

**Prisons &
Probation**

Ombudsman
Independent Investigations

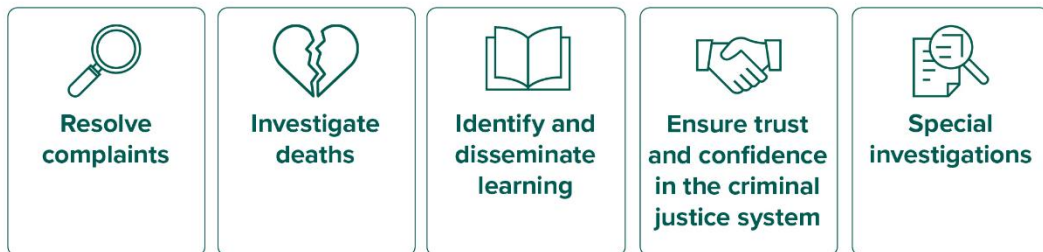
Independent investigation into the death of Mr Douglas Rusling, a prisoner at HMP Doncaster, on 23 December 2022

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. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.
3. Mr Douglas Rusling died of prostate cancer on 23 December 2022 at HMP Doncaster. He was 76 years old. We offer our condolences to Mr Rusling's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Rusling received at Doncaster was of a good standard and was equivalent to that which he could have expected to receive in the community.
5. We found no non-clinical issues of concern. We make no recommendations.

The Investigation Process

6. HMPPS notified us of Mr Rusling's death on 23 December 2023.
7. NHS England commissioned an independent clinical reviewer to review Mr Rusling's clinical care at Doncaster.
8. The PPO investigator investigated the non-clinical issues relating to Mr Rusling's care.
9. The PPO family liaison office wrote to Mr Rusling's wife to explain the investigation and to ask if she had any matters she wanted us to consider. She had no questions but asked for a copy of our report.
10. Mr Rusling's wife received a copy of the draft report. She did not make any comments.
11. The initial report was shared with HMPPS. There were no factual inaccuracies.

Previous deaths at HMP Doncaster

12. Mr Rusling was the twenty-fifth prisoner to die at Doncaster since December 2019. Of the previous deaths, 14 were from natural causes, six were self-inflicted and four were drug related.

Key Events

13. On 1 July 2021, Mr Douglas Rusling was sentenced to 16 years imprisonment for sexual offences and was sent to HMP Doncaster.
14. Mr Rusling had already been diagnosed with prostate cancer and was having hormone therapy treatment (which slows down the growth of cancer cells).
15. On 23 July, Mr Rusling saw his oncologist (cancer doctor) who told him that his cancer had spread to his adrenal glands. The oncologist stopped Mr Rusling's hormone therapy and spoke to him about chemotherapy options.
16. On 5 October, Mr Rusling started chemotherapy and continued treatment until 5 May 2022. His oncologist saw him regularly and his condition remained stable.
17. On 20 September, Mr Rusling had a blood test which showed he had a raised prostate-specific antigen (PSA) level (which can be a sign of prostate cancer). On 2 October, the GP at Doncaster asked for repeat blood tests, which also showed a raised PSA level. The GP made an appointment for Mr Rusling with the oncologist and referred him for a CT scan.
18. On 1 November, a GP at Doncaster saw Mr Rusling as he had weight loss and constipation. He referred him to the hospital colorectal team (specialist doctors for the colon, rectum, pelvic floor, and anus) using the two-week suspected cancer pathway.
19. On 22 November, the oncologist told Mr Rusling that he suspected his cancer had spread to his spine and was rapidly progressing. Mr Rusling was prescribed pain relief and was due to start chemotherapy in a month's time.
20. On 29 November, Mr Rusling's health deteriorated. He fell and was unable to stand. A nurse saw him and took his clinical observations, which were normal. The nurse helped him into a wheelchair.
21. At approximately 5.35pm, the nurse asked for an ambulance to transfer Mr Rusling to hospital but was told by prison staff that there were not enough staff to escort him. She escalated this to the governor in charge, who said he would arrange the transfer as soon as he could.
22. At 7.16pm, Mr Rusling was found on the floor by nursing staff unable to lift or support his legs. The nursing staff called for an ambulance.
23. At 12.31am on 30 November, Mr Rusling's condition deteriorated while he was waiting for the ambulance to arrive to take him to hospital. He told staff that he was unable to pass urine. A nurse spoke to the ambulance service to get an updated time of arrival and to inform them of his new symptoms. The call handler was unable to give an expected arrival time due to local pressures on the ambulance service.
24. At 1.05am, the ambulance arrived and took Mr Rusling to hospital at 1.35am. While at hospital he had a catheter inserted and was discharged to Doncaster later that day.

25. On 1 December, Mr Rusling was seen by a GP at Doncaster who found he had symptoms of spinal cord compression (pressure on the spinal cord that can cause paralysis). He was taken to hospital by ambulance and was subsequently admitted.
26. While in hospital Mr Rusling's condition deteriorated. He was treated for spinal cord compression and doctors tried to manage his pain.
27. On 7 December, the hospital doctors had a multi-disciplinary team (MDT) meeting and agreed that Mr Rusling's his cancer was terminal, and he was approaching the end of his life. They stopped all active treatment and started him on palliative care. A nurse at Doncaster spoke to a palliative care nurse at the hospital, who said that Mr Rusling would be discharged once his pain was under control.
28. On 15 December, the hospital doctors put a Do Not Attempt Resuscitation (DNAR) order in place for Mr Rusling. He was discharged from hospital to Doncaster for end-of-life care.
29. On 22 December, the prison started an application for Mr Rusling's early release on compassionate grounds. This was not completed before he died.
30. On 23 December, Mr Rusling's health continued to deteriorate. He died at 10.06pm, with the nursing team present. A member of the nursing team verified his death.

Post-mortem report

31. The post-mortem report concluded that Mr Rusling died of an acute cranial haemorrhage (bleed in the brain) caused by metastatic prostate cancer.

Good Practice

32. We consider it good practice that a member of the nursing team at Doncaster verified Mr Rusling's death. It meant that it was done quickly and without having to call out the ambulance service or a GP.

Inquest

33. The inquest, held on 23 October 2023, concluded that Mr Rusling died from natural causes.

Adrian Usher
Prisons and Probation Ombudsman

December 2023

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