

**Investigation into the death of a prisoner at HM Prison
Bullington on 8 March 2005**

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

June 2005

This is the report of an investigation into the death of a prisoner at HM Prison Bullingdon on 8 March 2005. His cause of death was Ischaemic heart disease, Coronary Artery Atherosclerosis and Chronic Obstructive Pulmonary disease. Apart from some very minor amendments, and removal of the names of those involved the text of my report is as I submitted it in June 2005.

One of my investigators, conducted this investigation. The North Oxfordshire Primary Care Trust provided a clinical review into the prisoner's care and treatment.

I would like to extend my sincere condolences to the prisoner's family for their loss. I would like to thank the Governor in charge of HMP Bullingdon and the staff for their help and co-operation during this investigation.

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Summary

The prisoner was 69 years old when he died in the Health Care Centre at HM Prison Bullingdon on 8 March 2005. At the time of his death the prisoner was suffering from Chronic Obstructive Pulmonary Disease (COPD) a debilitating disease that he had been diagnosed with in 1994. For some time his health had been deteriorating.

In the early hours of the morning of 8 March, the prisoner was observed by staff in the Health Care Centre experiencing difficulty with his breathing. When his cell door was opened staff noticed that the prisoner was not breathing and commenced Cardio – Pulmonary Respiration (CPR).

Paramedics quickly arrived on the scene and continued to perform CPR but with no response from the prisoner. Staff in the Health Care Centre in consultation with the Primary Care Trust Doctor pronounced death at 7.10am.

The post mortem confirms that the prisoner died of Ischaemic heart disease, Coronary Artery Atherosclerosis and Chronic Obstructive Pulmonary disease.

The clinical review into the death confirms that the level of care he received whilst in custody was the same as would have been expected in the wider community. Medical care during the final days of his life was of good quality with a rapid and appropriate response at the time of his death.

I make one specific recommendation in this report about how the prison maintained contact with the next of kin after the prisoner's death. I have also raised a concern about the length of time it can take for some cases to be dealt with at a Coroner's inquest.

The investigation process.

1. The investigation was opened at HMP Bullingdon on 10 March 2005. The Deputy Governor and his staff produced the prisoner's core record as well as his medical record for examination. Notices were issued to staff and prisoners telling them of the investigation. My investigator was able to speak to members of staff who knew the prisoner.
2. A Family Liaison Officer from my office contacted the prisoner's daughter on 23 March and offered her the opportunity to discuss the purpose of the investigation and to raise any concerns or questions that she would like explored and addressed. She raised no issues in respect of her father's care or circumstances of his death but would like to see a copy of the draft report.
3. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion, this report will be sent to the Coroner to assist him in his enquiries into the prisoner's death.

The prisoner

4. The prisoner was born in 1935 in South Yorkshire making him 69 years old when he died on 8 March 2005. He had served in the army for a number of years and from 1970 to 1985 was employed as a coalminer. In 1994 he was diagnosed with Emphysema. The prisoner's last period of work was between 1998 – 2000 when he worked as Security Guard.
5. The prisoner had been married for 41 years although his wife died in 1997 after a long illness. He had three daughters of whom one is the next of kin.
6. The prisoner had a partner. A Probation Report compiled shortly before his death indicated that the relationship had ended although they remained good friends and kept in contact by letter and telephone.
7. On 26 October 2000, the prisoner was sentenced to 10 years imprisonment by Sheffield Crown Court for numerous serious sexual offences committed against minors over a period of time. Some of these offences were committed against family members.
8. On 23 December 2003 he was transferred from HMP Rye-Hill to HMP Bullingdon. Whilst at Bullingdon, the prisoner was described as a quiet and respectful man who did not present any disciplinary problems at all. He was located in a wing for vulnerable prisoners. The prisoner had taken part in the Sexual Offences Treatment Programme (SOTP) during his sentence and was described as remorseful for his actions. In view of his good behaviour at Bullingdon he was placed on the enhanced privilege regime on the Edgcott wing.
9. The prisoner's preliminary date for parole was set for July 2005. The Probation Report indicates that it was his intention was to move away from his trial area and to seek appropriate hostel accommodation through the Probation Service.
10. The prisoner's youngest daughter is the nominated next of kin. She has looked after her father's interests whilst he has been in prison. He did not receive any visits from his family whilst at Bullingdon. His ex-partner was unable to visit him.
11. On 21 March, the prisoner's funeral took place. During the investigation, Bullingdon did not appear to be aware of the funeral arrangements, although following a review of the draft report Bullingdon commented that the chaplaincy team remained in contact with the prisoner's next of kin. Following this contact, a memorial service took place to coincide with the prisoner's funeral in the Health Care Centre. Additionally a memorial service took place on the wing, a number of days before the funeral that allowed prisoners who knew him to pay their last respects.

