

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Jeffrey Rookes a prisoner at HMP Erlestoke on 14 June 2017

**A report by the Prisons and Probation Ombudsman**

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## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

**We are:**

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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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.

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

Mr Jeffrey Rookes died on 14 June 2017 at Bristol Royal Infirmary of an infection caused by pancreatic cancer while a prisoner at HMP Erlestoke. He was 66 years old. We offer our condolences to Mr Rookes' family and friends.

Although it took a year to diagnose Mr Rookes' cancer, we are satisfied that his symptoms were investigated appropriately and that the standard of healthcare he received at Erlestoke was equivalent to that which he could have expected to receive in the community.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

**Elizabeth Moody**  
**Acting Prisons and Probation Ombudsman**

**November 2017**

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# Summary

## Events

1. Mr Jeffrey Rookes was serving a life sentence for wounding with intent and had been at HMP Erlestoke since 2010. Mr Rookes first reported symptoms of jaundice, weight loss and feeling unwell on 4 April 2016. A blood test revealed abnormal results and a doctor requested an abdominal ultrasound. Between April 2016 and January 2017, Mr Rookes underwent numerous scans to investigate his symptoms. Cancer of the pancreas was raised as a likely diagnosis but tests were inconclusive.
2. Mr Rookes became frustrated and worried about the lack of progress in his diagnosis and treatment. In January 2017, Mr Rookes requested a second opinion from Bristol Royal Infirmary.
3. On 18 April, Mr Rookes became unwell and was taken to Salisbury District Hospital. On 26 April, Mr Rookes was told that he had pancreatic cancer. He was discharged back to Erlestoke the following day.
4. On 12 May, Mr Rookes was taken to Salisbury District Hospital due to possible sepsis. He was transferred to Bristol Royal Infirmary on 18 May where he was treated for septic shock. On 12 June, the healthcare unit at Erlestoke was told that Mr Rookes' cancer was inoperable and palliative chemotherapy might be possible if he recovered from his infection.
5. On 13 June, the healthcare unit was informed that Mr Rookes was not responding to the antibiotics and he was asked to consider whether he wanted to continue with active treatment. Mr Rookes asked to discuss this with his next of kin. Mr Rookes' next of kin visited the following day at 1.30pm while Mr Rookes was asleep. He died in his sleep at 2.30pm. The post-mortem report shows that he died of biliary sepsis (infection within the biliary system - liver, gall bladder and bile ducts) which was caused by pancreatic cancer.

## Findings

6. Although it took a year for Mr Rookes' cancer to be diagnosed, we are satisfied that healthcare staff at Erlestoke investigated his symptoms appropriately and in a timely manner. We agree with the clinical reviewer that Mr Rookes received a good standard of clinical care at Erlestoke equivalent to that which he could have expected to receive in the community. We make no recommendations.

## The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Erlestoke informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
8. The investigator obtained copies of relevant extracts from Mr Rookes' prison and medical records.
9. NHS England commissioned a clinical reviewer to review Mr Rookes' clinical care at the prison.
10. We informed HM Coroner for Wiltshire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
11. The investigator wrote to Mr Rookes' nephew to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not respond to our letter.
12. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.
13. The investigation has assessed the main issues involved in Mr Rookes' care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.

# Background Information

## HM Prison Erlestoke

14. HMP Erlestoke is a medium security prison near Devizes in Wiltshire, which holds around 500 men. Since 1 April 2016, Inspire-Better-Health partnership has provided health services at the prison with Bristol Community Health providing the general nursing care. Healthcare is available between 8.00am and 5.00pm on weekdays and 7.30am and 1.30pm on weekends. During each shift, a GP, three nurses and two healthcare assistants available. No healthcare staff are available overnight, though Medvivo provides an out of hours GP service.

## HM Inspectorate of Prisons

15. The most recent inspection of HMP Erlestoke was in October 2013. Inspectors found that the health services at the prison were good and prisoners were satisfied with the care they received. Healthcare services were available each weekday with out of hours services provided for evenings and weekends. The prison assigned older prisoners with chronic diseases to a named nurse and clinical records were generally good.

## Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 31 March 2017, the IMB commended the improvement in healthcare services. They found improvements in staff numbers helped to provide healthcare to an equitable standard to the community. However, they were concerned that prisoners might have to wait unacceptably long times for outside appointments due to not enough escort staff being available.

