Investigation into the death of a man in June 2011 at John Radcliffe Hospital whilst in the custody of HMP Bullingdon

Report by the Prisons and Probation Ombudsman for England and Wales

January 2012

This is the report of an investigation into the death of a prisoner at HMP Bullingdon, who died at the John Radcliffe Hospital, Oxford. I would like to offer my condolences to his family and friends for their loss.

One of my investigators conducted the investigation into the man's death. I would like to thank the Governor of Bullingdon and his staff for their co-operation and assistance with the investigation.

Oxfordshire Primary Care Trust (PCT) was asked to review the standard of healthcare given to the man while he was in custody. The clinical reviewer conducted a review on their behalf and I am grateful for his assistance.

The man's diagnosis of lung cancer was confirmed on 24 March 2011. In discussions with consultants at the Churchill Hospital in Oxford, he decided to undergo lung surgery, which took place on 15 June. Unfortunately, he did not fully recover from the surgery.

In his clinical review, the clinical reviewer concludes that the care afforded to the man at Bullingdon was equal to that of which would have been expected in the community. This is commendable, but I do note that – despite his evident frailty and the advice of healthcare professionals, the man was required to wear double handcuffs as a security measure before being allowed to attend outside hospital. He refused and, therefore, missed two appointments. While the clinical reviewer did not consider that this made a difference to the man's health, it would have been distressing and was disproportionate. Accordingly, I recommend that risk assessment of prisoners' escort arrangements are better conducted in future.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2012**

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SUMMARY

1. The man was convicted on 22 October 2010 and taken into custody at HMP Bullingdon. On 11 November, he saw the prison doctor complaining of abnormal weight loss. Arrangements were made for him to have an X-ray. A week later, the results of the X-ray revealed a small lesion on his lung. The doctor referred him to a specialist at the Churchill Hospital. At the time of the referral, he was told that he could have lung cancer.

2. On 29 November the man was seen by a chest consultant at the hospital who arranged for further tests and a scan to be taken. On 13 January 2011, he refused to attend hospital for his scan as escorting staff said that for security reasons he would require to be double cuffed. (Double cuffing is where two sets of handcuffs are used. One set is applied to each of the prisoner's wrists and one cuff of the second set is attached to the prisoner and the other cuff to one of the escorting officers.) The man told staff that if he was to be double cuffed he would be unable to walk, as he had mobility problems and used crutches or walking sticks to move around.

3. A new appointment was made for the man the following week, but again staff said he could only attend if he was again double cuffed. The man refused to attend his hospital appointment for a second time. The man's scan eventually took place on 24 February, un-cuffed. He returned to the hospital for an appointment with the consultant on 10 March and was diagnosed with lung cancer on 25 March. The man attended several more appointments with his consultant and eventually elected to have surgery for the removal of part of his lung. The man's surgery took place on 15 June, but due to complications he died in the John Radcliffe Hospital.

4. The clinical reviewer concludes that the care the man received at the prison was comparable to that which he would have received in the community. Therefore, we make no recommendations with regard to his care at the prison. However, there is a recommendation with regard to the two appointments that the man missed at hospital as a consequence of the prison's escort risk assessment.

THE INVESTIGATION PROCESS

5. The investigation into the man's death was opened on 29 June, when one of my investigators spoke with the Deputy Governor. Notices announcing the investigation to staff and prisoners were also issued. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to the investigator. No one came forward as a result of these notices.

6. The investigator visited Bullingdon on 1 September, to conduct four interviews with members of staff. Although the investigator did not meet with the governing Governor, he provided feedback to the prison's liaison officer. This was subsequently confirmed in writing to the Governor.

7. A review of the man's clinical care in custody was undertaken by the clinical reviewer, who was appointed by Oxfordshire PCT. We are grateful to the clinical reviewer for his assistance in this matter.

