

**Investigation into the death of a man in October 2007
following his release on temporary licence
from HMP Bullingdon**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

June 2008

This is the report of an investigation into the death of a man who was a prisoner at HMP Bullingdon. The man died in October 2007 at a hospice in Oxfordshire, with his mother at his side. I offer my sincere sympathy and condolences to the man's mother, and to all of those affected by the loss of her son.

The man had been diagnosed with cancer around five months before his death. He died shortly after being released on temporary licence. A post mortem examination was not carried out, as the Coroner's office was not informed of the man's death.

This investigation was carried out on my behalf by one of my colleagues. An independent review of the man's medical care in prison was carried out by the Oxfordshire Primary Care Trust. I am most grateful to the clinical reviewer for his assistance.

I would also like to thank the Governor and staff at Bullingdon for their full and ready co-operation during the course of the investigation. I am especially obliged to the Deputy Governor for the liaison that he provided.

The man died shortly after an application for his compassionate release was turned down by the Ministry of Justice. I make four recommendations and highlight three examples of good practice.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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SUMMARY

The man who is the subject of this report was received into HMP Bullingdon on 16 May 2007, having been arrested by his local police force on the same day. He had been released on licence from HMP Usk the previous year, and the licence was revoked following his arrest. On the same day as his arrest, the man had been discharged from a local hospital, where he had been diagnosed with suspected penile cancer.

The man attended an outpatients appointment at a different hospital on 22 May, at which the diagnosis was confirmed. He was admitted to this hospital on 10 June, and a penectomy (surgical removal of the penis) was performed the following day. The man developed an infection in his wound following the operation, and this was treated by antibiotics. Other than this he was as well as could be expected, and he did not complain of any pain. However, on 6 August 2007, he was urgently admitted to the hospital with suspected methicillin-resistant staphylococcus aureus (commonly known as MRSA). This was confirmed on 13 August, and the man remained in hospital until the end of the month for treatment.

In the days following his return to Bullingdon, the man reported that his left leg was swollen and slightly painful. He was still mobile, however, and able to walk around the healthcare centre (where he was now living permanently as an inpatient). On 20 September, he was reviewed by a prison doctor, who noted that the man's left thigh was red, hot to the touch and painful. The prison doctor arranged for the man to be admitted to hospital that day.

The man did not return to Bullingdon following this admission. A computerised tomography (CT) scan on 3 October showed that the cancer was now so widespread that chemotherapy was inappropriate.

On 15 October, the man moved to a hospice in Oxfordshire. An application for early release on compassionate grounds, which had been signed by the Deputy Governor on 11 October, was refused by the Ministry of Justice on 17 October. The reasons for the refusal were that the prognosis was uncertain and there was a risk that the man would re-offend were he to be released.

Following this refusal, an application for release on temporary licence was approved by the Governor on the morning of 23 October. Sadly, the man died just a few hours later, at 2.15pm, with his mother at his side.

The man suffered from a rare and unpleasant form of cancer. The clinical reviewer concludes he received sensitive and appropriate care from healthcare staff at Bullingdon. He does raise concerns about a three week period in July 2007 in which it appears the man was not reviewed by a prison doctor or nurse. However, he goes on to say that "there is no evidence that any harm resulted".

I make four recommendations, and highlight three areas of good practice.

THE INVESTIGATION PROCESS

1. The investigation was opened on 25 October 2007, when my investigator issued notices announcing the investigation to staff and to prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to my investigator. No prisoners came forward as a result.
2. My investigator was given access to the man's prison files, including the medical record. He visited Bullingdon on 12 February 2008, and interviewed one member of staff during the course of the investigation. An independent clinical review of the man's health needs whilst he was in custody was carried out by the Clinical Governance Lead at Oxfordshire Primary Care Trust.
3. My senior family liaison officer contacted the man's mother on 15 November 2007. She said that she had found the prison to be very helpful and had no issues that she wished the investigation to address. She spoke particularly of a prison nurse who visited the man in hospital with the prison's family liaison officer, and of whom he was fond. She asked that the nurse be recognised in the report. The man's mother also asked that the prison's family liaison officer be recognised for the help that she provided.