## Previous deaths at HMP Erlestoke

17. Mr Rookes was the second prisoner to die of natural causes since January 2015. There were no significant similarities between these two deaths.

## Findings

### The diagnosis of Mr Rookes' terminal illness and informing him of his condition

18. Mr Jeffrey Rookes was serving a life sentence for wounding with intent and had been at HMP Erlestoke since 2010. He had diagnoses of Type 2 diabetes, hypertension and psoriasis.
19. On 4 April 2016, a prison GP saw Mr Rookes who had been feeling unwell for a week and presented with jaundice, dark urine and weight loss. He thought Mr Rookes had hepatitis, although he did consider the possibility of pancreatic cancer, and requested urgent blood tests. On 6 April, the GP followed up on Mr Rookes and found him to be feeling better but his blood tests were very abnormal. He told Mr Rookes that it may be serious and he would refer him to hospital for an urgent ultrasound.
20. On 19 April, Mr Rookes had an abdominal ultrasound which showed an obstruction at the end of the common bile duct. An Endoscopic Retrograde Cholangio-Pancreatography (ERCP) procedure, where a lit tube is passed through the mouth into the intestines, was recommended urgently and took place on 21 April. This showed a narrowing of the common bile duct which could be caused by cancer. Stents (hollow tubes) were inserted into the pancreas and bile duct to relieve the obstruction causing jaundice.
21. The National Institute for Health and Care Excellence (NICE) Guidance states that a suspected cancer pathway referral for pancreatic cancer should be made for a person over 40 with jaundice. Although NICE guidelines were not followed in this case, the clinical reviewer is content that the ultrasound and ERCP took place in a similar time frame to that of a suspected cancer pathway referral.
22. Between June and December 2016, Mr Rookes had numerous scans of his pancreas and a biopsy was taken. In September, he was told by hospital staff that he had an abnormality of his pancreas that was very likely to be cancer and that surgery was advised. However, in November, after scans to check for any spread of the presumed cancer, he was told that, as there had been no change to the appearance of his pancreas since April 2016, he may not have cancer after all. Further scans in November and December were inconclusive.
23. Mr Rookes was frustrated about the lack of progress in his treatment and the time spent waiting for further hospital appointments. On 21 November, he told a prison doctor he felt that he was 'being left to die'. His brother had recently died of pancreatic cancer and he was very worried because of that. On 3 January 2017, Mr Rookes wrote a long letter to the healthcare department at Erlestoke setting out his concerns and threatened legal action if his treatment did not improve.
24. On 9 January, Mr Rookes had an appointment at Southampton General Hospital where he expressed his concerns about his treatment. He was offered a second opinion at Bristol Royal Infirmary. Further scans took place in January but these were inconclusive.

25. On 14 February, a prison GP noted that Mr Rookes had received no recent communication from hospital. A prison healthcare administrator checked with Salisbury District Hospital and Southampton General Hospital to find out when Mr Rookes' next appointment was and when he would be seen at Bristol Royal Infirmary. The surgeon's secretary said that because a referral had been made to Bristol he had not made a further appointment.
26. On 4 April, a prison GP met Mr Rookes who told her he had still not received an appointment from Bristol Royal Infirmary and he had lost all confidence in Southampton and Salisbury hospitals. The GP wrote to Bristol Royal Infirmary to request a second opinion.
27. On 18 April, Mr Rookes became unwell and a prison doctor was concerned his stent had become blocked; he was taken to Salisbury District Hospital. Mr Rookes had a CT scan and ERCP, both of which indicated cancer. On 26 April, the hospital told the healthcare unit at Erlestoke that it was very likely that Mr Rookes had pancreatic cancer. The hospital informed Mr Rookes of his diagnosis.
28. Although it took over a year for Mr Rookes' cancer to be diagnosed, the clinical reviewer is satisfied that healthcare staff at Erlestoke investigated his symptoms appropriately, referred him for hospital tests and provided good follow up care. He is also satisfied that the lack of a referral under the two-week suspected cancer pathway did not affect the timescale for diagnosis. We agree with the clinical reviewer that Mr Rookes received a good standard of clinical care at Erlestoke equivalent to that which he could have expected to receive in the community.

