

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Budd, a prisoner at HMP Hollesley Bay, on 21 November 2023

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100

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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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.

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.

Mr David Budd died in hospital, on 21 November 2023, from lung cancer which had spread to other parts of his body, while a prisoner at HMP Hollesley Bay. He was 77 years old. I offer my condolences to his family and friends.

The clinical reviewer concluded that the clinical care Mr Budd received at Hollesley Bay was of a good standard and equivalent to that which he could have expected to receive in the community. I make no recommendations.

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

Adrian Usher
Prisons and Probation Ombudsman

August 2024

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Summary

Events

1. In August 2018, Mr David Budd was sentenced to eight years and four months imprisonment for sex offences. On 24 February 2023, Mr Budd transferred to HMP Hollesley Bay.
2. On 12 April, Mr Budd told a nurse that he had had a lump in his oesophagus (the tube that connects the mouth to the stomach) for the past three years. Mr Budd told the nurse that he had difficulty swallowing food. Mr Budd saw a GP and was referred to hospital for tests. The hospital found no evidence of cancer.
3. On 7 November, Mr Budd told the nurse that he had constant pain in his ribs, shoulders and knees. The nurse referred Mr Budd for an abdominal ultrasound and chest X-ray.
4. On 14 November, Mr Budd told an officer that he felt unwell and that he wanted to see a GP. A nurse saw Mr Budd and noted that he was pale, short of breath and was struggling to talk in full sentences. The nurse sent him to hospital.
5. On 20 November, hospital staff diagnosed Mr Budd with lung cancer which had spread to his liver and bones.
6. Mr Budd's condition rapidly deteriorated and he died the following day.

Findings

7. The clinical reviewer concluded that the clinical care Mr Budd received was of a good standard and equivalent to that which he could have expected to receive in the community.

The Investigation Process

8. HMPPS notified us of Mr Budd's death on 21 November 2023.
9. The investigator issued notices to staff and prisoners at Hollesley Bay informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
10. The investigator obtained copies of relevant extracts from Mr Budd's prison and medical records.
11. NHS England commissioned a clinical reviewer to review Mr Budd's clinical care at the prison. The investigator and clinical reviewer jointly interviewed three members of staff and a prisoner by video link and telephone between January and March 2024.
12. We informed HM Coroner for Suffolk of the investigation. He told us the cause of Mr Budd's death. We have sent the Coroner a copy of this report.
13. The Ombudsman's family liaison officer wrote to Mr Budd's daughter to explain the investigation and to ask if she had any matters she wanted us to consider. She asked why Mr Budd's cancer was not detected sooner, given that he attended healthcare and hospital many times in his last months of life. The clinical reviewer has addressed this question in their report.
14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.
15. Mr Budd's family received a copy of the draft report. They did not make any comments.

Background Information

HMP Hollesley Bay

16. HMP Hollesley Bay is a category D prison. Practice Plus Group are responsible for delivering healthcare. Primary care services are available on weekdays between 7.00am and 6.30pm, and at weekends between 7.00am and 5.00pm.

HM Inspectorate of Prisons

17. The most recent inspection of Hollesley Bay was in October and November 2018. Inspectors reported that the prison had continued to deliver good or reasonably good outcomes for prisoners. Prisoners with social care needs were identified and supported, however, there was no systematic way of identifying new needs during prisoners' time at Hollesley Bay. Primary healthcare services were easily accessible to all prisoners with an appropriate range of primary care services.

Independent Monitoring Board

18. 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 December 2022, the IMB reported that there was a culture within the prison that encouraged dignity and respect between staff and prisoners. The IMB found that at times Hollesley Bay lacked the facilities and staff to provide the necessary level of care prisoners required. The IMB were satisfied that the healthcare needs of prisoners were being met and commended the healthcare team for their hard work.