The kind and respectful way in which healthcare staff and the family liaison officer liaised with the man and his mother during the last weeks of his life should be formally recognised.

HMP BULLINGDON

4. HMP Bullingdon is located near the town of Bicester, Oxfordshire. It is a modern prison, accommodating up to 963 prisoners. There are five wings, made up of both single and shared cell accommodation. The majority of prisoners are category C, although some category B prisoners are received from the local courts.
5. Bullingdon has a 22-bed inpatients facility, with clinical care available at all times. The outpatients facility delivers a daily triage (assessment) system, referring prisoners to a doctor as necessary. Medication is also dispensed from the facility. A doctor is available for prisoners every weekday, and there is an on-call system at weekends and out of hours.
6. Her Majesty's Chief Inspector of Prisons, Ms Anne Owers, carried out an unannounced inspection of Bullingdon in 2004. She found a prison that had "visibly improved" since an inspection that had taken place two years earlier.
7. Many of the recommendations that Ms Owers had made regarding healthcare in the earlier inspection had been achieved or partially achieved. Notably, Ms Owers said that the regime in healthcare had improved. However, Ms Owers expressed concern about the length of the waiting list to see a doctor (this was two weeks at the time). She recommended an urgent review to address the situation.
8. This is the eleventh death to have occurred at Bullingdon since April 2004, when I began investigating all deaths in prison custody, and the seventh to have been due to natural causes. Although some also involved patients suffering from terminal cancer, there are few similarities in the issues raised in those cases to that of the man.

KEY FINDINGS

9. On 14 May 2007, the man was admitted to his local hospital with a fungating penile lesion (a growth on the penis). He was given a likely diagnosis of penile cancer.
10. The man was discharged from on 16 May. On the same day, he was arrested by the local police for a similar offence to those for which he had previously been imprisoned. His licence was revoked and the man was received into HMP Bullingdon that day.
11. The man was seen by a Healthcare Officer (HCO) on 16 May 2007, following his arrival at Bullingdon. The HCO completed a first reception health screen (a routine health screen for all new arrivals into prison) at which the man spoke of no health concerns other than his recent diagnosis. The man said that he was anxious about his medical condition, but was otherwise okay. The HCO admitted him to the healthcare centre overnight, for observation.
12. On the following morning, the man was seen by a Staff Nurse. He spoke of a family history of heart disease, and they discussed the probable diagnosis that he had been given. The nurse referred the man to a prison doctor and he was subsequently seen that afternoon.
13. The man told the prison doctor that he had first noticed the penile lesion around six months previously. He was taking antibiotics and the doctor renewed his prescription. She also passed the man as being fit for ordinary location. He subsequently moved from healthcare to a cell on E wing.
14. On 22 May, the man attended an outpatients appointment at a local hospital. A diagnosis of penile cancer and suspected lymph nodes (small organs that can trap cancer cells travelling through the body) was confirmed. The man was told that he would have to undergo a penectomy (surgical removal of the penis) on a date yet to be confirmed.
15. The man was scheduled for a review with a prison doctor on 24 May, but did not attend. On 29 May, he was admitted as an inpatient to the local hospital for a penile biopsy. The man was discharged on 31 May and admitted to the healthcare centre on his return on account of a wound to his penis that had resulted from the biopsy. He was seen by a prison doctor on his return and the wound was assessed.
16. The prison doctor saw the man again the following day, and passed him fit to return to E wing. The man said that he was able to dress his own wounds, and that his pain control (he was taking paracetamol and ibuprofen) was adequate.
17. On 10 June, the man was again admitted to the local hospital as an inpatient. A penectomy was performed on 11 June, and the man was

discharged to Bullingdon on 14 June. He was admitted to the healthcare centre on his return, for observation.

