Investigation into the circumstances surrounding the death of a man in December 2010, at a hospice, whilst in the custody of HMP Bullingdon

Report by the Prisons and Probation Ombudsman for England and Wales

June 2011

This report considers the circumstances surrounding the death of a man at a hospice in Oxfordshire in December 2010.

I offer my sincere condolences to the man's family and all those who knew him.

The investigation was conducted by one of my investigators on my behalf. I would like to thank the governing Governor at HMP Bullingdon and his staff for their co-operation. I also extend thanks to the prison liaison who liaised with my office. In addition, I thank the clinical reviewer, who reviewed the man's clinical care. He was appointed by Oxfordshire Primary Care Trust.

The man transferred to HMP Bullingdon in June 2010. He had little contact with healthcare staff there until November. He was subsequently admitted to hospital and diagnosed with metastatic cancer (this means that the cancer has spread from the primary source to other parts of the body). When he returned to the prison, the man continued to live on a residential unit until he became too unwell to care for himself. On 27 December, he was taken back to hospital and moved to a hospice three days later on 30 December. He died shortly thereafter.

This is the tenth death from natural causes at Bullingdon since 2004, when my office began investigating all deaths in prison custody. Before this man's death, the last such death occurred in 2009.

My investigation has looked into the diagnosis of the man's illness, various aspects of his palliative care, and liaison with his family. I find no failings in respect of the care that the man received in prison, and consider it equitable to what could have been expected in the wider community and so I make no recommendations.

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.

Jane Webb
Acting Prisons and Probation Ombudsman **June 2011**

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SUMMARY

1. The man transferred to Bullingdon from HMP Isle of Wight on 14 June 2010. He was already being treated for Crohn's disease (an inflammatory disease of the intestines). He had limited contact with the healthcare team at Bullingdon until the early hours of 17 November, when he contacted the nurses because he had blood in his urine.

2. The man saw a doctor on 18 November and was admitted to the inpatient unit. The doctor referred the man for investigation of the haematuria (blood in the urine). Three days later, on 21 November, he passed a lot of blood in his urine and was admitted to outside hospital as an emergency patient. He remained there until 9 December. He was diagnosed with metastatic cancer, meaning that the disease was present in multiple organs.

3. When he returned to Bullingdon from the hospital, the man stayed on the inpatient unit until 13 December when he returned to a normal residential wing. He had been keen to be discharged from the healthcare unit. After his discharge, members of healthcare staff visited the man on his unit regularly to check that he was able to function properly and care for himself.

4. On 23 and 26 December, healthcare staff noticed that the man was short of breath but he remained adamant he would not return to the inpatient unit. However, by 27 December, his health had deteriorated to such an extent that healthcare staff felt admission to the inpatient unit was necessary. The man was reluctant to leave his unit but did so.

5. The man moved to the inpatient unit and, later the same day, to hospital. He was reviewed by the palliative care team and moved to a local hospice on 30 December. He died shortly thereafter at 78 years of age.

6. I have investigated issues around the man's diagnosis, various aspects of his palliative care, and liaison with his family. I make no recommendations in my report.

THE INVESTIGATION PROCESS

7. One of my senior investigators was appointed to conduct the investigation on my behalf. Notices of the investigation were sent to the prison for distribution and display, giving staff and prisoners the opportunity to contact the investigator with any relevant information.

8. The investigator visited HMP Bullingdon to open the investigation on 25 January 2011. During this visit, he met the following people:
    - Two members of staff who were liaisons to my office
    - The governing Governor
    - The prison's family liaison officer
    - A registered general nurse involved in providing the man's care
    - A representative for the Prison Officers' Association
    - The police liaison officer.

9. The people present at the meeting provided the investigator with a brief overview of the man's time at Bullingdon, including his diagnosis and subsequent care. One of the liaisons to my office provided copies of documents relating to the man's time in custody, including his clinical record.

10. One of my family liaison officers (FLOs), contacted the man's wife to explain the purpose of my investigation and provide her with an opportunity to raise any issues or questions about the care her husband received in prison. The man's wife said that, as her husband had died from cancer, she felt there was probably little that could have been done to help him. She was, however, keen for any lessons to be learned for the benefit of other prisoners. I am pleased to learn that the man's wife found the prison's family liaison officer to be supportive and helpful following her husband's death. The man's wife said that when he was at HMP Isle of Wight, he underwent surgery and two follow-up appointments were cancelled. He had written to a solicitor regarding complaints about his healthcare at Isle of Wight.