### **Mr Rookes' clinical care**

29. On 27 April, Mr Rookes was returned to Erlestoke from Salisbury District Hospital, with medication, a discharge summary and an appointment at Southampton Hospital the following week to discuss his biopsy results.
30. On 4 May, a prison GP saw Mr Rookes as nurses were concerned that he was deteriorating. She found the plans for following up Mr Rookes' diagnosis unclear and contacted Salisbury and Southampton hospitals to find out more. Later that afternoon an administrator noted that Mr Rookes had been given an appointment at Southampton General Hospital on 17 May.
31. On 12 May, Mr Rookes was taken to Salisbury District Hospital as an emergency due to concerns that he may have sepsis. On 16 May, the Head of Healthcare held a multidisciplinary meeting at Erlestoke to discuss Mr Rookes' care, which was attended by the lead GP, Mr Rookes' named nurse, a Family Liaison Officer and the Safer Custody Governor. They discussed how to manage Mr Rookes if he returned to prison and required end of life care arrangements.
32. A multidisciplinary team meeting took place at Salisbury District Hospital on 17 May. Hospital staff agreed that although the cancer had not spread, Mr Rookes was not a candidate for surgery. Mr Rookes was due to be transferred to Southampton General Hospital but he refused to go and said he had lost confidence with the surgical team at that hospital.

33. On 19 May, Mr Rookes was transferred to Bristol Royal Infirmary. On 23 May, Mr Rookes was treated with intravenous antibiotics for septic shock. On 26 May, a multidisciplinary team at Bristol Royal Infirmary concluded that a CT scan had revealed more extensive disease and surgery to remove it was doubtful. They planned to make a further assessment when Mr Rookes had recovered from his infection.
34. On 12 June, a prison GP spoke with a doctor at Bristol Royal Infirmary who confirmed that Mr Rookes' cancer was inoperable. He was still being treated for an infection and, if his condition improved, he was to be considered for palliative chemotherapy. Mr Rookes said he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect on 12 June 2017.
35. On 13 June, a prison GP contacted the hospital who confirmed that Mr Rookes was not responding to the antibiotics and the hospital palliative care team had become involved.
36. On 14 June, Mr Rookes requested the presence of his next of kin to discuss the decision to stop active treatment. At 1.30pm his nephew arrived and Mr Rookes was asleep. Mr Rookes died in his sleep at 2.30pm. The post-mortem report shows he died of biliary sepsis (infection within the biliary system - liver, gall bladder and bile ducts) which was caused by pancreatic cancer.
37. We agree with the clinical reviewer that the standard of clinical care Mr Rookes received at Erlestoke was equivalent to that which he could have expected to receive in the community.

### **Mr Rookes' location**

38. There is no inpatient healthcare at Erlestoke. Mr Rookes lived on a wing at Erlestoke, and was cared for in his cell when necessary. The clinical reviewer found that Mr Rookes was transferred to hospital appropriately when required. We are satisfied that Mr Rookes was located appropriately during his illness.

### **Restraints, security and escorts**

39. 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.
40. Mr Rookes was restrained with single cuffs for his transfers to hospital. Although he was unwell, he was not seriously ill on these occasions and we consider the use of single cuffs for his hospital transfers was reasonable. Apart from one occasion in April 2016 when an escort chain was applied for Mr Rookes' ERCP, restraints were removed for medical procedures, such as scans. On 9 June, restraints were removed permanently when Mr Rookes' condition deteriorated in hospital.
41. While we consider that the use of an escort chain was inappropriate for the ERCP (during which Mr Rookes was sedated and complained that he had woken

because the chain was causing discomfort), we are pleased to note that thereafter, restraints were not applied for medical procedures. We do not, therefore, make a recommendation.

### **Liaison with Mr Rookes' family**

42. Mr Rookes' nephew was aware that Mr Rookes was in hospital and he visited him regularly. He was present when Mr Rookes died. A prison manager was appointed as the Family Liaison Officer after Mr Rookes died.
43. Mr Rookes' funeral was held on 10 July and the Pagan chaplain from Erlestoke led the service. A memorial service was held at the prison two days later. Erlestoke contributed to the funeral costs in line with national policy. We are satisfied that the prison liaised appropriately with Mr Rookes' family.

### **Compassionate release**

44. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.
45. On 26 April 2017, Mr Rookes was diagnosed with pancreatic cancer that had not spread and treatment options were being considered. On 26 May, it was determined that his pancreatic cancer was inoperable and on 13 June, hospital staff said that Mr Rookes only had a short time to live. On 14 June, prison staff started an application for compassionate release but Mr Rookes died the same day. We are satisfied that the prison acted appropriately.

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