Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Raymond Mitchell, a prisoner at HMP Exeter, on 19 September 2022

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

OGL

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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 Raymond Mitchell died of lung cancer, which had spread to other parts of his body, in hospital on 19 September 2022, while a prisoner at HMP Exeter. He was 66 years old. We offer our condolences to his family and friends.

4. The clinical reviewer concluded that the clinical care that Mr Mitchell received at Exeter was equivalent to that which he could have expected to receive in the community. She found that Mr Mitchell's care was compassionate and responsive to his deteriorating condition, and that medical assessments and treatment plans created by prison GPs were of a high clinical quality.

5. The clinical reviewer made a number of recommendations which are not directly related to Mr Mitchell's death but which the Head of Healthcare will need to address.

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

The Investigation Process

7. NHS England commissioned an independent clinical reviewer to review Mr Mitchell's clinical care at Exeter.

8. The PPO investigator investigated the non-clinical issues relating to Mr Mitchell's care, including Mr Mitchell's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

9. The Ombudsman's family liaison officer wrote to Mr Mitchell's daughter to explain our investigation. She did not respond.

10. We shared the initial report with the Prison Service. There were no factual inaccuracies.

Previous deaths at HMP Exeter

11. In the two years before Mr Mitchell's death, one prisoner died from natural causes at Exeter, which was as a result of COVID-19. There were also five self-inflicted deaths in the same period. One prisoner has died from a self-inflicted death at Exeter since Mr Mitchell's death. There are no significant similarities between our findings in this investigation and those of the other deaths.

Key Events

12. On 22 July 2022, Mr Raymond Mitchell was remanded in custody to HMP Exeter.

13. At his initial health screen, Mr Mitchell told a nurse that he had possible lung cancer and had a hospital appointment for a CT scan planned for 23 July.

14. Later that day, a prison GP saw Mr Mitchell and noted that it would not be possible for Mr Mitchell to attend the appointment on 23 July, and tasked healthcare administrators with arranging an urgent appointment for him. (It is standard practice to rearrange the pre-booked appointments for newly arrived prisoners, for security reasons.)

15. Healthcare staff requested Mr Mitchell's community medical records. They established that he had had the CT scan before he was sent to prison and did not therefore have any outstanding hospital appointments. Mr Mitchell's community records confirmed that he had been diagnosed with lung cancer and had walked out of the appointment when he was told this.

16. On 4 August, a prison GP received a letter from the Hospital Respiratory Team which said that Mr Mitchell had lung cancer and that it had spread to other parts of his body. The GP placed Mr Mitchell on the multi-professional complex case clinic (MPCCC – a care planning and risk management framework) agenda.

17. On 6 August, a prison GP prescribed Mr Mitchell morphine sulphate (strong pain relief) because he told a nurse that the codeine and paracetamol he received was no longer effective.

18. On 10 August, a nurse received a telephone call from a specialist nurse from the lung clinic who confirmed that radiology results showed that Mr Mitchell had advanced lung cancer and that he would need a biopsy and a CT scan. The specialist nurse said that Mr Mitchell had walked out of his last hospital appointment (which took place when he was in the community). The specialist nurse said that she would write to Mr Mitchell to confirm his diagnosis and to invite him to return to the hospital for further tests.

19. On 13 August, a prison GP prescribed Mr Mitchell pregabalin (for pain relief) and nutritional supplements (as Mr Mitchell had lost weight).

20. On 7 September, a nurse received a telephone call from a specialist nurse from the lung clinic to ask if Mr Mitchell would consider chemotherapy as a palliative treatment option. Mr Mitchell said that he would like to have the chemotherapy.

21. On 10 September, Mr Mitchell's health deteriorated. That evening, a nurse noted that his National Early Warning Score (NEWS, a tool to detect and respond to clinical deterioration) was six, which indicated medium to high clinical risk. She telephoned the NHS urgent healthcare telephone response (because the healthcare services at Exeter were out-of-hours), who agreed that he should go to hospital. Ambulance paramedics transferred Mr Mitchell to hospital. Prison staff did not apply handcuffs.

22. Hospital staff referred Mr Mitchell to a local hospice. He died on 19 September, before the transfer could be arranged.

Post-mortem report

23. There was no post-mortem examination. A hospital doctor concluded that Mr Mitchell died of metastatic non-small cell carcinoma of the lung (an advanced form of lung cancer which had spread from the lungs to other parts of the body).

Inquest

24. The inquest, heard on 3 August 2023, concluded that Mr Mitchell died from natural causes.

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