8. One of the Ombudsman's family liaison officers spoke on the telephone with the man's partner. He explained the purpose of the investigation and asked the man's partner if they had any concerns about the care he received whilst in prison. The man's partner said she was concerned that he was not allowed to use the toilet during a visit, without cutting the visit short. The investigator asked the Head of Security, about arrangements for prisoners to use the toilet during a visit and the governor confirmed it was the prison's policy. However, she explained there were exceptions based on prisoners' individual needs. For example, if there was evidence from healthcare to say that the prisoner's medical condition required frequent use of the toilet, he could return to the visit afterwards. She said that there was no evidence from healthcare that the man had any special requirements and the investigator could find no evidence in his medical records to support this either.

HMP BULLINGDON

9. HMP Bullingdon is a large local Category B, training prison in Oxfordshire, accommodating convicted and un-convicted adult male prisoners. The prison is made up of six wings or units which are made up of single and shared cell accommodation.

10. Healthcare at the prison is provided by Oxfordshire Primary Care Trust (PCT). There is a 24 bed inpatient facility which is staffed throughout the day and has two nurses on duty during the night. An outpatients' facility delivers a daily assessment system referring prisoners to a doctor as necessary. A doctor is available every weekday and there is an on-call system during weekends and at night.

11. There has been one previous natural cause death in custody at the prison since 2009 and one since the death of the man. There appear to be no similarities between the circumstances of these deaths and that of the man.

Independent inspection and monitoring

12. HM Chief Inspector of Prisons inspected Bullingdon in July 2010. Although he reported that the prison delivered reasonably good outcomes for prisoners, he reported that the current GP contract had led to unacceptable delays in GP access and that staff vacancies were affecting healthcare services. He said that there was no nurse triage (the process of sorting people's need for medical treatment based on need), in place, although there had been some increase in nurse-led clinics. He also reported that clinical governance, a systematic approach to maintaining and improving the quality of patient care within a health system, was acceptable but consultation with patients was underdeveloped.

13. The Independent Monitoring Board's (IMB) annual report 2009/10 reported that overall they were satisfied with the standard of the prison management, treatment of prisoners and facilities provided. The Board raised serious concerns with the poor provision of education and healthcare, provided by outsourced contracts. It was their view that although this was deeply worrying because of the impact on prisoners, these issues were not of the prison's making. (IMB members are independent and unpaid. They monitor day to day life in the prison to ensure that proper standards of care and decency are maintained.)

Categorisation

14. All adult male prisoners are classified on reception into prison and put into one of four security categories based on the likelihood of escape and the risk to the public if they did escape. The categories are: Category A: prisoners require the highest security and who would be highly dangerous to the public, police or national security if they were to escape. Category B: prisoners for whom the highest security conditions are not necessary, but for whom escape needs to be made very difficult. Category C: prisoners who cannot be trusted in open conditions but who are unlikely to make a determined escape attempt. Category

D: open conditions, prisoners who can be trusted not to try and escape.

Escort Risk Assessment

15. On each occasion a prisoner is escorted outside the prison, a risk assessment is undertaken to consider the risk to the public, potential for escape and likelihood of outside assistance. The assessment informs the decision about the number of escorting officers and the type of restraint to be used (single cuffs, double cuffs or two metre long escort chain with a cuff at either end). It also determines the circumstances and the authority required for the restraints to be removed. The risk assessment is reviewed each day that a prisoner is in hospital and amended where necessary.

Bedwatches

16. Any prisoner required to remain in hospital is escorted and monitored by prison officers under the 'Bedwatch' procedures. Officers remain at the bedside and record any significant changes or events. Bedwatch is subject to a risk assessment process, whereby the Governor decides the number of officers required to stay with the prisoner.

KEY EVENTS

17. On 14 April 2010, the man was arrested and remanded into custody at HMP Bullingdon charged with a number of sexual offences. Having been released on bail on 24 June 2010, he was convicted on 22 October and was taken back into the custody of Bullingdon.

18. Whilst at the prison, the man received treatment for Type 2 Diabetes, (a long-term condition caused by too much glucose in the blood), Chronic Obstructive Pulmonary Disease (COPD, a term used for respiratory conditions, where there is a narrowing of the airways) and arthritis, all of which he had been receiving treatment for in the community. It was also noted that he had difficulty walking long distances without a stick and was a smoker. Although medical staff wanted to admit him to the prison's healthcare unit for the monitoring of his diabetes, he signed a disclaimer refusing to be admitted.

