admitted as an inpatient. However, while in hospital, Mr Mitcheson developed an acute kidney injury. His condition was stabilised, and he was discharged back to the prison on 22 May.
5. On 30 September, Mr Mitcheson was reviewed by a prison nurse. She took his observations and noted he was tachycardic, with a heart rate of 193bpm, his oxygen saturation level was 91% and that his temperature was 36.1 degrees. She used the sepsis risk stratification tool, the results of which indicated his sepsis may have again returned. He was taken to Doncaster Royal Infirmary by emergency ambulance and admitted to hospital as an inpatient.
6. His condition continued to deteriorate, and at 1.50am on the 1 October, Mr Mitcheson died. His death was immediately confirmed by a hospital doctor.

## Findings

7. The clinical reviewer concluded that the care Mr Mitcheson received at Doncaster was of a good standard and was more than equivalent to that which he would have expected to receive in the wider community.
8. However, she was concerned that DNACPR and ReSPECT (a summary of personalised recommendations for a person's clinical care in a future emergency) forms initiated at during his inpatient stay in Doncaster Royal Infirmary were not scanned onto Mr Mitcheson's medical records.

## Recommendations

- The Head of Healthcare should ensure that all DNACPR and ReSPECT forms relating to patients' decisions around cardiopulmonary resuscitation and future care decisions are scanned into the patients' medical records.

## The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Doncaster informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
10. The investigator obtained copies of relevant extracts from Mr Mitcheson's prison and medical records.
11. NHS England commissioned a clinical reviewer to review Mr Mitcheson's clinical care at the prison.
12. We informed HM Coroner for Yorkshire South East of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
13. One of the PPO's family liaison officers wrote to Mr Mitcheson's next of kin, his partner, to explain the investigation. He did not respond.
14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

## Background Information

### HMP/YOI Doncaster

15. HMP Doncaster is a local prison, operated by Serco. It holds up to 1,145 remanded or convicted male prisoners. Care UK provides clinical services. The prison directly employs qualified paramedics as part of the healthcare team, and they respond to emergency calls in the prison.

### HM Inspectorate of Prisons

16. HM Inspectorate of Prisons carried out an unannounced inspection of Doncaster in September 2019. Inspectors were pleased to note that health services overall had improved and that working relationships with other prison departments was good. They were also pleased to note there was a wide range of primary care services available at the prison and that waiting lists were generally short. There was age-appropriate emphasis on well-being, and the management of prisoners with long-term conditions was effective. Social care provision was also noted to be of a good standard.
17. However, inspectors were concerned that not all recommendations made in previous Prisons and Probation Ombudsman investigations, were being regularly reviewed, or that appropriate action was being taken to ensure that the recommendations were being embedded in operational practice.

### Independent Monitoring Board

18. 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 the most recent published report for the year to 30 September 2020, there were concerns that not all of prisoner's health needs were being met in a timely and effective manner. The Board were also concerned that the systems in place to enable prisoners to make appointments with healthcare staff, were not working effectively.
19. The Board also encouraged the Head of Healthcare and Director to review and implement the recommendations made in previous Prisons and Probation Ombudsman's investigations at the prison.

### Previous deaths at HMP/YOI Doncaster

20. Mr Mitcheson was the nineteenth prisoner to die at Doncaster since October 2019. Of the previous deaths, nine were from natural causes, six were self-inflicted and three were drug related. There were no similarities between Mr Mitcheson's death and the previous deaths.

