

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Dillon a prisoner at HMP Moorland on 11 December 2016

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 John Dillon died on 11 December 2016 from drug toxicity while a prisoner at HMP Moorland. He was 50 years old. I offer my condolences to Mr Dillon's family and friends.

Mr Dillon had terminal throat cancer. The investigation found that he received good healthcare in relation to his cancer and that the prison treated him with dignity and compassion.

However, there were failings in the monitoring of his medications. The post mortem found levels of both prescribed and non-prescribed drugs in his system. We are concerned that there appear to be insufficient controls over the trading of prescription medication at the prison.

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

February 2018

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Summary

Events

1. In 2008, Mr John Dillon received a nine year sentence for sexual offences. In December 2011, he received a further sentence of three years and six months for a separate sexual offence. He was transferred to HMP Moorland on 18 January 2016. Mr Dillon had a history of schizophrenia, alcohol dependency and substance misuse.
2. In February 2016, Mr Dillon complained of a sore throat, which the prison and hospital investigated. In May, hospital doctors diagnosed him with inoperable throat cancer. A mental health nurse monitored Mr Dillon, and discussed his prognosis with him. He seemed to accept his diagnosis.
3. Mr Dillon received some chemotherapy and, as part of his treatment for the tumour obstructing his throat, the hospital inserted a tracheostomy (an opening into the windpipe to assist breathing). Doctors subsequently inserted a percutaneous endoscopic gastrostomy (PEG) tube into his stomach so that food, liquid, his chemotherapy treatment and other medications could be introduced directly when he had trouble swallowing.
4. On 26 September, Mr Dillon decided that he did not want to receive further treatment. Records show that Mr Dillon was fully aware of the consequences of his decision and how the cancer would progress. It was recorded that he had the mental capacity to make this decision. He told a mental health nurse that he had no thoughts of suicide or self-harm. Four days later, a hospital consultant confirmed that Mr Dillon's illness was terminal and he had between four months to a year to live. On 17 October, Mr Dillon said that he did not want to receive cardiopulmonary resuscitation (CPR) in the case of a cardiac arrest, but did want to be resuscitated if his tracheostomy tube became blocked.
5. While he was unwell, Mr Dillon received a prescription for four Fortisips (a nutritional drink) a day and medication for pain relief.
6. On 11 December, officers became concerned about Mr Dillon and alerted nurses. At 8.00am, nurses visited Mr Dillon's cell, saw him through the observation panel and decided not to disturb him because he was asleep. At 9.22am, after unlock, a prisoner found Mr Dillon unresponsive and alerted an officer. The officer called an emergency code and the control room called an ambulance. Healthcare staff attended. In accordance with Mr Dillon's wishes, staff did not perform CPR. Paramedics pronounced Mr Dillon dead at 9.50am.
7. The post mortem found that Mr Dillon died from the effects of taking a number of medications, including tramadol (a strong pain killer), amitriptyline (an anti-depressant), and olanzapine (an anti-psychotic), which he was not prescribed at the time of his death.
8. After Mr Dillon's death, a prisoner reported to a prison officer that two other prisoners had been selling Mr Dillon their prescribed medication. The prisoner later reported to police that the other prisoners had helped to dissolve the drugs in water, and poured this solution into Mr Dillon's PEG tube for him. A police

investigation concluded that there was insufficient evidence to support further action.

Findings

9. The PPO's investigation found that Mr Dillon was probably trading medications and canteen items (purchases from the prison shop) with other prisoners. It appears likely that the non-prescribed medications he took, and which contributed to his death, came from other prisoners on the wing.
10. Moorland did not record any suspicions that Mr Dillon might be trading medication, although some minor events, if recorded as intelligence, might have built a wider picture of Mr Dillon's behaviour.
11. The checking of cells as a means of ensuring compliance with medication is not effective enough to prevent the diversion of medications.

Recommendation

- The Governor and Head of Healthcare should ensure there is an effective drug strategy to reduce the trading of prescribed medication, which includes:
 - A greater emphasis on the risks from prescribed medication, and action to address the diversion of medication.
 - Ensuring all staff understand the importance of the intelligence system for the effective management of risk and are properly trained to identify and submit intelligence.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Moorland informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
13. The investigator obtained copies of relevant extracts from Mr Dillon's prison and medical records. Our investigation was suspended while police investigations took place.
14. Another investigator interviewed nine members of staff at HMP Moorland on 12 and 13 July.
15. NHS England commissioned a clinical reviewer to review Mr Dillon's clinical care at the prison. The clinical reviewer carried out interviews with the investigator on 12 and 13 July.
16. We informed HM Coroner for Doncaster of the investigation and she gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
17. The investigator wrote to Mr Dillon's mother to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. A family liaison officer then contacted Mr Dillon's mother to discuss her concerns. She wanted to know:
 - The extent of overnight checks conducted when Mr Dillon was ill.
 - What happened in the months before he died?
 - How promptly the diagnosis of cancer was made.
18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.
19. Mr Dillon's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