Previous deaths at HMP Hollesley Bay

19. Mr Budd's death was the first death at HMP Hollesley Bay since November 2020.

Key Events

20. On 23 August 2018, Mr David Budd was sentenced to eight years and 4 months imprisonment for sex offences. Having spent time in HMP Pentonville and HMP Littlehey, on 24 February 2022, he transferred to HMP Hollesley Bay.
21. Mr Budd had several pre-existing health conditions including chronic obstructive pulmonary disease (COPD- a lung disease), hypertension (high blood pressure), arthritis and glaucoma (eye disease which caused blindness in his left eye).
22. On 12 April 2023, a nurse saw Mr Budd, who said that he had had a lump in his oesophagus (the tube that connects the mouth to the stomach) for three years. He said that when he ate, he had to cough to dislodge food. She arranged for Mr Budd to see a GP operating at Hollesley Bay.
23. On 14 April, a prison GP saw Mr Budd. The GP requested blood tests and referred Mr Budd to the upper gastro-intestinal team under the two-week-wait NHS pathway, which requires patients with suspected cancer to be seen by a specialist within two weeks.
24. On 5 May, Mr Budd went to hospital for a gastroscopy (an examination of the inside of the throat, oesophagus and stomach).
25. On 11 May, a prison GP noted that Mr Budd had duodenitis (inflammation of the duodenum, the first part of the small intestine).
26. On 30 June, Mr Budd's gastroscopy showed that he had a four-centimetre hernia (where an organ pushes through an opening in the muscle or tissue holding it in place) and an oesophageal ring (an abnormal ring of tissue that forms where the tube from the mouth to the stomach meet). The hospital staff found no evidence that he had cancer.
27. On 30 September, Mr Budd told a nurse that he had had food lodged in his oesophagus since the previous day and that it had never lasted this long before. Mr Budd said that he vomited whenever he tried to swallow food or fluids. He vomited in the healthcare department. The nurse sent Mr Budd to hospital. Hospital staff removed the food from his oesophagus and gave him IV fluids. On 2 October, Mr Budd returned to Hollesley Bay.
28. On 2 November, Mr Budd told a GP that he had pain in his shoulders, knee and groin. He said he might have overdone it and planned to rest. The GP examined him, prescribed him painkillers and told him to tell healthcare staff in one week if his pain did not improve.
29. On 7 November, Mr Budd attended healthcare and saw an Advanced Nurse Practitioner (ANP). Mr Budd told her that he had been unwell for a few weeks and had constant pain in his ribs, shoulder and knees. She noted that he was short of breath, had a reduced appetite and had lost weight. She requested blood tests.
30. On 9 November, the ANP told Mr Budd that she had referred him for an abdominal ultrasound and chest X-ray and that cancer could not be ruled out.

31. On 11 November, prison staff moved Mr Budd to Blything Unit as a 'disability move'. Blything Unit accommodates prisoners with social care needs and prisoners accessing support from Phoenix Trust (a substance misuse service). There are also prisoners on the unit that are allocated to be carers for other prisoners. No further details about why this move took place were recorded. The ANP told us that she was unaware that Mr Budd had moved. A Supervising Officer (SO) told the investigator that when a prisoner moves to a new unit for medical reasons, information is shared with prison officers on a need-to-know basis.
32. After the move, prison staff allocated Mr Budd a carer. Prisoner A, and Mr Budd's carer, told the investigator that Mr Budd was unwell and in pain. He said that he told prison staff that Mr Budd was not eating his meals. He said that he helped Mr Budd wash his clothes because he had urinated in them, collected his meals and gave him clean bedding. He said staff had not told him how much care Mr Budd needed before he met him.
33. An officer worked on Blything Unit between 11 and 13 November. Generally, only one officer works on the unit at a time. He told the investigator that Mr Budd was constantly incontinent during the day and night, and he noticed a strong smell of urine coming from him. He was unsure how to approach the situation as he was a relatively new member of staff, so emailed his Custodial Manager (CM). The CM told him to speak to healthcare staff. The officer said that he informed healthcare staff but could not recall how he did this nor is there any evidence that he did. He said that Mr Budd was not bedbound and used his mobility scooter to collect his lunch but seemed incoherent, confused and unaware of his surroundings.
34. On 14 November, Prisoner A asked an officer to speak to Mr Budd because he was unwell. An officer noted that he saw Mr Budd in his room because he was late for the morning roll check. (During morning roll checks, prisoners have to sign in at the office between 7.00am and 8.00am.) Mr Budd asked the officer if he could see a GP as he had been unwell for five months. At approximately 9.05am, an SO saw Mr Budd and telephoned healthcare to see Mr Budd as soon as possible.
35. A nurse saw Mr Budd in his room and noted a strong smell of urine. Mr Budd told her that he had chest, shoulder, back and knee pain and was unable to move to go to the toilet. She noted that Mr Budd's carer told her that he had been in this condition since arriving on Blything unit. She noted that the carer had tried to clean him, but he was in too much pain when he tried to move him.
36. The nurse examined Mr Budd and noted that he was pale, had shortness of breath and difficulty talking in full sentences. The nurse noted that Mr Budd's National Early Warning Score (NEWS – a tool to detect and respond to clinical deterioration) was 4 (a low clinical risk). The nurse asked the ANP to review Mr Budd because she was concerned about his health.
37. The nurse told the investigator that when she last saw Mr Budd in September, he was independent and mobile and by this stage he had lost weight and looked like a different person.
38. At approximately 11.00am, the ANP saw Mr Budd in his room. She noted that Mr Budd was lying naked in bed with a coat covering his lower body. He smelt strongly of urine, and she saw urine stains on the bed. She noted that Mr Budd

