

**Prisons &
Probation**

Ombudsman
Independent Investigations

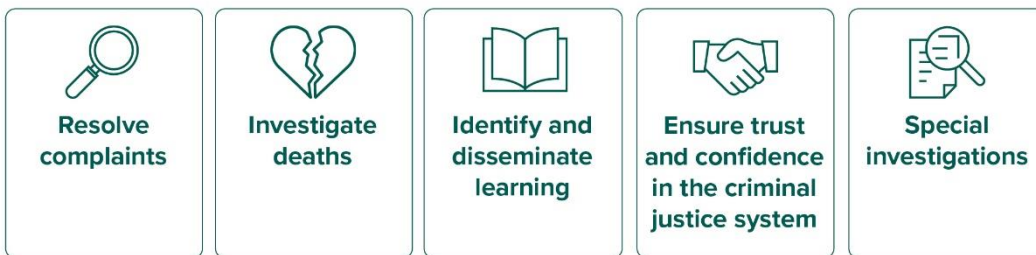
Independent investigation into the death of Mr George Shaw, a prisoner at HMP Doncaster, on 24 November 2022

A report by the 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. Mr George Shaw, who was 89 years old, died of pneumonia on 24 November 2022, at HMP/YOI Doncaster. We offer our condolences to Mr Shaw's family and friends.
3. The clinical reviewer concluded that the care Mr Shaw received at Doncaster was of a good standard and therefore equivalent to that which he could have expected to receive in the community. She has made recommendations about completing secondary health screens in accordance with National Institute for Health and Care Excellence (NICE) guidance and recording prisoners' preferred place of death. We repeat her recommendations below.
4. We did not find any non-clinical issues of concern.

Recommendations

- The Head of Healthcare should ensure that the first-stage health screening assessment is completed within the required timescales as per NICE guidance NG57.
- The Head of Healthcare should ensure that there is a process in place for discussing and recording a prisoner's preferred place of death, which is implemented and audited regularly.

The Investigation Process

5. NHS England commissioned an independent clinical reviewer to review Mr Shaw's clinical care at Doncaster.
6. The PPO investigator investigated the non-clinical issues relating to Mr Shaw's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
7. The PPO family liaison officer wrote to Mr Shaw's partner to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.
8. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP Doncaster

9. Mr Shaw was the nineteenth prisoner to die at Doncaster since November 2019. Of the previous deaths, thirteen were from natural causes, four were self-inflicted and one was drug related. There are no similarities between Mr Shaw's death and the previous deaths at the prison.

Key Events

10. On 25 May 2021, Mr George Shaw was charged with historic sexual offences. He was 88 years old. On 2 July, he was sentenced to four years and two months imprisonment, with an extended licence period of two years to serve upon his release. He was sent to HMP/YOI Doncaster.
11. Mr Shaw had several pre-existing medical conditions, including ischaemic heart disease (blood flow to the heart is reduced due to a blockage of the arteries), erratic heart rate, stage 3 chronic kidney disease, raised blood pressure and cervical spondylosis (age-related wear and tear affecting the spinal disks in the neck).
12. A nurse completed an initial health screen and noted Mr Shaw's medical conditions. Mr Shaw told her that prior to being sent to prison, his community GP had made an urgent hospital referral for suspected pancreatic cancer. She repeated the referral to ensure continuity of his care. She created care plans to manage Mr Shaw's care, referred him to the prison's long-term and older prisoner clinics. He lived in the prison's social care unit, so he could benefit from an increased level of care and support. Healthcare staff discussed Mr Shaw's care needs at weekly complex care meetings.
13. On 12 July, a prison GP saw Mr Shaw. Mr Shaw underwent blood and urine tests and the results showed that he had kidney failure. The GP also considered Mr Shaw was at risk of developing a blockage in his kidney, so referred him to hospital for further review.
14. On 15 July, Mr Shaw went to hospital and was admitted as an inpatient for further tests. The results showed a mass in his abdomen and hospital staff diagnosed him with prostate cancer. Mr Shaw was suitable for palliative treatment only. In an attempt to lessen his symptoms, he had regular injections of degarelix (used to treat advanced prostate cancer) and had a catheter inserted. Hospital staff completed a Recommended Summary Plan for Emergency Care and Treatment form on his behalf (The ReSPECT form creates a summary of personalised recommendations for a person's clinical care in a future emergency where they do not have capacity to make or express choices.) On 20 July, Mr Shaw was discharged from hospital and returned to Doncaster.
15. That day, the prison appointed a Family Liaison Officer (FLO). She contacted Mr Shaw's next of kin, his wife, to inform her of his diagnosis. She remained in contact with Mr Shaw's family and updated them about his condition and offered continued support.
16. Over the weeks that followed, Mr Shaw was subject to a number of hospital admissions due to developing urosepsis (an infection of the urinary tract to the kidney which causes sepsis) and kidney failure.
17. On 17 October, healthcare staff completed Mr Shaw's second stage health screen. Healthcare staff should have completed this within seven days of the reception health screen, (which took place on 2 July), in line with NICE guidance, but they failed to do so.