Background Information

HMP Moorland

20. HMP & YOI Moorland is a Category C prison in South Yorkshire, which holds up to 1,000 adult men and young offenders. Nottinghamshire Healthcare NHS Trust runs healthcare services at the prison, including primary care, mental health and substance misuse services. The prison does not have an inpatient facility or full time nursing cover.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Moorland was conducted in February 2016. Inspectors reported that healthcare staffing levels and the skill mix were appropriate, but high demand and continuing vacancies placed significant pressure on frontline staff.
22. The number of prisoners reporting that it was easy to get drugs in Moorland had increased since the last inspection, from 28% to 48%. 13% of prisoners also said they had developed a drug problem since being at Moorland. The drug strategy committee met inconsistently and was poorly attended, failing to provide a strategic action plan. Although supply reduction measures had been developed, there was a lack of a cross-prison approach and targeted interventions.

Independent Monitoring Board

23. 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 February 2017 the Board reported that, overall, the range of healthcare provision including mental health, substance misuse and the arrangements for social care compared well with services available to the general population. However, the report also stated that the impact of drugs and violence at HMP Moorland was a major concern as it led to debt, bullying and serious damage to health and property.

Previous deaths at HMP Moorland

24. Mr Dillon was the fourth person to die of self-inflicted causes at HMP Moorland since January 2015. Although we made no similar recommendations in any of these cases, we did comment on the misuse of medication and drugs.

Key Events

25. In 2008, Mr John Dillon received a nine year sentence for sexual offences. In December 2011 he received a further sentence of three years and six months for a separate sexual offence. He was transferred to HMP Moorland on 18 January 2016.
26. He had a long-term diagnosis of schizophrenia (that was managed with aripiprazole - an antipsychotic) and acid reflux (that was managed with omeprazole). He also had a history of alcohol dependency and substance misuse. While in Moorland, Mr Dillon did not access the substance misuse services, and the prison had no intelligence or record that he was involved in misusing substances. There was, however, intelligence suggesting that Mr Dillon had previously been involved in trading illicit drugs including tobacco when he was at HMP Hull.
27. On 26 February, the prison's GP saw Mr Dillon as he was complaining of a sore throat. He initially, treated this as a viral infection, but when it did not improve after several weeks of treatment, on 12 April he made an urgent referral for suspected cancer to an ear nose and throat (ENT) specialist. The NHS pathway requires patients with suspected cancer to be seen by a specialist within two weeks.
28. On 27 April, Mr Dillon attended an appointment with an ENT specialist at a hospital. The hospital booked him for a subsequent computerised tomography (CT) scan and for further investigations. Before these could take place, Mr Dillon became unwell and was admitted to the ENT department on 18 May. Hospital doctors detected what they believed to be anaplastic thyroid cancer. (This is a form of thyroid cancer with a very poor prognosis due to its aggressive nature and resistance to treatment.) This diagnosis was confirmed on 23 May. A consultant said the cancer was inoperable but Mr Dillon received chemotherapy to shrink the tumour.
29. On 1 June, Mr Dillon returned to Moorland. A mental health nurse and a community psychiatric nurse met him to confirm that he understood his diagnosis and treatment plan. The mental health nurse recorded that Mr Dillon appeared positive, and accepted the possibility that he might be terminally ill.
30. On 8 June, a nurse met Mr Dillon and discussed the plans for his treatment. The prison held multidisciplinary team (MDT) meetings, which Mr Dillon sometimes attended.
31. A mental health nurse monitored Mr Dillon's mental health over the following weeks while he underwent chemotherapy. She noted that he appeared accepting of his condition, and understood what was happening to him. He never reported any intention of self-harm or suicide, sometimes stating, "The cancer is doing it for me".
32. On 20 June, Mr Dillon had a reaction to the chemotherapy and his airway became obstructed. He had a tracheostomy (an opening into the windpipe to assist breathing) inserted at a Hospital, and a PEG tube fitted at another hospital on 19 August. (This is a tube that is passed into the stomach to provide a means

of feeding when a patient is unable to swallow.) This was to assist with administering chemotherapy and radiotherapy treatment.

