Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Francis Beaumont, a prisoner at HMP Moorland, on 28 December 2022

A report by the Prisons and Probation Ombudsman

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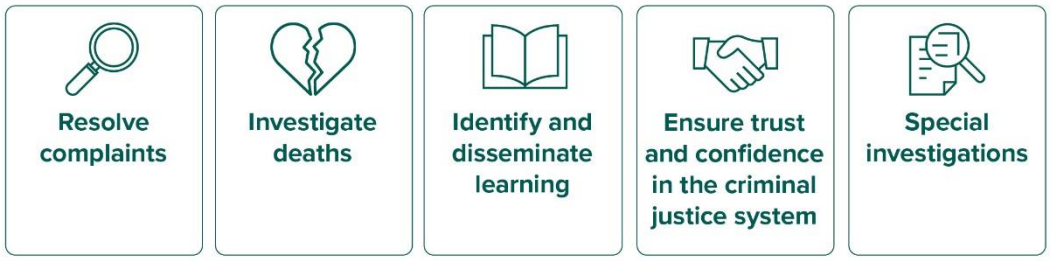
OUR VISION

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 HM Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate then our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. Mr Francis Beaumont died at HMP Moorland on 28 December 2022, of advanced stomach carcinoma. He was 84 years old. We offer our condolences to Mr Beaumont's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Beaumont received at Moorland was of a reasonable standard and at least equivalent to that which he could have expected in the community. She highlighted examples of good practice and opportunities for improvement in areas not directly related to Mr Beaumont's death, for the Head of Healthcare to address.

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

The Investigation Process

6. We were notified of Mr Beaumont's death on 28 December 2022.

7. NHS England commissioned an independent clinical reviewer to review Mr Beaumont's clinical care at HMP Moorland.

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

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

10. We shared the initial report with HMPPS and there were no factual inaccuracies.

Previous deaths at HMP Moorland

11. Mr Beaumont was the 13th prisoner to die at HMP Moorland since 28 December 2019. Of the previous deaths, 11 were from natural causes and one was drugs related. There are no significant similarities between our findings in the investigation into Mr Beaumont's death and our investigation findings for the previous deaths.

Key Events

12. On 1 May 2018, Mr Francis Beaumont was given a 20-year sentence for sexual offences and transferred to HMP Leeds. He transferred to HMP Moorland on 31 July 2019.

13. On 12 May 2021, Mr Beaumont was admitted to hospital for cellulitis (a deep skin infection). He had an unexpected gastro-intestinal bleed which led to a diagnosis of a large stomach ulcer.

14. On 30 July, Mr Beaumont attended hospital for an endoscopy (an examination of the digestive system using an internal camera). He had a further gastro-intestinal bleed during the endoscopy and was kept in hospital overnight for observation. His discharge summary reported a probable cancerous antral (part of the stomach) ulcer.

15. In August, Mr Beaumont received a confirmed diagnosis of cancer of the stomach. He was added to the Multi-Professional Complex Care Case register (a multi-disciplinary approach to managing patients with complex care needs).

16. On 25 August, hospital staff advised Mr Beaumont that he was not a suitable candidate for radical treatment (aimed to cure rather than manage symptoms) nor palliative chemotherapy (aims to manage rather than cure symptoms).

17. Throughout his time in prison, Mr Beaumont sometimes did not take his medication as prescribed. Healthcare staff assessed that he had capacity to make these choices. He indicated a number of times that he was unaware that his cancer was not curable. Healthcare staff frequently spoke to him to make him aware of this and to offer support.

18. On 22 May 2022, a nurse reviewed Mr Beaumont and was concerned there may have been some disease progression. Staff called an ambulance. Mr Beaumont refused to attend hospital or to have any treatment.

19. On 9 August, healthcare staff discussed Mr Beaumont's presentation with a cancer nurse specialist, who offered him a blood transfusion. Mr Beaumont's blood test results indicated an urgent referral to hospital for further assessment was appropriate. He refused the transfusion or to attend hospital.

20. On 10 August, a GP at Moorland advised Mr Beaumont of the dangers and risks associated with his refusal to attend hospital. He continued to refuse to attend hospital several times over the following weeks.

21. On 4 September, an ambulance crew persuaded Mr Beaumont to attend hospital after he vomited black fluid. He refused a blood transfusion and discharged himself early in the morning of 5 September 2022.

22. On 11 September, a family liaison officer was assigned to Mr Beaumont and made contact with his family.

23. On 12 September, a GP persuaded Mr Beaumont to attend hospital for a blood transfusion. At hospital he refused all treatment and chose not to speak to medical

staff. On 13 September, Mr Beaumont discharged himself and returned to Moorland. The next day, Mr Beaumont again agreed to attend hospital for a transfusion, but again discharged himself against advice.

24. On 1 December, the pathology laboratory reported that Mr Beaumont's blood test results were outside normal values. He was advised that it was crucial that he attend hospital for further assessment but declined to do so.

25. Over the following four weeks, Mr Beaumont's health declined. He was advised to attend hospital several times but refused.

26. On 27 December, Mr Beaumont's daughter visited him. Staff explained that they were organising medication for end-of-life support. A healthcare assistant remained with him.

27. On 28 December, Mr Beaumont's daughter visited him. Staff discussed end of life choices and all parties agreed that CPR would not be undertaken. They decided that he should remain in the prison's care suite rather than attend hospital, in line with his wishes.

28. At 1.42pm on 28 December, healthcare staff recorded that Mr Beaumont had died. His daughter was present.

Post-mortem report

29. The post-mortem report concluded that Mr Beaumont died of advanced stomach carcinoma.

Findings

30. Given his frequent refusal of treatment or to attend hospital, caring for Mr Beaumont during his final illness was not always straightforward. The clinical reviewer concluded that the care that Mr Beaumont received was consistent, thorough and well documented. She found that the care was of a good standard and equivalent to that he could expect to receive in the community.

Inquest

31. The inquest into Mr Beaumont's death concluded on 7 December 2023. Mr Beaumont's cause of death was advanced stomach carcinoma.

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

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