18. The man saw the prison doctor on the following day, and said that he was feeling well. The prison doctor assessed him as being fit to return to E wing, but the man remained as an inpatient until 18 June as there was no room on the wing.
19. The man returned to the local hospital on 21 June in preparation for a bilateral inguinal node dissection (an operation to examine the lymph nodes in the groin) scheduled for the following day. However, the operation was cancelled due to an infection in the man's wound, and he therefore returned to Bullingdon's healthcare on 26 June. He was prescribed a course of antibiotics to fight the infection.
20. The man's wound was assessed by a Staff Nurse on 28 June. She noted that it still looked to be infected. The nurse advised the man to make sure that he kept the wound dry most of the time. On 3 July, the man was assessed by a prison doctor and passed as fit to return to E wing. Again, however, there was no room on the wing, and the man therefore stayed in healthcare until 8 July.
21. On 23 July, the man was admitted as an inpatient to the local hospital. The procedure that had previously been postponed went ahead on 24 July, and the man was discharged on 3 August. On his return to Bullingdon he was again admitted to the healthcare centre as an inpatient, and was reviewed by a prison doctor.
22. The man was seen again by the prison doctor on 4 August, and said that he was feeling well and was not in pain. The doctor saw him again on the following day and noted that the man's wound was infected, reddened and painful. He prescribed a course of antibiotics.
23. The infection did not improve, however, and the wound on the man's groin was noted on 6 August to be very inflamed and firm to the touch. The prison doctor suspected methicillin-resistant staphylococcus aureus (commonly known as MRSA). He arranged an urgent admission to the local hospital for tests and the man was admitted on the same day. He was accompanied by two officers and cuffed to one by means of an escort chain (a long chain with a handcuff at both ends).
24. A Staff Nurse from Bullingdon visited the man at the local hospital on 9 August. He said that he was feeling well, apart from some discomfort to his wound. The nurse noted that the man was receiving intravenous antibiotics and daily dressings. She spoke to the Senior House Officer, who confirmed that they had been able to drain a lot of fluid from the man's wound and were hopeful that the antibiotics would prevent the need for further surgery. The Senior House Officer added that they were, at that stage, unsure of the man's prognosis.

25. On 13 August, it was confirmed that the man was MRSA positive. He therefore remained at the hospital until the end of the month for treatment. The man's cuffs were removed on 16 August, following a risk assessment.
26. On his return to Bullingdon on 30 August, the man was again admitted to the healthcare centre as an inpatient. He was reviewed by a prison doctor on 31 August, and told him that he was feeling better and had no pain. The doctor noted that the man's left leg was swollen. At his next review, on 2 September, the doctor noted that the leg was still swollen but not painful. However, on 3 September, the man said that his leg was now slightly painful. He was given paracetamol.
27. The man's wound was cleaned and dressed by nursing staff every day. He developed a cough and sore throat for a few days from 8 September, but otherwise his condition was stable. The man was still mobile, and able to walk around healthcare and carry out tasks such as collecting his own meals.
28. On 20 September, the man was seen in the morning by a Staff Nurse. The man told her that he had been getting hot flushes at night, and the nurse noted that his left thigh was red and hot to touch. She referred him to the prison doctor who saw the man later that morning. The doctor noted that the man's left thigh was painful, and arranged for him to be admitted to the local hospital.
29. The man arrived at hospital on the same day and was admitted as an inpatient. He was accompanied by two prison officers and cuffed to one by means of an escort chain. The escort was reduced to one officer on 21 September, and the chain was removed on 23 September at the request of an unidentified residential governor.
30. Healthcare staff at Bullingdon were in telephone contact with the man's ward every few days for updates on his progress. On 3 October he had a CT scan, the results of which indicated that the lymph nodes were enlarged and that cancer was widespread within the nodes. A Bullingdon nurse, who telephoned the ward on 4 October, was told that the man had been given a prognosis of around one month. This was disputed, however, on the following day when the man was visited by the Head of Healthcare. The Head of Healthcare was told by the senior registrar that the man's life expectancy was indeterminate and that he was unaware that anyone had given a prognosis of one month. It was also revealed that the man had a deep vein thrombosis (DVT, a clot that forms when the flow of blood is restricted in a vein). Despite this news, the man was in good spirits, and looking forward to a visit from his mother that afternoon.
31. On 10 October, it was noted that the man was refusing all pain relief. He also had a cough which was getting worse. On the same day, the oncologist (cancer specialist) reviewed the man's CT scan and decided