19. Having made a request to see the prison doctor, the man was seen by the prison doctor on 11 November. The doctor noted that the man had been suffering from abnormal weight loss and upon examination noticed 'clubbing' and decolourisation of his fingers. (Clubbing is a deformity of the finger nails which can be associated with serious illness.) An X-ray and blood tests were taken, and the doctor arranged for him to return the following day for a further assessment. However, the man chose not to return for his appointment the next day.

20. On 18 November, the prison doctor realised that the man had not returned for his follow up appointment. On reviewing his results, the prison doctor noted that his chest X-ray showed a two centimetre, lesion on his lung. The doctor made a referral under the 'two week rule' for him to be seen at hospital. (The two week rule is the target maximum wait from urgent GP referral to first outpatient appointment for all urgent suspected cancers.) The doctor said that the man was aware that his referral to hospital was as a consequence of suspected lung cancer. The following day, he was offered smoking cessation classes at the prison's asthma clinic, but he said he was not interested.

21. The man was seen by the consultant chest physician at the Churchill Hospital, Oxford, on 29 November. In view of his symptoms, the doctor recommended further investigations, including a computerised tomography scan, more commonly known as a CT scan. (A CT Scan uses X-rays and a computer to create detailed images of the inside of the body.) The investigator was unable to find any documentaion or evidence to confirm whether a risk assesment was completed for this transfer of the man to hospital.

22. During his time at Bullingdon, the man appears to have settled well into prison life and to have adhered to the prison's regime. According to a note in his prison record dated 3 December: "the man getting on well – uses care orderlies as he has mobility issues to get lunch dinner and whenever he needs to get around."

23. On 22 December, a member of the healthcare administration team completed the healthcare section of the prison escort risk assessment in preparation for the man's attendance at hospital for a CT scan. She wrote on the form, "Still has the ability to escape" and indicated that there were no medical objections for the use of restraints. She told the investigator that when completing the assessment she would base the risk on information available to her in the prisoner's electronic medical record, also known as 'SystmOne'. Once the healthcare section has been completed with relevant information, the risk assessment must be authorised by a governor.

24. On 12 January 2011, the Head of Operations, assessed that the man should be escorted by two officers and be doubled cuffed to go to hospital. Although the man had been convicted, he had not been sentenced and therefore remained an uncategorised prisoner. All uncategorised prisoners are treated as Category B prisoners for security arrangements, and therefore are double cuffed for movements outside the prison. A Person Escort Record (PER) competed the same day noted that his use of crutches and that caution should be used with regard to the use of cuffs. (A PER accompanies prisoners on all journeys from and between prisons. It serves as a communication tool about risks a prisoner poses on escort or transfer.)

25. On 13 January, the man refused to attend his hospital appointment because he was told by officers that during the journey to hospital he would be double cuffed. He explained that he would not be able to walk if he was double cuffed, because he used crutches. The man signed a disclaimer for refusing to attend his appointment.

26. Another appointment with the consultant chest physician was arranged for the following week, on 20 January. However, once again the man refused to attend as he was told that he would be double cuffed during the escort. A note in his medical record made by the member of the healthcare administration team says:

> "Patient was supposed to attend the hospital again today but we had more issues relating to him being double cuffed. I specified on the risk assessment paperwork that he walks with a crutch, but staff still tried to coming to healthcare and discussing it with a doctor the escort was cancelled. I have complained to the security SO about this and he said that they will facilitate sending patient out as an extra as soon as I can get another appointment."

27. The member of the healthcare administration team told the investigator that she was absolutely certain that she completed a new risk assessment for the man's appointment on 20 January, as she wrote in his medical record. In the second risk assessment, she concluded that he should not be cuffed. Although, the investigator requested all risk assessments relating to the man from Bullingdon, her second risk assessment was not found. Senior Officer (SO) A, one of the reception officers who dealt with the man when he refused to attend his second hospital appointment, also confirmed with the investigator that a risk assessment was completed for the escort on 20 January, which noted the

man's mobility issues, but still concluded that he should be double cuffed.

