

**Prisons &
Probation**

Ombudsman
Independent Investigations

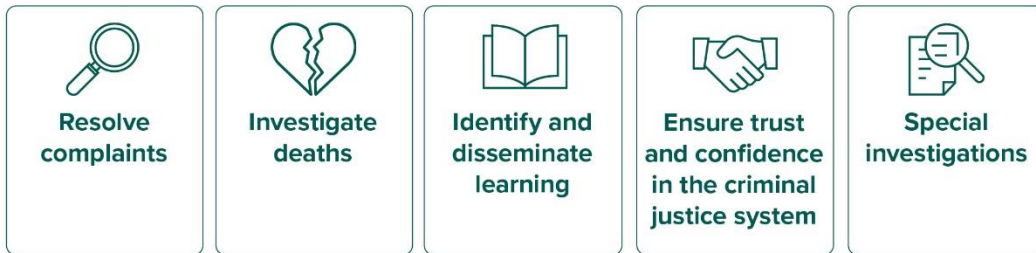
Independent investigation into the death of Mr Simon Crowther, a prisoner at HMP Doncaster, on 17 August 2020

A report by Prisons and Probation Ombudsman

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE



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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 Simon Crowther died on 17 August 2020 of cancer at Doncaster Royal Infirmary while a prisoner at HMP Doncaster. Mr Crowther was 66 years old. I offer my condolences to Mr Crowther's family and friends.
4. The clinical reviewer concluded that the direct care Mr Crowther received at Doncaster was of an acceptable standard and equivalent to that which he could have expected to receive in the community. However, she assessed that there were several aspects of his care which fell below a reasonable standard. She made six recommendations two of which have been merged into one recommendation to make five recommendations in total. She was particularly concerned that there was a significant delay in telling Mr Crowther of his terminal cancer diagnosis. She assessed this was unacceptable.
5. We found two issues of concern and made two recommendations about the significant delay in telling Mr Crowther's family of his terminal diagnosis, and about the Early Release on Compassionate Grounds (ERCG) application process.

Recommendations

- The Head of Healthcare should undertake an investigation to establish why further cancer care hospital follow up did not take place. They should subsequently ensure that there is a robust system in place to ensure that prisoners are followed up within the recommended timeframes, particularly where there is a previous or current diagnosis of cancer.
- The NHS Commissioner for Yorkshire and Humber and the Head of Healthcare should engage with Patient Safety, Quality and Governance colleagues at Doncaster Royal Infirmary and review the need for follow up arrangements and instructions to be robust and specific and devise an action plan detailing how this will be delivered in future.
- The Head of Healthcare should ensure that secondary health screenings include a review of the person's first- and second-stage health assessment records, medical history, and GP and vaccination records in line with NICE guidelines.
- The Head of Healthcare should ensure that there is a clear pathway for patients with anxiety and/or depression, with an associated plan of care detailing interventions and support strategies. Where patients are being discharged from the caseload there should be a clear, documented rationale.

- The Director and Head of Healthcare should consider how the Multi-Disciplinary Team can promote family engagement in situations where the prisoner has withdrawn from family communication, particularly those prisoners who are seriously or terminally ill.
- The Director should ensure that staff notify a prisoner's next of kin as soon as possible when a prisoner becomes seriously ill in line with PSI 64/2011, and in complex cases, a Multi-Disciplinary Team (MDT) meeting or similar should be convened and decision making recorded.
- The Director should ensure that when a prisoner is diagnosed with a terminal illness, the necessary compassionate release paperwork is completed in a timely manner in line with PSO 6000.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Crowther's clinical care at Doncaster.
7. The PPO investigator has investigated non-clinical issues, including Mr Crowther'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 Crowther's next of kin, his wife and daughter, to explain the investigation. They had questions relating to Mr Crowther's health deterioration, their contact with the prison including when Mr Crowther was in hospital in August 2020 and the delay in telling them that Mr Crowther was terminally ill.
9. Mr Crowther's family received a copy of the initial report. The solicitor representing the family wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.
10. The initial report was shared with the Prison Service. The Prison Service pointed out some factual inaccuracies and this report has been amended accordingly.