against chemotherapy due to the widespread disease. A cancer care nurse discussed with a Staff Nurse from Bullingdon the possibility of the man moving to a hospice. She spoke about this to the Head of Healthcare, who felt that it was an appropriate move and agreed to speak to the Deputy Governor about the possibility. On the following day, it was agreed that the man would move to a hospice in Oxfordshire on 15 October.

32. An application for early release on compassionate grounds was completed at Bullingdon on 11 October 2007. It was faxed to the Pre Release Section (PRS) of the Ministry of Justice on the same day. The application form includes a section to be completed by the prison's Medical Officer. The prison doctor who completed the section wrote that:

"The man has been suffering from penile cancer. The cancer was diagnosed a few months ago. He had an operation in a local hospital. At present the cancer is widespread, therefore he is terminally ill. The oncologist has reviewed his CT scan and does not give him chemotherapy or radiotherapy. He is symptomatic with shortness of breath and cough. The palliative care team are now involved in his treatment. In my opinion the man should be transferred to a hospice."

33. The form also contained a section asking for the Medical Officer's prognosis. The prison doctor wrote that the prognosis was "bad".
34. The application for early release on compassionate grounds also includes a section to be completed by the prison's probation officer. It was completed by the Public Protection Probation Officer, on 10 October. On the grounds of the man's offending behaviour, she concluded that:

"In the event of a release, suitable resettlement arrangements would have to include an element of frequent, if not constant, supervision ... I cannot support early release on compassionate grounds."

35. The final section of the application was completed by the Deputy Governor on 11 October. He noted that he considered the man's risk to be "minimal", and concluded:

"Considering the medical condition with death likely within 14 days and the location within a hospice balanced against nature of offending, I would recommend early release."

36. An HCO spoke to staff on the man's ward on 12 October, and was told that he was still mobile and not complaining of pain. As arranged, the man moved to the hospice on 15 October. He was still accompanied by one officer, but not cuffed.

37. The man was visited by a Staff Nurse from Bullingdon and the prison's family liaison officer on 16 October. The nurse noted that the man appeared to be relaxed and comfortable. His mobility was impaired by his shortness of breath, but the man was still able to walk to his en suite toilet. The nurse added that the man seemed to be in denial about his prognosis.
38. On 17 October, the application for early release on compassionate grounds was refused by PRS for two reasons. First, advice from the Department of Health was that the prognosis given was "uncertain" and "not expressed authoritatively". Secondly, given the advice in the probation officer's report and the man's offending history, PRS considered that there remained a significant risk of re-offending.
39. Following the refusal of the man's application for early release, the possibility of release on temporary licence was discussed on 19 October. The man was also offered the opportunity of having his property brought to the hospice so that he could give it to his mother. He accepted this offer.

The man was given the opportunity personally to hand over his property to his mother in the last few days of his life.