28. In a similar entry the prison doctor noted in the medical record,

> "Note events today!! I was called earlier today at 13.40pm about this patient form Nurse A in in-patients. I told her specifically that the patient walked with crutches and does not need to be double cuffed – he is quite frail. Being in for severe lung disease / possible lung cancer – and that I would be on E wing shortly as usual for my clinic. I informed her I was prepared to sign any document to confirm these requirements. I arrived on E wing at 13.50pm to sign alleged documents. Officer said that I would have to go to security but the patient was still on the wing. He contacted security to confirm that I was authorising that he was still to go out. I continued my usual E wing clinic expecting the forms to be signed to come to me when they took the patient. But I see the patient never went out!!"

29. SO A wrote on the PER for the man's transfer that he "refused to be double cuffed" and that healthcare and security had been informed. The SO also noted that "the head of security was aware and still insisted he be double cuffed." The head of security told the investigator that she could not recall having a conversation with SO A about the man's escort or any difficulties about cuffing. She said:

> "Had I been notified I would have changed the risk assessment, I would have made comments on the risk assessment and explained why the risk assessment was changing. I wouldn't have ignored advice from healthcare and I wouldn't have ignored advice from a doctor."

During interview, SO A said that he was mindful of the man's mobility issues. In consultation with other officers, he contacted security to resolve the situation. He said:

> "When I went upstairs to clarify this, they [security] said that there was no latitude and I had to abide by the risk assessments that he had to remain double cuffed throughout the period of the escort…"

30. On 24 February, the man attended the chest clinic in hospital and had a CT scan. On 10 March, he returned for a further appointment at the clinic. (Due to there being no available paperwork relating to these transfers we are unable to confirm what type of escort arrangements were put in place. However, given that the man attended it is to be assumed he was not double cuffed on these and future attendances at hospital.) On his return to prison, he told nursing staff that he had been told that he had possible lung cancer. It was noted on his medical record that staff at the hospital were to complete a full review of his CT scan at the following chest clinic meeting. On 25 March, his diagnosis of a primary lung carcinoma (cancer) was confirmed in a letter to the prison and a PET scan was requested. (A PET scan or positive emission tomography scan is used to produce a detailed, three-dimensional picture of the inside of the

body and is used to diagnose a range of cancers and work out the best ways of treating them.)

31. The man attended the Churchill Hospital for his PET scan on 14 April and on his return to the prison remained in the healthcare unit for 24 hours under observation by healthcare staff. In a letter dated 21 April, the consultant chest physician confirmed to the prison that the PET scan confirmed that the man had non-small cell lung cancer. The consultant advised the prison that there would be a further review of potential treatment with surgeons from the hospital in three weeks time and the man would be expected to attend.

32. On 12 May, the man attended hospital once again and was seen at the chest clinic and a lung clinic. In a letter on 17 May, the hospital confirmed to the prison that they had explained possible treatments to the man, along with the associated risks. The letter advised that the man had elected to have surgery. An appointment for the surgery was made for 7 June, however this was later cancelled by the hospital and a new date for his surgery was confirmed for 14 June.

33. Following surgery on 15 June, the man suffered from a collapsed lung and was moved to the Intensive Care Unit. Unfortunately, his condition deteriorated and he died in hospital.

34. Members of the man's family spent time with him on the afternoon of his death, but were not present when he died that evening. The prison's family liaison officer had previously been in contact with the man's family. She rang his partner the following day to offer her condolences and explain the processes that would follow. She also advised that the prison would make a contribution to the man's funeral expenses.

