Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Robert Blanchard, a prisoner at HMP Parc, on 4 June 2022

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

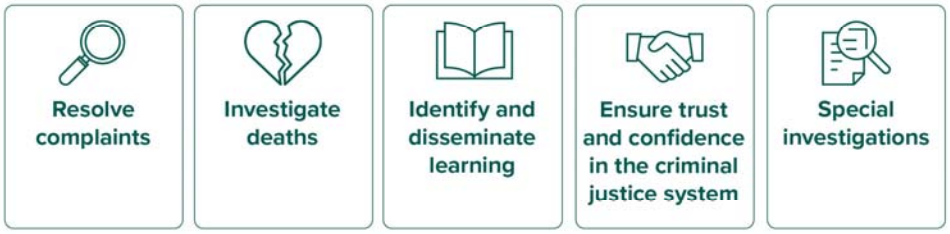
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100

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

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100

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 Robert Blanchard died of kidney cancer which had spread to his liver and pancreas on 4 June 2022 at HMP Parc. He was 69 years old. We offer our condolences to his family and friends.

4. When he arrived at Parc, Mr Blanchard told healthcare staff that he had kidney cancer and was awaiting an operation to remove a kidney. His community medical records were not obtained, and no one followed up any outstanding hospital appointments. Several months therefore passed before anyone contacted the hospital treating Mr Blanchard's cancer, leading to a delay before his operation.

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

Recommendations

- The Head of Healthcare should ensure that staff obtain community medical records for newly arrived prisoners, especially those with long-term or potentially terminal conditions, and manage all outstanding hospital appointments in line with national guidelines.

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100

The Investigation Process

6. Healthcare Inspectorate Wales (HIW) commissioned an independent clinical reviewer, to review Mr Blanchard's clinical care at Parc. The clinical reviewer's report is attached as Annex 1.

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

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

9. We shared the initial report with the Prison Service. There were no factual inaccuracies. Their action plan has been appended to the report.

Previous deaths at HMP Parc

10. In the two years before Mr Blanchard's death, nine prisoners died from natural causes at Parc, three of which were as a result of COVID-19. There were also three drug related deaths in the same period. One prisoner has died from a self-inflicted death at Parc since Mr Blanchard's death. There are no significant similarities between our findings in this investigation and those of the other deaths.

Key Events

11. On 18 August 2020, Mr Robert Blanchard was remanded to HMP Parc. At his initial health screen, a Healthcare Assistant (HCA) noted that Mr Blanchard had been diagnosed with cancer of the left kidney.

12. The following day, at his secondary health screen, a HCA noted that Mr Blanchard was waiting for an operation to remove the cancerous kidney. On the same day, a healthcare administrator recorded that she has telephoned the GP surgery recorded in Mr Blanchard's medical record, but they said that he was not registered with them. There is no record that anyone spoke to Mr Blanchard about this or sought details of the hospital that had been treating his cancer.

13. On 29 September, Mr Blanchard was convicted of sex offences. He was not sentenced and was remanded in custody to be tried for further offences.

14. On 28 January 2021, a prison GP saw Mr Blanchard. The prison GP noted that Mr Blanchard had had an appointment to have his left kidney removed in September 2020, which he did not attend. (There is no other record of this appointment anywhere in Mr Blanchard's prison records.) He noted that he would check with healthcare administration that Mr Blanchard was going to be called back by the hospital for the operation or if they needed to make alternative arrangements.

15. On 11 February, a healthcare administrator received a telephone call from the hospital urology department who told her that Mr Blanchard had an appointment to see a consultant in hospital on 3 March.

16. On 3 March, Mr Blanchard went to a urology appointment where arrangements were made for him to have his kidney removed.

17. On 12 April, Mr Blanchard went to hospital for a CT scan. On 16 April, a prison GP noted the result of the scan which showed that he had a mass on his left kidney consistent with cancer.