looked unwell, dehydrated, pale and in pain. He said he had not eaten for two days as he had no appetite. He said he had “terrible pain” all over and it was the worse he had ever felt. She asked an officer to call an ambulance. She stayed with Mr Budd for two hours until paramedics arrived at 12.55pm and took Mr Budd to hospital. He was not restrained.

39. On 20 November, hospital staff told Mr Budd that he had lung cancer which had spread to his liver and bones. The next day at 12.18am, Mr Budd died.

Contact with Mr Budd’s family

40. Hollesley Bay appointed a CM as the Family Liaison Officer. Mr Budd did not want his family to be told he was in hospital. The CM contacted Mr Budd’s daughter on 21 November to inform her of his death. The prison contributed to funeral costs in line with national policy.

Support for prisoners and staff

41. The prison posted notices informing staff and prisoners of Mr Budd’s death and offered support. The Head of Safety, Inclusion and Diversity arranged for Listeners (prisoners who are trained by the Samaritans to listen and provide emotional support) to support prisoners on Blything and Plomesgate Units (where Mr Budd had previously been located).

Cause of death

42. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Budd’s cause of death as metastatic lung cancer.

Inquest

43. The inquest, held on 29 July 2024, concluded that Mr Budd died from natural causes.

Findings

Clinical Care

44. The clinical reviewer concluded that the clinical care Mr Budd received at Hollesley Bay was of a good standard and equivalent to that which he could have expected to receive in the community. On 7 and 9 September, when Mr Budd attended healthcare feeling unwell, the clinical reviewer noted that healthcare staff completed blood tests and referred him for the appropriate scans and X-rays.

Governor and Head of Healthcare to note

Recording and communication of information

45. It is clear that Mr Budd was not very well on 7 November when the ANP assessed him. However, the clinical reviewer is satisfied that the nurse took appropriate action at this point.
46. Mr Budd moved to Blything Unit on 11 November as a “disability move”. No further details of the reasons for this move are recorded so it is not possible to determine Mr Budd’s state at the time or who requested or arranged the move and Mr Budd’s carer. However, his carer said that he was incontinent, not eating, unwell and in pain. An officer also said Mr Budd was incontinent, incoherent, confused and unaware of his surroundings. The officer said that he told healthcare staff about Mr Budd’s condition, but he did not record his contact with healthcare staff anywhere. Healthcare staff we spoke to said they were unaware that Mr Budd’s health had deteriorated until an SO told them on 14 November.
47. Over the days before Mr Budd went to hospital for the final time, staff did not adequately record information about his health or decisions made about his location. There is also little evidence of satisfactory communication between prison and healthcare staff about Mr Budd during this period.
48. The clinical reviewer could not say if a transfer to hospital earlier than 14 November would have made any difference to the outcome for Mr Budd. He had undetected lung cancer with secondary cancers also present. However, she concluded that if Mr Budd’s deterioration had been escalated sooner, this would have provided better symptom management and pain relief in hospital.
49. The Head of Healthcare told the investigator that prison officers are good at communicating concerns about a prisoner’s health issues to healthcare staff. In a subsequent death at the prison in January 2024, we have no initial concerns about prison staff raising concerns about the prisoner’s health to healthcare staff. We therefore do not consider this to be a systemic issue but bring this to the Governor and Head of Healthcare’s attention.

Prisoner carer

50. Prisoner A demonstrated a high degree of empathy, care and compassion for Mr Budd, whom he had only just met. He tried to assist him washing his clothes when he had been incontinent, got him clean bedding and collected his meals. This is to be commended. The Governor may wish to formally recognise his efforts.



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