Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Harvey, a prisoner at HMP Wymott, on 20 June 2023

A report by the Prisons and Probation Ombudsman

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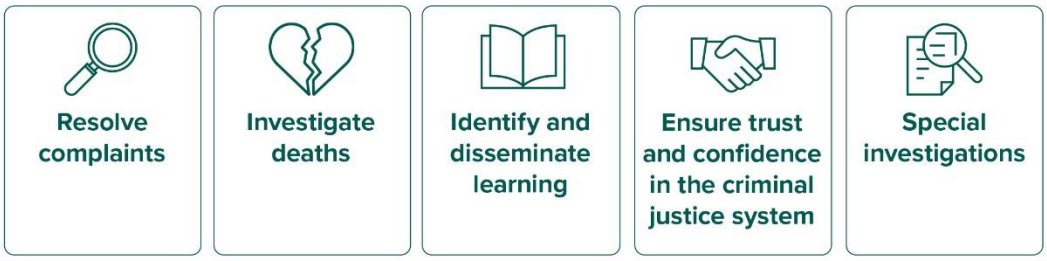
OUR VISION

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. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

4. Mr Peter Harvey died in a hospice on 20 June 2023 from oesophageal cancer which had spread to other parts of the body, while a prisoner at HMP Wymott. He was 65 years old. We offer our condolences to his family and friends.

5. The clinical reviewer concluded that the clinical care Mr Harvey received at Wymott was equivalent to that which he could have expected to receive in the community. The clinical reviewer made no recommendations.

6. We found that Mr Harvey was inappropriately restrained on 26 May 2023 because healthcare staff had not completed the medical section of the escort risk assessment and the authorising manager was not able to access security intelligence and was not aware of the Graham judgement (a court judgement on the use of restraints).

Recommendations

- The Head of Healthcare should ensure that staff complete the medical risk assessment form in full, providing the authorising manager with sufficient information to make informed decisions.

- The Governor should ensure that all staff involved in the escort decision-making process:

    - have received the required training, including on the legal framework relating to hospital escorts; and

    - have access to and know how to use relevant information systems before they need to access the information to make decisions.

The Investigation Process

7. HMPPS notified us of Mr Harvey's death on 20 June 2023.

8. NHS England commissioned an independent clinical reviewer to review Mr Harvey's clinical care at Wymott.

9. The PPO investigator investigated the non-clinical issues relating to Mr Harvey's care.

10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

11. Mr Harvey's partner received a copy of the draft report. She raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

Previous deaths at HMP Wymott

12. Mr Harvey was the twenty-third prisoner to die at Wymott since 20 June 2020. Of the previous deaths, 22 were from natural causes and one was self-inflicted. Our report into the death of a prisoner in September 2021 raised concerns about the use of restraints. However, the circumstances which led to the use of restraints were different.

Key Events

13. Mr Peter Harvey was sentenced to 14 years imprisonment for sex offences on 27 January 2017. He was transferred to HMP Wymott on 13 February 2019.

14. On 5 October 2021, Mr Harvey was seen by a GP operating at HMP Wymott. Mr Harvey complained that he felt that food was stuck in his throat when he swallowed and that it was painful when the food reached the end of his oesophagus (the tube that connects the mouth to the stomach). The GP referred Mr Harvey to the gastroenterology department.

15. On 24 December, Mr Harvey attended hospital for a gastroscopy (a test to examine the upper part of the digestive system and take sample cells). However, they could not complete the procedure.

16. On 18 January 2022, Mr Harvey attended hospital for a gastroscopy but, again, they could not complete it.

17. On 1 March, Mr Harvey returned to the hospital for another gastroscopy appointment. The hospital suspected cancer and were waiting for the biopsy outcome.

18. On 4 March, the hospital wrote to the prison to advise that Mr Harvey needed a position emission tomography computerised tomography scan (PET CT Scan, a type of body scan.

