Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Devers, a prisoner at HMP Oakwood, on 21 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

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 John Devers died from lung cancer in hospital on 21 June 2023, while a prisoner at HMP Oakwood. He was 59 years old. We offer our condolences to Mr Devers' family and friends.

4. The clinical reviewer concluded that the clinical care Mr Devers received at Oakwood was of a good standard and equivalent to that which he could have expected to receive in the community. She made no recommendations.

5. We have previously found issues with the inappropriate use of restraints when prisoners were going to hospital from Oakwood, and the Director wrote to the Ombudsman in February 2023 to say that this issue had been addressed. However, once again we found that restraints were inappropriately used with Mr Devers.

The Investigation Process

6. HMPPS notified us of Mr Devers' death on 21 June 2023.

7. NHS England commissioned an independent clinical reviewer, to review Mr Devers' clinical care at Oakwood. The clinical reviewer's report is attached as Annex 1.

8. The PPO investigator investigated the non-clinical issues relating to Mr Devers' care. The investigator interviewed one member of staff.

9. The PPO family liaison officer wrote to Mr Devers' next of kin, his wife, to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.

10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found no factual inaccuracies with the report.

Previous deaths at HMP Oakwood

11. Mr Devers was the 12th prisoner to die at Oakwood since June 2020. Nine of the previous deaths were from natural causes, one was from drugs, and one was from burns injuries. In several of these previous cases, we have raised concerns about the inappropriate use of restraints.

Key Events

12. On 8 January 2021, Mr Devers was remanded in custody at HMP Preston, pending the outcome of a trial for sexual offences. On 19 July, he was sentenced to nine years imprisonment. On 7 October, he was sent to HMP Oakwood.

13. When Mr Devers went to prison, he was already taking regular opioid painkillers for arthritis (a common condition that causes pain and inflammation in joints) in his spine, elbows, and knees. When he arrived at Oakwood, he was having difficulties walking and shortly afterwards started using a walking stick for short distances and a wheelchair for longer distances.

14. On 8 November, Mr Devers reported feeling pins and needles in his legs and feet and a doctor at the prison referred him for an urgent MRI scan of his brain, neck, and spine. On 16 December, a physiotherapist at the prison assessed Mr Devers. They noted that he was unsteady, used a walking stick and held on to furniture to move short distances, and was using a wheelchair for longer distances. The physiotherapist thought that Mr Devers might have a brain lesion and noted that an MRI brain scan was pending.

15. On 23 December, Mr Devers was moved back to Preston because it was close to the court where he was standing trial on further criminal charges, for theft.

16. On 4 January 2022, Mr Devers said that he was experiencing stabbing pains in his legs and that was losing strength in his right hand. A prison nurse noted that the MRI scans were still pending and needed to be chased up.

17. Following his trial on 15 March, Mr Devers was sentenced to 15 months imprisonment, concurrent to the previous sentence. On 19 April, he was transferred back to Oakwood. Healthcare staff made a new referral for a brain and spine scan. On 20 May, the prison was notified by the hospital of an appointment on 28 June.

18. On 3 June, Mr Devers had some paralysis to the left side of his face and was taken to hospital with a suspected stroke (the term for when the blood supply is cut off to part of the brain). At the hospital he was diagnosed with Bell's palsy (a temporary muscle weakness usually to one side of the face) and Mr Devers returned to the prison the same day.

19. On 28 June, Mr Devers went to hospital for the scheduled scan. This showed no signs of a stroke or any brain lesions but did show multilevel degenerative changes to Mr Devers' spine. Healthcare staff at Oakwood made a referral to a spinal surgeon in August.

20. Mr Devers remained reliant on a wheelchair and his clinical notes in November recorded an increase in his body pains and a reduction in his mobility. In January 2023, Mr Devers moved to a disabled access cell.