HMP Bullingdon

12. Bullingdon operates jointly as a local and category B training prison for adult males. The primary catchment area is the Crown Courts at Oxford and Reading as well as the local Magistrates Courts.
13. Opened in 1992, Bullingdon is a 'New Gallery' style prison by design. It has four main house blocks that have been supplemented by a fifth since 1997 that can accommodate 955 prisoners. The wing the prisoner was on accommodates those prisoners defined as vulnerable because of the nature of the offences committed.
14. In March 2005, the Governor introduced an 'Over 65 Prisoner Policy' in the prison that allows for prisoners over the age of 65 to have their cells open during core hours. The policy is designed to facilitate a better quality of life and more opportunity to use the prison amenities.
15. The prison operates on a 3-tier system of regime (Basic, Enhanced and Standard) which was introduced in 1996 as part of the Incentive and Earned Privileges Scheme. The prison also has a range of work, education and training opportunities as well as a broad programme of Offending Behaviour Groups.
16. The prison also maintains a twenty – four hour Health Centre that can accommodate 15 inpatients. In April 2005, the Health Care Centre was to transfer to the Primary Care Trust. The prison stated that the centre was fully staffed by appropriately trained staff and that recruitment is not an issue.

Events prior to the prisoner's death

17. The prison knew about his medical condition when he transferred from HMP Rye- Hill to HMP Bullingdon. On transfer to Bullingdon, the prisoner's medical record was transferred with him. He also received a medical screen by the Health Care Centre.
18. On 16 April 2004, the prisoner was admitted as an inpatient to a hospital where he underwent surgery to remove a blood clot from his toe. After the operation he received anticoagulant treatment.
19. On 7 September, he was transferred from his wing, which houses vulnerable prisoners to the Health Care Centre because of breathing difficulties. The prisoner was treated as an inpatient and received nebuliser and anti-biotics.
20. On 5 October, the prisoner was taken under single escort to hospital as an outpatient. He had been complaining for some time of stomach pains and had an ultrasound. On receiving medication from the hospital he was taken back to the Health Care Centre at Bullingdon. He was subsequently referred for an endoscopy but this did not take place until 13 December. The clinical review indicates that this was an unreasonable length of time to wait, although the lapse is an issue in respect of the secondary care rather than a fault at Bullingdon. In the meantime the prisoner continued to be monitored by the Health Care Centre – primarily in relation to his breathing problems.
21. On 26 October, the prisoner visited his wing for the purpose of association with fellow prisoners. It was noted that he was still suffering some stomach pain and discomfort but is described by staff as uncomplaining and courteous at all times. Although he had been prescribed analgesics for his stomach pain this did not take away the pain completely.
22. On 19 November, the prisoner was able to visit the wing and attend the community meeting. The Medical Observation log for this time indicates that his stomach pain was more under control.
23. On 13 December, the prisoner attended the hospital for an endoscopy. The endoscopy determined that he had 2 duodenal ulcers. Medication was prescribed to reduce the amount of acid made in the stomach. Following this diagnosis he was prescribed codeine and analgesia. The prisoner returned to the Health Care Centre on the same day. The medical observation log records that following the visit to the hospital he was sleeping, taking meals normally and associating with other prisoners.
24. On 23 December, whilst in the Health Care Centre, the prisoner was suffering from acute abdominal pain for which he was taken, under escort to the hospital. He was released back to the care of the Health Care Centre on the same day.