19. On 1 April, Mr Harvey attended hospital for the PET CT scan. During this appointment, the hospital consultant told him that he had oesophageal cancer.

20. On 4 May, Mr Harvey began chemotherapy.

21. On 4 August, Mr Harvey went to hospital for key-hole surgery to determine the stage of the cancer.

22. On 9 August, a nurse at the prison saw Mr Harvey who told her that the hospital had said his cancer could not be cured and asked if he wanted to apply for early release on compassionate grounds (ERCG).

23. On 15 August, a nurse spoke to a specialist nurse, who told her that the hospital was planning to undertake surgery to remove Mr Harvey's oesophagus to cure the cancer.

24. On 7 October, a nurse made an entry in the medical record that Mr Harvey would have chemotherapy every three weeks and that he only had six to 12 months to live.

25. On 16 October, a nurse met Mr Harvey to discuss his situation. Mr Harvey asked her about early release and she told him he could apply. However, his prognosis did not meet the criteria of three months or less for ERCG. She told Mr Harvey that she would add him to the palliative care register and a family liaison officer would be appointed.

26. On 17 October, the prison began the ERCG application process.

27. On 13 November, a nurse carried out a palliative care review with Mr Harvey. During their meeting, she discussed with Mr Harvey a do not attempt cardiopulmonary resuscitation (DNACPR) order and also explained that staff from St Catherine's Hospice would visit him.

28. On 15 November, Mr Harvey signed a DNACPR order.

29. On 22 December, Mr Harvey's ERCG application was submitted to the Public Protection Casework Section (PPCS) of HM Prison and Probation Service.

30. On 31 January 2023, Mr Harvey attended a hospital appointment with the oncologist. Before Mr Harvey left the prison, staff completed an escort risk assessment and decided that Mr Harvey would be escorted by two officers but no restraints would be applied because he was receiving palliative care.

31. On 1 February, Mr Harvey was notified that his application for early release had been rejected because his circumstances did not meet all of the criteria.

32. Mr Harvey attended hospital on multiple occasions between January and April for cancer treatment. The escort risk assessments completed by prison staff determined that Mr Harvey would be escorted by two officers but restraints were not needed.

33. On 8 May, a Custodial Manager (CM) discussed Mr Harvey's health with a nurse. He noted in Mr Harvey's records that there had been a deterioration in Mr Harvey's health and St Catherine's Hospice would visit to reassess him.

34. At approximately 11.30am on 15 May, a GP at Wymott examined Mr Harvey as he had reported he was in significant pain. Clinical observations were taken and Mr Harvey's National Early Warning Score (NEWS2) was calculated as five. (NEWS2 is a tool to detect and respond to clinical deterioration.) A score of five to six indicates the need for an urgent review by a ward-based doctor or nurse. The GP decided that Mr Harvey should be sent to hospital.

35. On 22 May, a specialist nurse from St Catherine's Hospice noted that Mr Harvey's prognosis was "likely months".

36. On 25 May, Mr Harvey's prison offender manager (POM) emailed the Governor to ask if there was a new date to review Mr Harvey's case due to his current presentation.

37. At approximately 11.00pm on 25 May, a nurse went to see Mr Harvey as he had complained of feeling cold and nauseous and was unable to keep fluids or food down. The nurse carried out physical observations and calculated a NEWS2 score of three. A score of three indicates the need for a prompt assessment by a nurse to decide on the frequency of monitoring or escalation of clinical care.

38. At approximately 1.15am on 26 May, the nurse was called to attend to Mr Harvey again. He told the nurse that he had not been able to take his medications as he felt sick. The nurse concluded that Mr Harvey should be admitted to hospital for treatment.

39. Before Mr Harvey left the prison, the nurse contacted a CM to arrange the escort for Mr Harvey. The CM completed the risk assessment and wrote on the prisoner escort record that Mr Harvey needed palliative care. The medical section of the risk assessment document was not completed.