21. On 24 February, Mr Devers alerted staff with his personal wrist alarm that he had fallen over and could not get himself up. Healthcare staff who attended, recorded in Mr Devers' clinical notes that he was uninjured but due to frailty and poor mobility was unable to get himself off the floor by himself.

22. From mid-March, Mr Devers was consistently unwell. He had spells of headaches and vomiting, with a loss of appetite. Mr Devers was taken to hospital on 27 March and returned to prison with a diagnosis of a gastric or urinary infection. He fell out of bed that night and was helped back in by staff.

23. On 28 March, healthcare staff found Mr Devers was still very ill with very little ability to mobilise and sent him back to hospital. He was returned once again without much idea for the healthcare staff as to what was wrong with him and without a treatment plan.

24. Around 8.00am the following day, Mr Devers fell out of bed again. Initially the prison called an ambulance but stood it down as he had no injuries. However, by the afternoon healthcare staff felt that Mr Devers' constant dizziness and inability to stand up without falling over, was putting him in danger. Mr Devers once again returned to hospital.

25. By 30 March, although the hospital was waiting for biopsies to confirm the diagnosis, doctors said it was very likely that Mr Devers had lung cancer which had spread to his brain, and that he had approximately two months to live.

26. Mr Devers returned to prison on 10 April. On 12 April, the hospital confirmed that he had lung and brain cancer. Following another fall on 26 April, and his inability to get himself back up, Mr Devers was sent back to hospital where he remained until 2 May. Healthcare staff recorded in Mr Devers' clinical notes that now only palliative treatment (care with the focus on optimising the quality of life and reducing suffering) was possible. A special palliative care bed was delivered to the prison on 19 May.

27. On 20 May, Mr Devers fell out of his wheelchair. On the morning of 25 May, he fell over getting dressed, and in the afternoon, he fell out of his wheelchair again, after which he was taken to hospital but was returned to the prison later in the evening.

28. On 25 May, Mr Devers was given a different wheelchair to use. This, like the previous one, was a wheelchair for general use rather than one customised for Mr Devers, and at this point a dedicated wheelchair was ordered for Mr Devers by a First Line Manager (FLM) from the Prison's Safer Custody unit.

29. On the morning of 6 June, Mr Devers was taken to hospital with a possibly infected wound to his elbow and because of clinical observations, healthcare staff at the prison were concerned that he might have sepsis (a potentially life-threatening condition that occurs when the body's response to an infection damages its own tissues). Mr Devers discharged himself, because he did not like waiting in what he felt was an overcrowded area. However, because of his deteriorating condition, Mr Devers was taken back to the hospital in the early evening the same day. On both hospital trips Mr Devers was restrained by single cuffs and an escort chain.

30. Mr Devers remained in hospital until he died there on 21 June.

Cause of death

32. A post-mortem examination was not necessary as the Coroner accepted the cause of death provided by hospital doctors. They said that Mr Devers died from metastatic lung cancer (lung cancer which has spread to other parts of the body). Hydrocephalus due to brain metastasis (pressure in the brain from cancer tumours), was given as a condition that contributed to but did not cause the death.

Non-Clinical Findings

Restraints, security and escorts

33. 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. A judgment in the High Court in 2007, known as the Graham Judgement, 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 suffering from 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.

34. Mr Devers had limited mobility from the outset of his time in prison and this deteriorated. In June 2022, he was diagnosed with significant degenerative spine problems. Mr Devers moved into a disabled access cell in January 2023. He had an escalating problem with falls and by February, was already unable to get up by himself when he fell over, and later in the year was falling out of the wheelchair he was using. By that time, doctors had discovered that Mr Devers had lung cancer which had spread to his brain.