33. On 14 September, a nurse noted in Mr Dillon's records that swallowing was becoming difficult for him, and she did not think he would be able to tolerate taking medication orally for much longer. She requested a tablet crusher, and some medications in liquid form. Two days later a prison GP made a note to change Mr Dillon's tramadol (a painkiller) to a pain relief patch (fentanyl), and pregabalin (used to treat anxiety) to its liquid form.
34. Mr Dillon asked for a soft diet and eight Fortisip (nutritional drinks) a day because of his difficulty swallowing. A prison GP declined to increase the prescription of Fortisips as Mr Dillon was still eating soft food.
35. Despite problems swallowing, on 23 September Mr Dillon asked to go back on to pregabalin tablets, saying that the hospital had suggested it. A prison GP changed the medication to tablet form but asked the pharmacy to ensure Mr Dillon was checked, in case he was requesting tablets in order to trade them illicitly with other prisoners. There is no record by healthcare staff that Mr Dillon ever tried to secrete these tablets.
36. On 26 September, Mr Dillon told a prison GP that he did not want to receive any further treatment. Records show that Mr Dillon was fully aware of how the cancer would progress and of the consequences of his decision. A prison GP confirmed that Mr Dillon had the mental capacity to make this decision, although he arranged for an appointment with the mental health team to discuss the decision in more detail.
37. On 27 September, Mr Dillon told a mental health nurse that if he were not granted early release on compassionate grounds (ERCG), then he would prefer to remain in the prison, in a familiar place, with people he knew. She also discussed Mr Dillon's decision to stop treatment and concluded that he had the capacity to make this decision. His medical records note he discussed this with a consultant in hospital, and Mr Dillon is recorded as saying that he had thought about it for many weeks and had not taken the decision lightly. He did not want to continue with treatment and would not change his mind. On 30 September, the consultant confirmed that Mr Dillon's illness was terminal and that he could live for anything from four months to a year.
38. The same day, Mr Dillon reported to a nurse that he did not think the pain relief patch (fentanyl) was working and he wanted to be given tramadol tablets again. She discussed the difficulty in swallowing them because they were large tablets, but Mr Dillon said he would be able to swallow them.
39. On 17 October, a prison GP discussed 'A Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) order with Mr Dillon. Mr Dillon said he did not want to be resuscitated in the case of cardiac arrest caused by disease progression, but did want to be resuscitated if cardiac arrest was caused by a blocked tracheostomy tube. The form was placed in his cell, his medical file and the wing office so that those involved in Mr Dillon's care were aware of this decision.

40. Mr Dillon said he found it difficult to swallow paracetamol tablets even if they were broken in half so, on 21 October, he was given dissolvable tablets. On 23 October, Mr Dillon reported to a prison GP that he was having difficulty eating, even a soft and liquid diet. The doctor increased his prescription of Fortisip, and noted that Mr Dillon could be fed through the PEG tube if eating became too difficult. He, nevertheless, also requested that all his medication be dispensed in capsule form for the time being. On 28, a nurse requested liquid pregabalin again, because Mr Dillon coughed up a tablet after taking it. Mr Dillon also used a tablet crusher for his other tablets, to enable him to be fed through the PEG tube.
41. Weekly multi-disciplinary (MDT) meetings took place and, on 1 November, a Matron told the team that there had been a marked deterioration in Mr Dillon's health and he now had a prognosis of four months. Mr Dillon remained independent in respect of his personal care needs but both medication and food were administered using the PEG tube. At this meeting, an advanced care plan was developed, taking Mr Dillon's wishes into consideration.
42. Over the next month, Mr Dillon's health deteriorated further and prison and healthcare staff continued to support him. On 3 December, a Matron noted that Mr Dillon might be giving his Fortisip drinks away to other prisoners and that this should be monitored. He sent an email to colleagues to this effect.
43. On 11 December, at about 8.00am, a nurse was asked to visit Mr Dillon on the wing as officers were concerned they could hear a buzzing noise coming from his cell. She did not hear any buzzing, and the source of the noise was never established but, looking through the observation panel, she noted that Mr Dillon was of good colour, his chest was moving visibly, and that he was asleep on his bed. Staff decided that the cell did not need to be opened.
44. At 9.22am, after unlock, a prisoner told an officer that Mr Dillon was unresponsive in his cell. The officer went straight to Mr Dillon's cell, and called a code blue. (This is an emergency code used to indicate breathing difficulties.) A nurse responded and called for assistance from a senior nurse. Both nurses confirmed that Mr Dillon's tracheostomy tube was not blocked. They also noted that his pulse was irregular, that his pupils were fixed and dilated and his breathing was shallow.
45. Paramedics arrived at Mr Dillon's cell at 9.37am. A nurse explained his diagnosis to them, and that a DNACPR was in place. Paramedic staff pronounced Mr Dillon dead at 9.50am.
46. After Mr Dillon's death, a prisoner reported to a prison officer that two other prisoners had been selling Mr Dillon their prescribed medication. The prisoner later reported to police that the prisoners had helped to dissolve the drugs in water and poured this solution into Mr Dillon's PEG tube for him.

