

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Donald Chivers, a prisoner at HMP Swaleside, on 7 July 2022

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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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 detained individuals 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 Donald Chivers died in a hospice from cancer on 7 July 2022, while a prisoner at HMP Swaleside. He was 77 years old. We offer our condolences to Mr Chivers' family and friends.
4. The clinical reviewer concluded that the clinical care Mr Chivers received at Swaleside was equivalent to that which he could have expected to receive in the community. She said that his end of life care was of a high standard. However, she found that Mr Chivers' weight was not monitored as it should have been when he arrived at Swaleside and that the prison failed to obtain Mr Chivers' dentures, which he had been fitted for in February 2020 at his previous prison.
5. We found that although Swaleside generally had good communications with Mr Chivers and his wife, there was poor communication during his hospital admission in June 2022 and was a reason why he discharged himself against medical advice. Also, Swaleside were unable to find the hospital bedwatch logs for this stay in hospital, which would have potentially given a better understanding of the events of that period.

Recommendations

- The Head of Healthcare should ensure that if a newly arrived prisoner expresses concern about their weight, they are weighed, and their weight is monitored accordingly.
- The Head of Healthcare should ensure that if a prisoner is awaiting new dentures, these are chased up regularly and that a dental care plan is put in place to address their physical and nutritional care needs.
- The Governor should ensure, in line with PSI 64/2011, that the next of kin of seriously ill prisoners are kept informed of the prisoner's condition.
- The Governor should ensure that records are stored safely and provided promptly when requested as part of a PPO investigation.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Chivers' clinical care at HMP Swaleside.
7. The PPO investigator investigated the non-clinical issues relating to Mr Chivers' care, including Mr Chivers' 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 Chivers' next of kin, his wife, to explain the investigation and to ask if she had any matters she wanted us to consider. She had questions about communications with the prison and with Mr Chivers while he was in hospital in June 2022, which are addressed in this report. She also had queries about the healthcare her husband received which are addressed in the clinical reviewer's report. Other questions she raised, such as Mr Chivers' prison location, were outside the remit of this investigation.
9. The initial report was shared with Mr Chivers' wife. She did not make any comments in relation to factual accuracy, but she did wish to emphasise particular issues, and these have been addressed in separate correspondence.
10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found no factual inaccuracies.

Previous deaths at HMP Swaleside

11. Mr Chivers was the fifteenth prisoner to die at Swaleside since July 2020. Of the previous deaths, six were from natural causes, six were self-inflicted, one was drug-related, and in one, the cause was unascertained. There are no similarities between our findings in the investigation into Mr Chivers' death and our investigation findings for the previous deaths.

Key Events

12. On 20 January 2020, Mr Donald Chivers was sentenced to 16 years imprisonment for sexual offences and was sent to HMP Winchester.
13. On 10 February, a prison dentist identified that Mr Chivers' dentures were broken and fitted him for a new set.
14. On 19 August, Mr Chivers was moved to HMP Swaleside. When he arrived, he said that he had difficulty eating some foods as he was still waiting for his new dentures and that he was underweight. He was referred to a GP but did not attend the appointment.
15. In October, Mr Chivers told staff that he was concerned about his weight as he was still waiting for his dentures and could not eat properly without them. A nurse subsequently recorded his weight as 60.2kg. She also asked the prison kitchen to provide Mr Chivers with a soft diet.
16. On 30 January 2022, Mr Chivers said again that he was concerned that he was losing weight because he could not chew food properly, and healthcare staff booked an appointment for him to see a prison GP. Mr Chivers attended the GP appointment on 15 February but refused to be examined.
17. On 11 June, a member of healthcare staff was concerned that Mr Chivers appeared to have lost a lot of weight recently and referred him to a nurse. The nurse weighed Mr Chivers and recorded his weight as 40kg, a loss of 20kg, a third of his body weight, since October 2020.
18. On 14 June, a prison GP met with Mr Chivers and made an urgent referral to hospital. He was admitted to hospital for investigation two days later.
19. Although doctors suspected Mr Chivers had cancer, Mr Chivers discharged himself from hospital while tests were still ongoing and before a formal diagnosis was made. Mr Chivers refused further hospital tests and so a full diagnosis was not made before he died.
20. On 29 June, Mr Chivers agreed to move to the prison's inpatient department, where staff could provide the care he needed.
21. Mr Chivers continued to refuse to return to hospital. Healthcare staff arranged for him to go to a hospice when they were no longer able to care for him in prison.
22. On 5 July, Mr Chivers' condition suddenly deteriorated. The prison's family liaison officer (FLO) contacted his wife and arranged for her to visit Mr Chivers in prison that day, and she arrived late afternoon. The FLO had offered to arrange overnight accommodation, but this was declined by Mr Chivers' wife as she said she had pets that could not be left overnight.
23. Mr Chivers' condition worsened the next day. He was taken to the hospice early on the morning of 7 July and died there later that morning.

Post-mortem report

24. The post-mortem report concluded that Mr Chivers died of distal bowel cancer (cancer in the end section of the colon) with adhesion to the bladder wall and lung metastasis (meaning the cancer had spread to the lungs).

Non-Clinical Findings

Liaison with Mr Chivers' family

25. Prison Service Instruction (PSI) 64/2011, about safer custody, says that prisons must have arrangements in place for an appropriate member of staff to engage with the next of kin of prisoners who are either terminally or seriously ill.
26. Mr Chivers and his wife spoke to each other nearly every day on the telephone, and she was aware that he was going into hospital for investigations on 16 June and expected to be there for three or four days. She told us that when she had not heard from him in a week, she contacted the prison but was unable to get any information about him. She said that because Mr Chivers was unable to call her from the hospital and knew she would be worried, he discharged himself against medical advice (and before a diagnosis of his cancer had been made).
27. Swaleside told the investigator that the policy is that relatives are not contacted until the prisoner has spent 72 hours in hospital except in life threatening cases, and this is in line with normal security considerations. However, there was no record of any contact being made with Mr Chivers' wife at any time while he was in hospital. This contrasts with otherwise good liaison by Swaleside. For example, when Mr Chivers had been unable to speak to his wife in May, Swaleside contacted the local police to check that his wife was alright. After Mr Chivers discharged himself from hospital and it became clear that he was very ill, the FLO at Swaleside had frequent contact with both Mr Chivers and his wife.
28. Swaleside also told the investigator that after 72 hours in hospital a prisoner can apply to make phone calls and that subject to security considerations, they can also ask for a domestic visit. It is not possible to find out if Mr Chivers asked for either of these, or any discussions around his decision to discharge himself from hospital, as Swaleside were unable to find the bedwatch logs (a detailed diary of events maintained by prison officers assigned to a prisoner in hospital) for the hospital stay in June.
29. We recommend:

The Governor should ensure, in line with PSI 64/2011, that the next of kin of seriously ill prisoners are kept informed of the prisoner's condition.

The Governor should ensure that records are stored safely and provided promptly when requested as part of a PPO investigation.

**Louise Richards
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January 2023

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