35. At the time of his cancer diagnosis on 30 March, Mr Devers was noted in the Family Liaison Officer's (FLO) log, to be unrestrained because of his immobility. When he was taken to hospital on 26 April, Mr Devers was initially restrained, but the restraints were later removed after a review. A member of the healthcare staff, wrote in Mr Devers' clinical notes on 27 April, "Could Mr Devers be discussed [at] Director and security [level] … about the use of restraints if he is still cuffed. On review of his most recent CT scan, his probable diagnosis and his decreased mobility the risk of escape is very low so could this be [taken into] consideration."

36. On 6 June, when Mr Devers was taken to hospital in the morning, staff completed a risk assessment. In the section filled in by the Head of Security, she listed Mr Devers as medium risk to the public but as low risk in all the other categories including the risk of escape. The member of the healthcare staff who filled in the medical section of the risk assessment, in response to the question, "Are there any medical reasons that would prevent normal cuffing procedures from being applied for the duration of the escort / Bed Watch?", she circled "yes", and as an explanation wrote, "cancer patient". In response to the question, "Does the prisoner have the physical ability to attempt an escape (unaided) from the escort if the cuffs are removed?", she circled "No", and gave the explanation "wheelchair bound". She also recorded in Mr Devers' clinical notes that she had spoken to the Head of Security and told her that Mr Devers' risk was low, he was not in good health and due to the spread of his cancer he was immobile and used a wheelchair.

37. The Security Intelligence Manager, who was Duty Director on 6 June, was the authorising manager for the risk assessment. He authorised the use of single cuffs and an escort chain (a handcuff on a prisoner linked by a chain to a handcuff on an officer) to restrain Mr Devers, accompanied by two officers. In the comment section

he wrote, “Confirmed that is not wheelchair dependent by SC [Safer Custody]. Review when updated on treatment plan”.

38. When Mr Devers returned to hospital in the evening a separate risk assessment should have been carried out but there was no new assessment and Mr Devers was restrained for both trips.

39. On 7 June, a note in Mr Devers’ clinical records was made by a different nurse to the one who filled in the risk assessment. He said that he had spoken to the Head of Security and advised that because of Mr Devers’ terminal cancer, his restricted mobility, use of wheelchair and limb impairment, he should not be restrained. She told the nurse that the decision would go to the Director for sign off, which is what happened, and the restraints were removed.

40. The investigator asked the Security Intelligence Manager who he had spoken to in Safer Custody regarding Mr Devers’ wheelchair dependence. He said he recalled that it was a First Line Manager (FLM) in the Care Team. However, the FLM said this was not the case. She confirmed that Mr Devers had originally been using a wheelchair unofficially for his own convenience (they are available on the wings for prisoners to use as and when they need them), but following a request from healthcare staff, he had been issued with a dedicated wheelchair.

41. The investigator also asked the Security Intelligence Manager why he had referred the matter to Safer Custody, rather than relying on the information provided by the nurse on the risk assessment. He said it was because the prison has a lot of agency nurses who would not necessarily know the prisoners very well. He said that his understanding was that although Mr Devers used a wheelchair, he did not really need it.

42. With Mr Devers’ mobility history, it is hard to understand how the use of restraints could be justified with the presence of two able bodied prison officers in attendance. It is appropriate for healthcare related advice to be given by a healthcare professional, and if this was contradicted by other information, a contemporaneous note should have been made on the risk assessment to say exactly who had been spoken to, and exactly what they had said. The risk assessment should also be based on the actual presentation of a prisoner at the time of the assessment and not on any subsequent treatment plan. The decision to restrain Mr Devers was excessively precautionary and not compliant with the Graham Judgement, although we acknowledge this was addressed the next day.

43. The inappropriate use of restraints on prisoners being taken to hospital is an issue we have raised with Oakwood before. We recommend:

The Operational Security Group Director for HMPPS should monitor compliance with policy on the use of restraints during hospital escorts (for inpatient admissions and outpatient appointments), including at HMP Oakwood, and discuss the findings with the Ombudsman.

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

Inquest

44. The inquest into Mr Devers' death concluded in July 2024 and found that he died of natural causes.

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