18. On 13 December, a nurse saw Mr Shaw. She asked him if he wanted to be resuscitated in the event he had a heart attack or his breathing stopped. He told her that he did want to be resuscitated. She withdrew the ReSPECT form the hospital had completed to reflect Mr Shaw's wishes.

2022

19. On 16 March 2022, a nurse saw Mr Shaw after he fell in his cell and struck his head while trying to empty his catheter bag. She sent him to hospital by emergency ambulance. Hospital staff diagnosed him with a urine infection. They admitted him as an inpatient, and he was discharged back to Doncaster the following day.
20. Mr Shaw was admitted to hospital again on 19 March, after his condition deteriorated. Hospital staff diagnosed him with urosepsis, kidney failure, pneumonia, and right side hydronephrosis (the kidney becomes swollen due to a build-up of urine) and admitted him to the hospital as an inpatient. Hospital staff considered that due to his numerous conditions and frailty, he was not suitable for ventilation or resuscitation and signed a ReSPECT form on his behalf. Mr Shaw was discharged from hospital and returned to Doncaster on 24 March. Healthcare staff reviewed and updated his care plans.
21. On 15 June, a prison GP saw Mr Shaw after healthcare staff noted that he was becoming increasingly confused and disorientated. The GP referred him to the memory clinic at the hospital for further review.
22. On 4 October, Mr Shaw was reviewed in the memory clinic at the hospital. He was diagnosed with mixed dementia (dementia and Alzheimer's disease). Following his diagnosis, prison healthcare staff implemented a 24 hour open-door policy in case he needed urgent assistance.
23. On 12 October, a nurse saw Mr Shaw. She noted that he appeared very confused and was experiencing difficulty with his hand, eye coordination. She sent him to hospital by emergency ambulance. Hospital staff diagnosed him with an exacerbation of his kidney failure. They planned to carry out a nephrostomy (tube inserted through the skin into the kidney to allow urine to drain from the kidney into a collecting bag outside the body) but due to his frailty, they decided against the procedure. Mr Shaw was discharged back to Doncaster on 16 October.
24. Mr Shaw's family informed the FLO that they wanted Mr Shaw to remain in prison to receive end of life care until his eventual death. However, there is no evidence in his medical records to indicate that healthcare staff asked Mr Shaw if prison was his preferred place to be.
25. On 19 October, a nurse recorded that due to his prognosis and frailty, she completed a DNACR (Do Not Attempt Cardiopulmonary Resuscitation) order on Mr Shaw's behalf.
26. Mr Shaw's condition continued to deteriorate, and at 3.08pm on 24 November, Mr Shaw died in prison.

Post-mortem report

27. The post-mortem report gave Mr Shaw's cause of death as pneumonia. He also had metastatic prostate cancer and a stroke which were contributory factors.

Lisa Burrell
Assistant Ombudsman

May 2023

Inquest

The inquest, held on 17 July 2023, concluded that Mr Shaw died from natural causes.

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