Previous deaths at HMP Doncaster

11. Mr Crowther was the 17th prisoner to die at Doncaster in the past two years. Of those deaths, six were from natural causes.
12. In a previous investigation at Doncaster, we made a recommendation about the importance of secondary health screenings.

Key Events

13. On 13 December, Mr Simon Crowther was sentenced at Leeds Crown Court to four years imprisonment for sexual offences. He was sent to HMP Doncaster.
14. Prior to his arrival in prison, Mr Crowther was treated for cancer of his oesophagus. He also had an oesophageal tumour removed. Both were assessed as a success and he made a good recovery. A follow up care plan was devised by the consultant and was sent to his community GP.
15. On arrival at Doncaster, Mr Crowther had a reception health screen and secondary health screen. However, they were conducted without the benefit of the detailed information in Mr Crowther's GP community medical records. On 27 December, a prison GP referred Mr Crowther to an upper gastrointestinal surgeon to ensure continuity of care for his esophagectomy.
16. On 12 February 2019, Mr Crowther attended Doncaster Royal Infirmary (DRI) and was reviewed by an upper gastrointestinal surgeon. The doctor concluded that Mr Crowther would be followed up as appropriate and that the prison should get in touch if they needed further information. The available medical information indicates that no further appointments took place. On 27 August, Mr Crowther had a cancer care review with a prison GP.
17. On 4 January 2020, a nurse reviewed Mr Crowther's file and tasked healthcare administrators to chase up any hospital reviews for him. She noted that he had last been seen in February 2019 and that there should have been a further letter about further blood tests. She asked them to establish if there were follow up cancer care appointments. There is no evidence to indicate that this was progressed.
18. On 8 January, Mr Crowther saw a prison GP for a cancer care review. The GP noted that Mr Crowther was generally well and had no cancer symptoms. She reviewed his anxiety and he said that he had not been taking his mirtazapine for about three weeks. He reported struggling to sleep and feeling anxious. They agreed he would restart on mirtazapine.
19. In March, COVID-19 restrictions began to be imposed. As a result, prison regimes and access to services including healthcare and hospital appointments were significantly reduced. On 25 March, given his health conditions, Mr Crowther was issued with a shielding letter. He was put into isolation as he was deemed high risk of suffering severe COVID-19 symptoms.
20. On 2 April, Mr Crowther complained of significant pain and was seen by a nurse. Mr Crowther was referred for a GP appointment and had a telephone consultation with a prison GP, the next day. The GP prescribed amitriptyline (a drug used to treat nerve pain).
21. By 25 April, when Mr Crowther saw a nurse, he had lost a noticeable amount of weight. He told her that he did not feel like eating much and that he felt sick most of the time. She assessed his dietary status, and he was assessed as being low risk. Care plans were set up to monitor his weight and diet.

22. In the morning of 12 May, concerns were raised about Mr Crowther's cognitive behaviour and that he reported he was struggling with isolation. A referral was made to the prison's mental health team. He was assessed by the mental health team the next day and was discharged from the service with no further recorded follow up.
23. On 17 May, Mr Crowther complained of abdominal pain, but when physically examined by a nurse, he did not appear to be in discomfort. That day, he was added to the Multi Professional Complex Case Committee (MPCCC), which enabled multi-agency assessment, review, and monitoring of patient needs. The same day, his daughter rang the prison to report concerns about his mental wellbeing.
24. The next day on 18 May, Mr Crowther was seen by two prison GPs. Given his medical history and urgent referral was made to an upper-gastrointestinal surgeon.
25. On 22 May, Mr Crowther was reviewed by a prison GP. He was concerned that Mr Crowther was generally unwell, and that he needed to go to hospital. Mr Crowther went to hospital under prison escort and had blood tests and an x-ray. The x-ray showed a nodule in his right lung.
26. On 27 May, Mr Crowther's wife called the prison. She was concerned that he had stopped all communication with the family, which was out of character. She was advised by staff that they would pass her concerns on. Staff raised this with Mr Crowther on 30 May. Mr Crowther told staff he did not want to call his family.
27. On 2 June, healthcare staff had a telephone consultation with a gastroenterologist consultant at DRI. Mr Crowther was not well enough to attend. On 3 June, Mr Crowther went to hospital under prison escort for a CT scan of his chest and abdomen.
28. On 5 June, Mr Crowther's wife rang the prison again concerned that she had not heard from him in over a week. That day wing staff helped Mr Crowther to make a call to his wife.
29. On 11 June, Mr Crowther had a telephone consultation with a chest specialist at DRI. The consultant told Mr Crowther that a few spots had been detected on his lungs and there was a shadow on his oesophagus. His case would be reviewed by the hospital's Lung Multi-Disciplinary Team (MDT) the following week.
30. On 1 July, the prison healthcare team received a letter from DRI dated 23 June. It advised that the Lung MDT had confirmed that the lesions in his lung were metastatic. The same day, a nurse saw Mr Crowther and noted he was not in contact with his family and that he was struggling to retain information. She asked for permission to speak to his family on his behalf and he agreed.
31. On 3 July, a prison GP saw Mr Crowther to discuss his diagnosis and a Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) order with him, which meant that if his heart or breathing stopped he would not be resuscitated. She assessed that he was not in a frame of mind to discuss this and planned to see him the following week.