11. Where the man's wife's questions fall within the remit of my investigation, I have done my best to answer them. I hope that the report helps her to better understand the circumstances of her husband's death should she wish to receive it. My remit is to investigate the circumstances of the man's death, and his complaints about healthcare are outside my Terms of Reference.

12. Oxfordshire Primary Care Trust (PCT) appointed a clinical reviewer to review the man's clinical care whilst he was in custody. The purpose of a clinical review is to examine the medical care that a prisoner received in custody, which should be an equivalent standard to what might have been expected in the community. The clinical reviewer consulted the man's clinical records to inform his review. His findings are summarised within this report.

HMP BULLINGDON

13. HMP Bullingdon is a large prison in Bicester, Oxfordshire. It holds category B and category C prisoners. Category B prisoners are those for whom the very highest conditions of security are not necessary, but for whom escape must be made very difficult. Category C prisoners are defined as those who cannot be trusted in open conditions, but who would not have the ability or resources to make a determined escape. Bullingdon accommodates convicted and unconvicted adult male prisoners over six units, and has a mixture of single and shared cells.

14. Healthcare at the prison is provided by Oxfordshire Primary Care Trust (PCT). An inpatient facility can accommodate up to 24 patients. It is staffed throughout the day and has two nurses on duty at night. An outpatient facility delivers a daily assessment system, with prisoners referred to a doctor as necessary. A doctor is available every weekday, and there is an on-call service overnight and at weekends.

Performance

15. HM Chief Inspector of Prisons inspected Bullingdon in July 2010. He found that Bullingdon delivered "reasonably good outcomes for prisoners", had a good standard of accommodation, and positive relationships between staff and prisoners. In terms of older prisoners, he noted that, at the time of the inspection, 23 prisoners over the age of 60 were accommodated on E wing. (This man was one of these prisoners.) There was no annual survey of their needs and no quarterly meeting for them. Older prisoners who did not work were unlocked from their cells during the day, although there were no specific activities for them.

16. Each prison in England and Wales has an Independent Monitoring Board (IMB), made up of volunteers from the community in which the prison is located. IMBs must satisfy themselves as to the humane and just treatment of people held in custody, and they report to the Justice Secretary annually. At the time of writing, the most recently published report for Bullingdon covered the period August 2009 to July 2010. The IMB was "generally satisfied with the overall standard of the prison management, treatment of prisoners and facilities provided". However, the "poor provision of … healthcare" was "deeply worrying". The IMB reported that the healthcare department had suffered throughout the year from staffing shortages, and that inpatient prisoners spent too long locked in their cells.

Previous deaths at Bullingdon

17. My office has been responsible for investigating deaths in custody since April 2004. Prior to this man's death, my office investigated nine other deaths from natural causes at Bullingdon.

ISSUES

The diagnosis of the man's terminal illness

18. The man transferred to Bullingdon from HMP Isle of Wight on 14 June 2010, seven months before he died. He was being treated for Crohn's disease (an inflammatory disease of the intestines). An initial health screening was completed when he arrived at Bullingdon. There was mention of his Crohn's disease, but no evidence that he disclosed any other health problems.

19. The man had limited contact with the healthcare team at Bullingdon until the early hours of 17 November, when he contacted the nurses because he had blood in his urine. He saw a doctor from Bullingdon's healthcare team, the next day 18 November, and was admitted to the inpatient unit.

20. The doctor spoke to the on-call urologist at outside hospital and was advised to complete a two-week referral form. This process is used for the rapid investigation of haematuria (blood in the urine) in patients over 40 years of age. The clinical reviewer noted in his clinical review that this is the correct method of referral for someone presenting with blood in the urine. The referral form was completed on 19 November.

21. On 21 November, the man passed a lot of blood in his urine and was admitted to outside hospital as an emergency patient. He remained there until 9 December. During this time, he was diagnosed with metastatic cancer, meaning that the disease was present in multiple organs.