40. On 21 October, the man's condition deteriorated. He was more frequently out of breath and his cough got worse. He tried to remain independent by walking to the bathroom by himself, but was able to do so less often. On 22 October, the man's deterioration was described as "rapid". His mobility was now poor and he was only able to sit on his chair.
41. On the morning of 23 October, a second application for early release on compassionate grounds was initiated. A prognosis obtained from the hospice, which said that the man was unlikely to live for more than two to three days, was faxed to PRS. They then prepared a submission to Ministers advocating the man's release.
42. In the meantime, the man was released on temporary licence by the Governor. His escort remained at one officer, but the officer was asked to sit outside the room. The man was visited that morning by the prison's family liaison officer and a Staff Nurse. He was now restricted to bed and was very short of breath. The man died at 2.15pm, with his mother at his side. Sadly, this was before his release on compassionate grounds could be approved.

Following his release on temporary licence, the officer accompanying the man was asked to sit outside his room at the hospice. This allowed the man and his mother to spend time alone together before his death.

43. A post mortem examination was not carried out, as the Coroner was not informed of the man's death by prison staff. His funeral was held on 31 October. In arranging the funeral, the prison acted appropriately in accordance with Prison Service Order 2710, the Prison Service guidelines for dealing with a death in custody.

ISSUES

Issues raised by the clinical review

44. The clinical review was conducted by the Clinical Governance Lead at Oxfordshire Primary Care Trust. He comments that the man suffered from a “rare and particularly unpleasant form of cancer”. He goes on to say that the man’s care at Bullingdon “appears to have been sensitive, appropriate, caring and professional”, and that the man was “speedily readmitted” when he needed more intensive hospital treatment. I agree.
45. The clinical reviewer also notes that:
- “More detailed medical records would have been helpful in carrying out this review, but there is no evidence this would have improved the level of care the man received and nothing to suggest it was substandard.”
46. There is no evidence in the man’s medical record of him receiving a doctor’s or nursing review from 3 July 2007 until he was admitted to hospital three weeks later on 23 July. The man was an inpatient in the healthcare centre for a short time during this period until a bed was found for him on E wing. My investigator spoke to a prison doctor at Bullingdon who had reviewed the man regularly. The doctor recalled that the man was taking antibiotics at the time because of his infection, but that he was physically fine.
47. The clinical reviewer writes as follows:
- “There is nothing to suggest this was a period when he needed any specific care, but in the light of the attention paid to him at other times it seems strange that no reviews of his condition took place between these dates. If there was no contact there is no evidence that any harm resulted, although the man would undoubtedly have benefited from the support.”

The Head of Healthcare should ensure that procedures are in place to guarantee that all patients suffering from a potentially terminal illness are reviewed regularly by a nurse or doctor.

Compassionate release

48. Chapter 12 of Prison Service Order 6000 sets out the following criteria for compassionate release on medical grounds:
- the prisoner is suffering from a terminal illness and death is likely to occur soon; or the prisoner is bedridden or similarly incapacitated; and
 - the risk of re-offending is past; and

- there are adequate arrangements for the prisoner's care and treatment outside prison; and
 - early release will bring some significant benefit to the prisoner or his/her family.
49. As I have discussed in paragraphs 35-38 and 41, the Governor submitted an application for early release on compassionate grounds on 11 October 2007. The application was refused by the Ministry of Justice on 17 October because of an uncertain prognosis and a significant risk that the man would re-offend were he to be released. Given the content of the probation officer's report of 10 October, I consider that this was not an unreasonable decision. However, it was manifestly a risk-averse decision that paid relatively little heed to the operation the man had undergone, the terminal nature of his illness, and the fact that (by the time the decision was made) he had already been transferred to a hospice. A decision to have agreed the application would not have been unreasonable either.
50. I am, however, pleased to note that the Pre Release Section were advocating the man's release following the second referral on 23 October 2007. Sadly, he died before the application could be approved by Ministers.

A copy of this report should be sent to the head of the Pre Release Section for his consideration.