18. On 17 May, Mr Blanchard went to hospital where he had his left kidney removed.

19. On 8 June, a urology consultant, sent a letter to Parc which confirmed that Mr Blanchard had kidney cancer but now had a good prognosis.

20. On 5 August, the urology consultant told Mr Blanchard that his cancer had gone. He said that Mr Blanchard would need to have a CT scan annually for the next five years.

21. On 2 December, Mr Blanchard told a nurse that he had kidney pain. The nurse advised Mr Blanchard to book an appointment with a prison GP. On 29 December, a prison GP saw Mr Blanchard and referred him urgently to urology.

22. On 20 January 2022, a urology consultant, saw Mr Blanchard and told him that the kidney pain was unlikely to have a sinister cause, but that he would bring forward his annual CT scan. Mr Blanchard consequently had the scan on 27 January.

23. On 2 March, Mr Blanchard saw a urology consultant, who told him that he had cancer of the pancreas and liver, which would require chemotherapy. On 8 March, A prison GP noted that the urology consultant, asked a palliative care consultant, to support Mr Blanchard.

24. On 19 May, a prison GP saw Mr Blanchard and noted that his health was deteriorating and that he needed more support and assistance. The prison GP asked the specialist palliative care team for their input and, on 26 May, the palliative care consultant reviewed Mr Blanchard.

25. On 1 June 2022, after Mr Blanchard's health deteriorated, healthcare staff started end-of-life care and he had one-to-one nursing care throughout the night.

26. On 4 June, Mr Blanchard died at Parc.

Post-mortem report

27. There was no post-mortem examination. A prison GP recorded the cause of death as primary renal carcinoma with metastasis to the liver and pancreas (kidney cancer which had spread to the liver and pancreas).

Inquest

28. At an inquest held on 19 September 2023, the Coroner concluded that Mr Blanchard died from natural causes.

Findings

Clinical Care

29. Prison Service Order (PSO) 3050, regarding continuity of healthcare for prisoners, instructs that when a prisoner enters reception, efforts should be made to retrieve any information required from their GP or other relevant health service that they have recently been in contact with. National Institute for Health and Care Excellence (NICE) guidelines require healthcare staff to obtain details of any outstanding medical appointments for newly arrived prisoners and that healthcare administrative staff subsequently manage these appointments.

30. The clinical reviewer found that there was a delay in referring Mr Blanchard to the urology department for his kidney cancer operation. When he arrived in prison, Mr Blanchard told healthcare staff that he was waiting for an operation to have his cancerous kidney removed. On 28 January 2021, a prison GP recorded that Mr Blanchard had had an appointment for this procedure in September 2020, which he did not attend. The operation did not subsequently happen until 17 May 2021.

31. While healthcare staff attempted to telephone a GP surgery that Mr Blanchard's records suggested he was registered with, there is no evidence that this was followed up when the surgery said they did not have a record for him. No one spoke to Mr Blanchard to clarify the surgery he used or the hospital managing his kidney cancer. This is particularly worrying given that Mr Blanchard had told staff that he had a serious diagnosis and, while the records are not clear, it is potentially the case that he missed an operation to remove the kidney as a result. The clinical reviewer found that the delay to Mr Blanchard's operation may have contributed to the spread of his cancer, which he concluded might have led to a different outcome for Mr Blanchard.

32. The cause of death given by the prison GP was kidney cancer which had spread to the liver and pancreas. However, the clinical reviewer offered a different cause of death. His view was that Mr Blanchard's kidney cancer had been treated and that he had a new cancer of the pancreas, which spread to the liver and which was the cause of death. The clinical reviewer concluded that if his cause of death was accepted then this might have led to a different outcome for Mr Blanchard.

33. We make the following recommendation:

    The Head of Healthcare should ensure that staff obtain community medical records for newly arrived prisoners, especially those with long-term or potentially terminal conditions, and manage all outstanding hospital appointments in line with national guidelines.

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

Mark Judd
Assistant Prisons and Probation Ombudsman
December 2022

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100