## Key Events

21. On 5 March 2021, Mr John Mitcheson was sentenced to sixteen months in prison charged with possession of indecent images of children. He was sent to HMP Doncaster.
22. A nurse carried out an initial healthscreen. She noted Mr Mitcheson had arrived into prison with a number of pre-existing medical conditions, namely type 2 diabetes, neuropathy in his hands and feet (nerve damage caused by diabetes) a diabetic wound to his right heel (an open wound or sore caused by diabetes), atrial fibrillation (an irregular increased heart rate) and he was incontinent of urine. She also noted he had mobility issues and required the use of a Zimmer frame to help him move around and a wheelchair for longer distances. He was also a heavy smoker, but despite repeated attempts, he refused smoking cessation advice.
23. Following his health screen, care plans were created to manage his various conditions and he was referred to specialist diabetes and cardiac clinics at the prison. He received regular daily reviews by healthcare staff. In addition, healthcare assistants helped Mr Mitcheson with his daily tasks. In particular, his diabetic wound was reviewed and redressed three times weekly.
24. On 8 March, he was reviewed by a nurse. She noted Mr Mitcheson appeared not to be coping well with prison life. Following her review, she referred him to an occupational therapist that worked with the prison. She also considered that he should be moved to the Annex, part of the healthcare unit that provides an enhanced level of social care.
25. On 11 March, Mr Mitcheson was reviewed by an occupational therapist. He considered that Mr Mitcheson required assistance with the simplest of daily tasks and that he would benefit from a shower seat to enable him to wash himself. Later the same day, Mr Mitcheson moved to the Annex.
26. On 17 March, he suffered a fall while attempting to get to the toilet in his cell. Although he suffered no significant injury, his falls risk assessment was reviewed and updated. Mr Mitcheson was advised to use his cell call button to summon help should he require it.
27. On 30 March, he was reviewed by a nurse after becoming unresponsive while in his wheelchair. She took a note of his observations, his oxygen saturation level fluctuated between 89-91% (a normal oxygen saturation level is 95-100%) and his temperature was 35.3 degrees (normal body temperature is 37 degrees). She considered he had suffered a hypoglycaemia attack (a sudden drop in the blood sugar levels) and that he required a review by hospital staff. He was sent to Doncaster Royal Infirmary (DRI) by emergency ambulance.
28. Following a review by hospital staff, he was admitted as an inpatient. While in hospital, Mr Mitcheson suffered a series of further hypoglycaemic attacks. He was discharged back to the prison on 2 April, after his condition had been stabilised and his medications reviewed.
29. Following his return to Doncaster, he continued to receive daily reviews by both healthcare staff and healthcare assistants.

30. On 18 April, Mr Mitcheson accepted smoking cessation advice. However, he insisted that he would use a Vape inhaler (a smoking substitute), against the advice of healthcare staff.
31. On 21 April, during a routine diabetes review, a nurse noted his recent hypoglycaemic attack. She ensured that he understood the importance of monitoring his blood sugar levels and how to spot the signs of the onset of hypoglycaemic attack.
32. On 4 May, Mr Mitcheson was reviewed by a prison GP after reporting a feeling of congestion in his lungs. She prescribed him with a course of antibiotics.
33. The following day, a nurse was on her way to Mr Mitcheson's cell to review him. However, before she arrived at the cell, Mr Mitcheson was the subject of a Code Blue radio call. When she arrived, he was unresponsive in his chair and very short of breath. She took his observations and noted that his oxygen saturation level was 91%. She administered oxygen therapy, but his condition showed little improvement. Paramedics arrived and he was taken to DRI by emergency ambulance.
34. Following a review by hospital staff, Mr Mitcheson was diagnosed as suffering from community acquired pneumonia, and admitted as an inpatient. He was discharged back to the prison on 11 May.
35. On 13 May, a nurse reviewed Mr Mitcheson after he again reported feeling unwell. She noted in his medical records that a healthcare assistant had recorded Mr Mitcheson's heart rate as 55bpm earlier that day, and that she had asked him to recheck his heart rate manually. However, he had failed to do so. Following her review, she was concerned he may have developed sepsis (blood poisoning) so sent him to DRI by taxi for review.
36. Following a review, hospital staff confirmed he had developed sepsis, possibly caused by a chest infection or the diabetic wound on his foot. He was admitted to hospital as an inpatient. However, while in hospital, Mr Mitcheson developed an acute kidney injury. His condition was eventually stabilised, and he was discharged back to the prison on 22 May.
37. However, during a routine review the following day, a nurse noted that his chest was congested, and he was pale. She assessed his condition using the sepsis risk stratification tool (a flow chart to aid healthcare professionals diagnose sepsis), the results of which indicated his sepsis may have returned. He was taken to DRI by emergency ambulance. Hospital staff confirmed his sepsis had returned and he was admitted as an inpatient.
38. While he was in hospital, hospital staff signed a do not attempt cardiopulmonary resuscitation order (DNACPR) on his behalf. He was discharged back to the prison on 18 June.
39. Following his return to the prison, he was located in a dormitory ward in the Annex, enabling healthcare staff twenty-four-hour access to him should it be deemed necessary. He continued to receive daily reviews by both healthcare staff and healthcare assistants, in the weeks that followed.