32. From the medical records, Mr Crowther was not seen by a prison GP until he saw a prison GP on 13 July. There is no record of any discussion about Mr Crowther's diagnosis. In the following days, prison healthcare staff contacted DRI to determine whether the prison or hospital should tell Mr Crowther about his diagnosis.
33. On 15 July, a nurse spoke to prison staff about appointing a Family Liaison Officer (FLO) for Mr Crowther. However, she was advised this could only happen once Mr Crowther had been told of his diagnosis. On 17 July, a prison GP saw Mr Crowther again and tried to speak with him about his illness. She recorded that he did not want to speak about his health.
34. On 23 July, Mr Crowther went to hospital and saw a consultant. The consultant told Mr Crowther that his cancer had spread and that his condition was terminal. Mr Crowther agreed that it was appropriate to tell his wife of his diagnosis. Mr Crowther did not want to know his prognosis, which was between two and eight weeks.
35. The same day, the prison appointed a FLO. The FLO rang Mr Crowther's wife to tell her of his diagnosis. On 24 July, a prison GP tried to discuss the DNACPR order with Mr Crowther, but he said that he wanted to speak to his wife first. On 28 July, the prison facilitated a visit for Mr Crowther's family.
36. On 30 July, prison healthcare staff created Mr Crowther's palliative care plan, and an open-door policy and extended family visits were put in place. An application for Early Release on Compassionate Grounds (ERCG) was started by staff on Mr Crowther's behalf.
37. On 1 August, at around 1.35pm, a social care worker assessed Mr Crowther using the National Early Warning Score (NEWS-2 - a tool to measure clinical deterioration and an important tool to improve patient outcomes). His NEWS-2 score was 7. The care worker called the healthcare unit and a nurse attended to see Mr Crowther. She assessed him and his NEWS-2 score was 12. At 2.15pm, Mr Crowther was taken to DRI by emergency ambulance. The FLO notified Mr Crowther's family.
38. On 2 August, Mr Crowther had a CT scan, which showed that he had a brain tumour. A DNACPR order had been put in place the previous day. The FLO contacted Mr Crowther's family, and they visited him on 4 August and on subsequent days.
39. On 5 August, Mr Crowther was seen by the End of Life Care team at DRI. The next day it was agreed that he remain in hospital until the end of his life.
40. On or around 7 August, the application for ERCG was stopped. This appears to have been caused by concerns raised by the Probation Service about the suitability of the proposed release address and the issue of further police charges. An application for Release on Temporary Licence (ROTL) was started.
41. On 11 August, the ROTL application was submitted to the prison's Controller for consideration. The same day the hospital started a syringe driver for pain relief and symptom control. On 13 August, the Controller refused the ROTL application because of ongoing victim issues and the outstanding charges.