25. On 30 December, the medical observation log indicated that whilst the stomach pain was more under control there was a loss of appetite. However, on 2 January 2005, the prisoner reported to staff that he felt a lot better and appeared to be more mobile. Indeed, he felt so much better in himself that he asked to be discharged from the Health Care Centre back to the wing. It was suggested that the discharge could take place a week later on provided that his health was continually monitored and his needs assessed by staff.
26. On 12 January 2005, the prisoner was discharged from the Health Care Centre back to the wing. He was looking forward to the move and believed that his health had much improved.
27. At 9am on 1 February, Health Centre Staff were asked to attend the wing in order to assess the physical health of the prisoner. He was suffering with a shortness of breath. He was given the aid of a nebuliser and medication was taken for his ulcers. By 2pm his health had deteriorated to such an extent that he was transferred back to the Health Care Centre where observations continued. The prisoner continued to suffer from shortness of breath, and an irregular pulse rate as well as a high temperature. A nebuliser continued to be given and paracetamol administered in order to reduce his temperature.
28. The prisoner continued to be treated and observed in the Health Care Centre. Although his health had slightly improved it was noted that he was spending more of his time in bed. He also continued to suffer a loss of appetite. By 13 February, he was finding it difficult to eat solid meals, although staff encouraged him to drink regularly.
29. By 18 February, and in light of a slight improvement in his health, the prisoner asked to be discharged once again from the Health Care Centre back to the wing for the purpose of association with fellow prisoners. This request was granted and a health care plan was prepared for his discharge to the residential wing provided that his condition was monitored.
30. On 2 March, the prisoner was admitted to the Health Care Centre from the wing, once again suffering from a shortness of breath. It was noted that he was using his nebuliser more frequently. Whilst in the Health Care Centre arrangements were made for his cell to be left open during the day to allow for easier observation and unfettered access to him by health care staff.
31. On 3 March, it is recorded that the prisoner's breathing was erratic and that he was suffering from chest pains. In view of this he was given subutamol. He was also placed in a special medical bed that could be elevated to allow for a greater degree of comfort and to aid his breathing. The prisoner continued to use his nebuliser and was monitored frequently by staff within the Health Care Centre.

32. On 4 March, the prisoner had a settled day. It was apparent to staff that he required his nebuliser less frequently and that he was able to attend to his own hygienic needs. His appetite had also improved slightly.
33. On 7 March, the day before he died, the prisoner told staff and fellow prisoners in the Health Care centre that he was feeling much better. A member from the Independent Monitoring Board (IMB), who visited the centre on that day, also reports that he was mobile, associating with staff and prisoners. The prisoner also confirmed to the IMB Member that he was receiving good care and attention in the centre. At 9.30pm, the prisoner was seen by staff to be watching television in his cell. He indicated to staff that he felt okay.
34. At 5.27am on 8 March, the prisoner was heard to be coughing in his cell. A member of the Health Centre observed him sitting upright in his bed administering his nebuliser. At 5.30am, the prisoner's breathing appeared to be shallower and arrangements were made to open his cell so that Health Care staff could assist and attend to him.
35. At 5.35am, the prisoner's cell was opened. It was noted that he did not appear to be breathing. A pulse could not be detected. Staff started Cardio-Pulmonary Resuscitation (CPR). An ambulance was called.
36. At 5.40am, slight breathing was detected, although his condition had worsened. Paramedics arrived in the prisoner's cell and continued with CPR for a further 30 minutes. Despite efforts from prison staff and paramedics he remained unresponsive. At 6.30am, a doctor from the Health Care Centre contacted the Primary Care Doctor to inform him about the prisoner's condition.
37. At 7.10am on 8 March, a doctor attended the prisoner's cell and pronounced him dead. The cause of death is recorded as Cardio-Respiratory failure.
38. A clinical review into the prisoner's treatment and the action taken at the time of his death determines that the action taken by staff at the Health Care Centre to have been entirely appropriate with a rapid response at the time of his death.