40. On 28 September, a healthcare assistant carried out a routine urine test. However, it is not clear from the medical records what the result of that test was.
41. On 30 September, Mr Mitcheson was reviewed by a nurse. She took his observations and noted he was tachycardic with a heart rate of 193bpm, his oxygen saturation level was 91% and that his temperature was 36.1 degrees. She used the sepsis risk stratification tool, the results of which indicated his sepsis may have again returned. He was taken to DRI by emergency ambulance and admitted to hospital as an inpatient.
42. His condition continued to deteriorate and at 1.50am on the 1 October, Mr Mitcheson died. His death was immediately confirmed by a hospital doctor.

### **Contact with Mr Mitcheson's family**

43. In the early hours of 1 October, the prison appointed a Family Liaison Officer (FLO). She telephoned Mr Mitcheson's next of kin, his partner, to inform him that Mr Mitcheson had died. He told her that hospital staff had already telephoned him and informed him of his death.
44. The FLO remained in contact Mr Mitcheson's family, offering support and information.
45. Mr Mitcheson's funeral was held on 2 November 2021. The prison contributed to the costs of Mr Mitcheson's funeral in line with national policy.

### **Support for prisoners and staff**

46. The prison posted notices informing other prisoners of Mr Mitcheson's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by his death.

### **Post-mortem report**

47. The post-mortem report gave Mr Mitcheson's cause of death as sepsis (a life threatening reaction to an infection) urinary tract infection, diabetes mellitus, ischaemic heart disease and cerebrovascular disease (refers to a group of conditions, diseases, and disorders that affect the blood vessels and blood supply to the brain).

# Findings

## Clinical care

48. The clinical reviewer concluded that the care Mr Mitcheson received at Doncaster was of a good standard and was more than equivalent to that which he would have expected to receive in the wider community.
49. She noted that following his arrival at HMP/YOI Doncaster, Mr Mitcheson had received a high level of support, care and treatment with his many physical healthcare needs. A social care package had been agreed which included morning, lunch, tea, bedtime assistance and should he require it, help overnight. In addition, an occupational therapy assessment and subsequent package of care, was initiated soon after Mr Mitcheson arrived.
50. Mr Mitcheson's care needs were discussed weekly at Multi-Disciplinary Team meetings and also Complex Care meetings, attended by staff from the various departments of the prison involved in his care.
51. The clinical reviewer was also pleased to note that regular falls risk assessments were carried out to minimise the risk of Mr Mitcheson injuring himself while moving around his cell.
52. However, the clinical reviewer was concerned that both the DNACPR and ReSPECT (a summary of personalised recommendations for a person's clinical care in a future emergency) forms initiated while he was an inpatient at Doncaster Royal Infirmary were not scanned onto Mr Mitcheson's medical records. We therefore recommend:

**The Head of Healthcare should ensure that all DNACPR ReSPECT forms relating to patients' decisions around cardiopulmonary resuscitation and future care decisions are scanned into the patients' medical records.**

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