Contact with Mr Dillon's family

47. A family liaison officer (FLO) was appointed on 18 October 2016. Mr Dillon's family visited him in the prison on a number of occasions before he died, the last being 9 December 2016. It was agreed that when Mr Dillon could no longer

speak, he would write down what he wanted to say and the FLO would relay this information to the family. The FLO also agreed to call Mr Dillon's mother when he died.

48. When Mr Dillon died, the FLO telephoned Mr Dillon's mother and informed her of her son's death. He also spoke to Mr Dillon's brother. He visited them at home on 13 December, and offered condolences and support. The prison contributed towards the costs of the funeral, in line with national guidance.

Support for prisoners and staff

49. After Mr Dillon's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
50. The prison posted notices informing other prisoners of Mr Dillon's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Dillon's death.

Post-mortem report

51. The post-mortem concluded that Mr Dillon died as a result of mixed drug toxicity, in the context of advanced laryngeal squamous carcinoma (advanced throat cancer). This means that, although the levels of morphine, tramadol, amitriptyline, mirtazapine, and olanzapine were within therapeutic levels and would not necessarily cause death in a healthy person, they were sufficient to cause Mr Dillon's death because he was very ill.
52. Contributing factors to Mr Dillon's death were cardiac hypertrophy, which results in a decrease in size of the chambers of the heart, and pulmonary emphysema, which is a long-term, progressive disease of the lungs.

Findings

Clinical care

53. The clinical reviewer concluded that the care Mr Dillon received for his terminal illness was compassionate and equivalent to that he could have expected to receive in the community. However, there were shortcomings in the prescribing and monitoring practices of medications within the prison.

Medication management

54. Mr Dillon died from the effects of taking a number of medications including tramadol, amitriptyline and olanzapine, which he was not prescribed at the time of his death.
55. After Mr Dillon's death, the police conducted an investigation, in which the prison was involved. It became apparent that there was an arrangement operating on the wing on which Mr Dillon was living. Prisoners would swap items, including Fortisips and other medications. When the police searched Mr Dillon's cell after his death they found a number of unknown tablets and powders, as well as over fifty Fortisip bottles. Fortisip is a monitored drink, which is supposed to be provided by swapping an empty bottle for a full one at the medication hatch. Mr Dillon should only have had four bottles, the maximum daily allowance, in possession in his cell.
56. Interviews revealed that staff were aware of an excess amount of Fortisips in Mr Dillon's cell, of up to twelve bottles on occasions. Although staff said they watched him take his controlled medications, they admitted they were lenient with the Fortisips because of the nature of Mr Dillon's illness, and the difficulty he had in swallowing. With hindsight, it is clear that Mr Dillon was able to use the leeway he was given to enable him to trade Fortisips with other prisoners.
57. It seems possible that Mr Dillon traded Fortisip for other medications. Some of these are likely to have resulted in his overdose and death. No intelligence had been submitted, but warning signs went unremarked by staff.
58. When Mr Dillon had been at HMP Hull earlier in his sentence, there had been intelligence that he was trading illicit drugs. There was no intelligence of this kind at Moorland. Staff at Moorland said, however, that while they had no concrete concerns, they had had occasional suspicions that Mr Dillon might be misusing his medication because of things he said. For example, Mr Dillon told them he needed more Fortisips because he was still hungry, and, although he had problems swallowing, he said that he preferred pain relief tablets, rather than patches. (Tablets are easier to trade.) However, neither of these instances was recorded as intelligence. Staff said they were, though, alert to the risk of trading medication and took care to ensure Mr Dillon was not secreting his tablets when they were issued. There is no evidence that Mr Dillon was able to secrete any other controlled medication that he was prescribed.
59. The in-possession cell checks for medication in Moorland do not consider the risk of hoarding and do not align sufficiently with the prison's searching strategy. Prisoners are asked to present the medications they have in possession to

ensure that they tally with what the pharmacy calculates a prisoner should have. This does not address the risk of them concealing any additional holdings. To make a full search of a cell, checks must be intelligence-led. Moorland's Drug Reduction Strategy mentions irregular cell checks, but does not detail how these should happen.

60. We make the following recommendation:

The Governor and Head of Healthcare should ensure there is an effective drug strategy to reduce the trading of prescribed medication, which includes:

- **A greater emphasis on the risks from prescribed medication, and action to address the diversion of medication.**
- **Ensuring all staff understand the importance of the intelligence system for the effective management of risk and are properly trained to identify and submit intelligence.**

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