40. The CM told the investigator that in addition to the two-officer escort, he decided that Mr Harvey would be restrained using a single cuff and escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). He stated that he was unable to recall why he decided this but considered that he had decided to err on the side of caution and that the escort chain would not have affected Mr Harvey's health.

41. The CM said that at the time, he had not been given access to the security intelligence system and therefore had not checked if there was any intelligence about Mr Harvey. He told the investigator that he was not aware of and had not been trained on the Graham judgment about the use of restraints on prisoners who are unwell.

42. On 7 June, a CM emailed colleagues, telling them that Mr Harvey was ready to be discharged but needed 24-hour nursing care as he had been described as being in his "last days". He stated that the healthcare team was seeing whether with St Catherine's Hospice could take him. He asked a CM to chase up Mr Harvey's ERCG application.

43. On 8 June, a member of the Offender Management Unit emailed colleagues to advise that Mr Harvey was being considered for ERCG. She asked them to complete the necessary report. She said that a medical report was needed from the prison GP and the hospital doctor.

44. That day, the member of the Offender Management Unit submitted her report for the ERCG application.

45. On 14 June, the hospital contacted a prison nurse. They told her that Mr Harvey's condition had deteriorated rapidly and he was being given comfort care only. He had told hospital staff that his preferred place of death was a hospice. A prison manager approved Mr Harvey's move to a hospice, and he moved on 19 June.

46. At approximately 2.45pm on 20 June, the prison was told that Mr Harvey had died.

Post-mortem report

47. The doctor gave Mr Harvey's cause of death as metastatic oesophageal adenocarcinoma (cancer which had started in the oesophagus but had spread to other parts of the body). The coroner accepted this cause of death and no post-mortem examination was carried out.

Inquest into Mr Harvey's death

48. The inquest into Mr Harvey's death was held on 20 February 2024 and a verdict of natural causes was recorded. The coroner concluded that Mr Harvey's death was due to metastatic oesophageal adenocarcinoma.

Non-Clinical Findings

Restraints, security and escorts

47. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility.

48. A judgment in the High Court in 2007 (the Graham judgment) made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when he has a serious medical condition. It said that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

49. This is reinforced in the escort policy which states that if a prisoner is receiving chemotherapy or any other life-saving treatment, restraints by handcuffs must be justified by "documented security conditions which are specific to the prisoner."

50. On 26 May, Mr Harvey was sent to hospital and was restrained using a single cuff and escort chain. At this time, he was in the last weeks of his life, receiving palliative care and undergoing chemotherapy.

51. When a prisoner is admitted to hospital, healthcare staff must complete a medical risk assessment which is considered alongside all relevant intelligence and information. However, this was not done and despite asking, the investigator was not told why the medical section was not completed. It is crucial that this section is completed to inform proportionate and justified decisions about the use of restraints. We make the following recommendation:

    The Head of Healthcare should ensure that staff complete the medical risk assessment form in full, providing the authorising manager with sufficient information to make informed decisions.

52. A CM told the investigator that he was aware that Mr Harvey was receiving palliative care. However, he was not aware of the Graham judgment and could not access the prison's security information system. This is concerning as he was solely responsible for making escort decisions at the time.

53. Before 26 May, Mr Harvey had appropriately attended his hospital appointments without being restrained, and we have seen no evidence to suggest that his risk had increased. Given this and the absence of evidence to the contrary, the use of restraints on 26 May was not justified. We therefore make the following recommendations:

    The Governor should ensure that all staff involved in the decision-making process:

- **have received the required training, including on the legal framework relating to hospital escorts; and**

- **have access to and know how to use relevant information systems before they need to access the information to make decisions.**

Governor to note

49. On 22 May, it was identified that Mr Harvey's prognosis was "likely months" and his presentation at that time prompted his POM to enquire with the Governor if his case was due to be reviewed. However, despite this change in Mr Harvey's health, a new ERCG application was not considered until 6 June.

Adrian Usher
Prisons and Probation Ombudsman **January 2024**

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