ISSUES

Clinical Review

35. Oxfordshire Primary Care Trust (PCT) was asked to review the standard of healthcare that the man received whilst he was in the care of Bullingdon to ascertain whether or not it was equitable to that he would have received in the community. In his review the clinical reviewer, concludes:

> "The man's medical care while in HMP Bullingdon was good and equal to that which I would expect in the community. In particular the care provided by the prison doctor appears to have been very good … The medical care of the man while in HMP Bullingdon was of a good standard and in no way contributed to his untimely post-operative death."

Cancelled medical appointments due to escort arrangements

36. However, in his clinical review the clinical reviewer highlights that:

> "The man missed two appointments because of his escort insisting on double cuffing, despite him using crutches and the prison doctor clearly saying that double cuffing was not necessary."

The clinical reviewer goes on to say that:

> "This short delay, although distressing, would have made no physical difference to the man's health."

37. Clear guidance with regard to the type of restraints to be used during escorts is detailed in the National Offender Management Service's National Security Framework. The section on restraints on prisoners attending for medical treatment outside the prison requires their removal:

> "if the prisoner's medical condition renders restraints inappropriate or a risk assessment demonstrates they are unnecessary in all the circumstances. Restraints will not normally be necessary when the prisoner's mobility is severely limited, e.g. when he or she is on crutches.)

38. Having missed his first hospital appointment on 13 January, the member of the healthcare administration team completed another risk assessment in preparation for the man's appointment on 20 January. She said she specified on the assessment that the man walked with crutches but despite this staff still tried to double cuff him. In her entry in the man's medical record she noted that instead of discussing the issue with healthcare, security staff took the decision that, as the man refused to be double cuffed, he would not be able to attend his appointment.

39. The problems relating to the man's transfer to hospital were also brought to the attention of the prison doctor. Although it is unclear exactly what happened with regard to subsequent communications between staff, and who was in contact with who, the prison doctor clearly gave the instruction that as the man walked with crutches, and was quite frail, there was no need for him to be double cuffed.

40. SO A confirmed with the investigator that he and other officers working in reception could see that the man had difficulty in walking. The SO mindful of the man's mobility issues made further enquiries, telling the investigator that he would not have ignored the advice from healthcare, by contacting security. However, staff's efforts to let the man attend hospital without being double cuffed were blocked by security staff. The SO said that the answer from security was no, and that the man was to remain,

> "… double cuffed due to the fact they had very little information to base a further in-depth risk assessment on him because he was just coming into the prison and he was unclassified at that point."

41. Given the man's age, limited mobility and poor health, the risk of his escape was clearly limited. It is appreciated that this had to be weighed against the nature of the man's offence and the associated risk to the public. However, the evidence from both health professionals and experienced reception officers makes clear the man experienced mobility issues. This information was clearly relayed to security for further consideration but the decision was taken that he must be double cuffed, he therefore refused to attend his second appointment. Given the information available to security staff, both anecdotal and evidential, we believe that on this occasion the decision to double cuff was excessive.

42. The clinical reviewer records that the missed appointments would have had no bearing upon the man's health, or of the ultimate outcome, but recognises that it would have been distressing for the man. In future, the Governor should ensure that healthcare staff's contributions to escort risk assessments are taken into account in every case. As such, we make the following recommendation.

The Governor should remind all security staff undertaking risk assessments of the need to ensure that escort arrangements are proportionate and to take into consideration the opinions of health professionals.

CONCLUSION

43. The man's, diagnosis of lung cancer was prompt, once he presented himself to the prison doctors. However, he sadly died during subsequent treatment whilst in hospital.

44. The investigation agreed with the clinical reviewer's conclusions that the man received a good standard of medical care in custody which was equal to that to which he would have expected in the community. In light of the findings of this investigation, it is to be hoped that the Governor will review communication arrangements with healthcare when considering escort risk assessments.

RECOMMENDATIONS

1. The Governor should remind all security staff undertaking risk assessments of the need to ensure that escort arrangements are proportionate and to take into consideration the opinions of health professionals.

   Accepted – *This situation was picked up prior to the PPO investigation, All operational senior team who are responsible for the final completion of the risk assessments has been informed that escorting arrangements must always take into account the individuals mobility issues or opinions of the health professionals.*