Events after the prisoner's death

39. When the prisoner was pronounced dead there were some issues about telling the next of kin. The prison was aware of the prisoner's offences and in view of the fact that some family members were victims, contact was made in the first instance with the prisoner's Probation Officer. At 11.50am on 8 March, a Governor from Bullingdon telephoned the prisoner's daughter and informed her of her father's death. The prisoner's ex-partner was also informed by telephone later the same day.
40. On 21 March, the prisoner's funeral took place. During the course of the investigation the prison did not appear to be aware of the funeral arrangements. Indeed it appeared that no further contact had taken place between the prison and the family since the prisoner's death including the offer of financial support for the funeral. The Deputy Governor's view was that the onus was on the family to ask for support in the first instance, primarily because of the known family sensitivities in respect of the prisoner's offences. Following a review of the draft report by the prison, it was noted that the chaplaincy team maintained some contact with the prisoner's next of kin and that memorial services took place in Health Care and on the wing.

Clinical Review

41. The clinical review undertaken by the North Oxfordshire Primary Care Trust confirms that the prisoner's death was not related to the quality of care he received whilst in prison but was from natural causes. From his medical records it appears that that level of care he received whilst at Bullingdon was appropriate and the same as would have been expected from a local general practice.

Post Mortem report

42. Although the Coroner's Office has not been able to provide a Post Mortem report the Coroner's Officer has confirmed that the cause of death is recorded as Ischaemic heart disease, Coronary Artery Atherosclerosis and Chronic Obstructive Pulmonary disease. There was no trace of alcohol or drugs.

Findings and conclusions

43. The medical care and treatment given to the prisoner whilst in custody and in the last days of his life does not raise any issues. It is reassuring to know that the level of care afforded to him was appropriate, satisfactory and equitable to that which exists in the general community. The prisoner had a long term and serious medical condition for which the outcome was inevitable.
44. Because of the nature of the crimes committed against family members, the prison rightly sought the advice of the Probation Service before contacting the family after his death. It was agreed that the youngest daughter, should be contacted as well as the prisoner's ex-partner. During the course of the investigation there was no evidence to suggest that any further contact had been initiated or maintained by the prison with the family after the prisoner's death. There was no offer of financial support towards his funeral costs and the prison did not send a representative to the funeral. Following a review of the draft report, Bullingdon has stated that there was some contact between the prison chaplaincy and the next of kin and that following contact, memorial services were held for the prisoner in the prison.
45. One general observation that was raised as a general issue during my visit to Bullingdon is the time it is taking for inquests to take place. At Bullingdon there are 5 outstanding inquests still to be heard spanning a period of 4 years. The prison has remained in contact with both the Coroner's Office and the Prison Service Safer Custody Group in an attempt to expedite these matters. I understand that this was also brought to the attention of the Minister through the IMB Annual Report 2003/2004. Although I can acknowledge that there are reasons for the delays these can cause unbearable anguish for the bereaved families.

Recommendations

46. During the investigation it was brought to my attention that there are several deaths in custody at HMP Bullingdon that have yet to be concluded by way of an inquest. Some of these incidents span several years. Although this issue is not within my terms of reference my observation is that the time delays is unacceptable to both staff and families affected by such events. To those individuals who are affected by such traumatic events the Coroner's Inquest is viewed as natural closure on what is considered to be a traumatic event. Expediting such matters is clearly in the interests of family members and prison officials alike and would be welcomed.