42. On 17 August, at 1.15pm Mr Crowther died at Doncaster Royal Infirmary with his family at his bedside.

Post-mortem report

43. The Coroner concluded that Mr Crowther died of disseminated carcinoma of the oesophagus.

Non-Clinical Findings

Liaison with Mr Crowther's family

44. Prison Rule 22 says that prisons should inform the next of kin immediately if a prisoner becomes seriously ill. Prison Service Instruction (PSI) 64/2011, says that if a prisoner suffers an unpredicted or rapid deterioration in their physical health, an appropriate member of prison staff should engage with their next of kin to provide information and support. If a prisoner's health deteriorates a family liaison officer should be appointed immediately and next of kin should be contacted. The PSI does not prohibit liaison with the family where a diagnosis has not been relayed to the prisoner.
45. Prison healthcare staff became aware of Mr Crowther's terminal medical diagnosis on or around 1 July 2020. When his terminal diagnosis was confirmed, a prison GP assessed that he was not in the right mind to hear the news. However, despite the diagnosis, there is limited evidence that the prison healthcare team proactively sought to assess and review his mental state or to support and engage Mr Crowther with this news. The delay was in part driven by disagreements between the prison and Doncaster Royal Infirmary as to who should deliver the news. Liaison between the prison and hospital took two and a half weeks to resolve. He was not told of his diagnosis until 23 July. The clinical reviewer considered that the delay in Mr Crowther receiving his diagnosis was unacceptable.
46. As Mr Crowther had not been told his diagnosis, the prison assessed that they could not start processes such as the appointment of a FLO. This meant Mr Crowther's family were not told of his terminal diagnosis until 23 July.
47. PSI 64/2011 Chapter 11 - Management of prisoners who are terminally or seriously ill - says that: "Prisons must ensure that arrangements are in place for an appropriate member of staff to engage with the next of kin or a nominated person of prisoners who are either terminally or seriously ill" and "Prisoners who have a terminal illness must be encouraged to engage with their families or a nominated person".
48. It further says; "...where the prisoner is unable to communicate their wishes, the prison must contact the next of kin or a nominated person who must be given an accurate account of what has happened, including treatment given, whether the prisoner is in hospital, and information about visiting the prisoner".
49. Given the policy and the concerns with Mr Crowther's wellbeing, we consider that the prison could have contacted Mr Crowther's family at an earlier stage separate to Mr Crowther being informed of his diagnosis. We recommend:

The Director should ensure that staff notify a prisoner's next of kin as soon as possible when a prisoner becomes seriously ill in line with PSI 64/2011, and in complex cases, a Multi-Disciplinary Team (MDT) meeting or similar should be convened and decision making recorded.

Compassionate release

50. Release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months, can be permanently released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. The criteria for early release for determinate sentenced prisoners are set out in Prison Service Order (PSO) 6000. Among the criteria is that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of HMPPS.
51. Mr Crowther's application for release on compassionate grounds was started after he had been told of his diagnosis but nearly a month after his diagnosis was known by staff at Doncaster. Given that eligibility for compassionate release is generally confined to those with a life expectancy of less than three months, this delay was significant.
52. Mr Crowther's diagnosis confirmed that he was medically eligible for consideration. It appears the application was stopped on or around 7 August because of concerns raised by Probation Service colleagues that the proposed address Mr Crowther was to be released to was not suitable and that he was facing further charges.
53. However, on 6 August 2020 it had been agreed that Mr Crowther would remain in hospital until his death. In addition, from the paperwork received it appears West Yorkshire Constabulary (who were the investigating police force) had been informed of Mr Crowther's terminal diagnosis on or around 3 August and informed the Crown Prosecution Service (CPS) to inform the CPS decision. The CPS had not yet made a decision whether to charge Mr Crowther.
54. When the release on compassionate grounds application was stopped, West Yorkshire Police had not had a charging decision back from the CPS. In their correspondence to the prison, they indicated they expected a decision in a week or so.
55. We consider that the compassionate release application should have been completed and submitted to PPCS for consideration in line with PSO 6000. We also consider that the application should have begun in early July rather than late July. We make the following recommendation.

The Director should ensure that when a prisoner is diagnosed with a terminal illness, the necessary compassionate release paperwork is completed in a timely manner in line with PSO 6000.

Lisa Burrell
Assistant Ombudsman

August 2021

Inquest

The inquest, held on 20 June 2023, concluded that Mr Crowther died from natural causes.

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