51. The prison doctor who my investigator interviewed completed the section required of the Medical Officer in the application. He told my investigator that this was the first time he had completed such an application, and he was not given any guidance how to complete the form. In the form, the doctor noted that the man's prognosis was "bad" but did not provide a timeframe.
52. PSO 6000, section 12.4.1 says that "it is essential to try to obtain a clear medical opinion on the likely life expectancy". It goes on to say, in section 12.5.1, that "it is essential that an indication of likely life expectancy is included in the report".
53. Advice from the Department of Health was that the prognosis given was "uncertain" and "not expressed authoritatively". This was one of the factors for the refusal of the man's application, although the risk of re-offending was more significant. Nevertheless, it would be unfortunate if the success of a future application were to be delayed because further details of the prognosis had to be sought by the Ministry of Justice.

The Governor should ensure that guidance and advice is available to the Medical Officer when completing the relevant section of an application for early release on compassionate grounds.

Informing the Coroner of the man's death

54. Following the man's death on 23 October, the Coroner was not informed of his death by staff at Bullingdon. This is an important process following a death in custody, as it is the Coroner who presides over the inquest into the death and who orders the post mortem. As the Coroner was not informed of the man's death, a post mortem examination to determine the cause of death did not take place.
55. PSO 2710, regarding actions to be taken following a death in custody, provides a list of those who must be "promptly" notified by telephone. Second on this list is the Coroner.
56. The Deputy Governor told my investigator that he understood it was the role of the hospice or the police to inform the Coroner in this case. I note that the man had been released on temporary licence for around three hours before his death, and was not therefore technically in custody when he died. Strictly speaking, it might be considered that PSO 2710 did not apply.
57. However, three hours was a very short time between the man's release on temporary licence and his death. I also note that the man was escorted by a prison officer when he died, as required by his licence conditions. The Duty Governor was therefore informed of the man's death immediately after it occurred.
58. Given these circumstances, I think it would be reasonable to have expected Bullingdon to have informed the Coroner of the man's death. The Coroner would then have been able to make a prompt decision regarding whether to request a post mortem examination.

The Governor should ensure that all future deaths of prisoners who have been released on temporary licence are reported promptly to the Coroner.

RECOMMENDATIONS

The Head of Healthcare should ensure that procedures are in place to guarantee that all patients suffering from a potentially terminal illness are reviewed regularly by a nurse or doctor.

Partially accepted – Procedures to be formalised regarding this area. Some patients, however, may not wish to participate with such requirements.

A copy of this report should be sent to the head of the Pre Release Section for his consideration.

Accepted - this should have been referred to the Head of Pre Release Section as Release and Recall section hasn't existed since April 2007.

Paragraph 49 - Pre Release Section have said that the criteria for early release on compassionate grounds clearly state that the risk of re-offending must be past. Given the high level of concern expressed by the Probation Service they were not convinced that it had decreased to such a level. In addition Offender Health did not support the application for early release either, a key factor being the evident risk of harm/re-offending, despite the man's surgery.

The covering page to Pre-Release Section's refusal notification expressly invited the Governor to refer the case again if there was any significant deterioration in the man's condition. The Governor did so by faxing a prognosis from the Sue Ryder Hospice Care on 23 October. This stated that the man would be unlikely to live for more than another 2-3 days. A submission to Ministers advocating release was started but very shortly afterwards the man died.

The Governor should ensure that guidance and advice is available to the Medical Officer when completing the relevant section of an application for early release on compassionate grounds.

Accepted – In all cases the Deputy Governor will continue to personally liaise with the relevant medical practitioners to try to ensure that reports completed are, where possible, able to provide timescales for life expectancy for individual patients.

The Governor should ensure that all future deaths of prisoners who have been released on temporary licence are reported promptly to the Coroner.

Accepted – Guidance issued within contingency plans to Operational Managers.

GOOD PRACTICE

The kind and respectful way in which healthcare staff and the family liaison officer liaised with the man and his mother during the last weeks of his life should be formally recognised.

The man was given the opportunity personally to hand over his property to his mother in the last few days of his life.

Following his release on temporary licence, the officer accompanying the man was asked to sit outside his room at the hospice. This allowed the man and his mother to spend time alone together before his death.