22. I am satisfied that the medical intervention was swift following the man's initial report of blood in his urine. A two-week referral form was completed, and he was admitted to hospital just two days later when his condition worsened. During his time in hospital, tests were conducted and the diagnosis was made. As such, I do not believe that there were any apparent delays before the man's illness was diagnosed.

Informing the man about his condition and treatment

23. The man was in hospital when the diagnosis of his illness was made. The clinical reviewer reported in his clinical review that the man was kept fully informed, including the reasons for referral. Details of his diagnosis were given by the hospital consultant.

24. No invasive treatment, such as surgery, was offered in response to the man's diagnosis. He received palliative care, which focuses on relieving and preventing suffering, and is given to patients who are nearing the end of their lives.

The man's medical appointments and treatment

25. Following diagnosis, the man remained in hospital until 9 December. Healthcare staff from Bullingdon liaised closely with the hospital about his condition. This was successful apart from on one occasion, when the hospital staff refused to provide information on the grounds of patient confidentiality. However, this problem was rectified the following day.

26. After he returned to Bullingdon, the man remained in the inpatient unit until 13 December. He then returned to E wing where healthcare staff continued to see him regularly. The man's condition deteriorated rapidly on 27 December, and he was admitted to the inpatient unit and then to hospital. Three days later he was moved to a hospice.

27. The clinical reviewer found in his clinical review that the man's care was well followed up by the healthcare staff at Bullingdon. It is clear from the records that he was keen to live on a normal residential location rather than in the inpatient unit, and this was facilitated until he became too unwell to manage there.

The man's pain relief and medication

28. No treatment options were offered as a result of the man's diagnosis and he was given palliative care. The clinical reviewer reported that pain was not mentioned as a problem for the man during his time at Bullingdon.

29. On 30 December, a nurse from the prison spoke to the nurse looking after the man at the hospice who reported that pain relief medication was being offered as often as it was needed.

Liaison with the man's family

30. According to the clinical record, the man explained his diagnosis to his wife. She knew about his admission to hospital and subsequent move to a hospice.

31. The man's wife telephoned the hospice to enquire about her husband's condition very soon after he died, and the hospice staff told her that he had died. A member of staff from the prison was appointed as Bullingdon's family liaison officer on 31 December, and she and the chaplain visited the man's wife the same day. The family liaison officer remained in contact with the man's wife, who said that she found the ongoing liaison useful and supportive. The family liaison officer and the chaplain attended the man's funeral.

32. When prisoners are being cared for on a palliative basis, it can be useful for family liaison officers to be appointed as early as possible, to facilitate family contact during end of life care. In this case, the man was able to look after himself until very shortly before he died. His health deteriorated rapidly on 27 December, and he died shortly thereafter. Whilst a designated family liaison officer may have been beneficial during the last few days of the man's life, there is nothing to suggest that the absence of this support was detrimental.

Indeed his wife has commented that she found the prison's family liaison officers to be supportive and helpful.

The man's location in the prison

33. After seeing the overnight nursing staff on 17 November, the man moved from E wing to the inpatient unit the next day, 18 November, and was admitted to hospital three days later. He returned to Bullingdon on 9 December, initially to the inpatient unit. He returned to E wing on 13 December, then was re-admitted to the inpatient unit and then to hospital on 27 December. He moved to a hospice on 30 December and died shortly thereafter.

34. It is clear from the man's clinical record that he did not want to live on the inpatient unit, and he was keen to return to E wing. After 13 December, he was seen regularly by healthcare staff on E wing. On 23 and 26 December, the man was short of breath but he remained adamant that he would not go to the inpatient unit. However, by 27 December, his health had deteriorated to such an extent that healthcare staff felt admission to the inpatient unit was necessary. Even at this point, he was reluctant to leave E wing.

35. The man moved to a hospice only the day before his death. However, until a few days earlier he had been able to care for himself, and wanted to remain on E wing. After his admission to hospital on 27 December, he was seen by the palliative care team and moved to the hospice. Given the rapid deterioration in his health, and his wish to stay on E wing for as long as possible, I believe that he lived in the place which suited him and where he received appropriate care.

Consideration of compassionate release

36. Compassionate release can be considered by prison governors for prisoners at any point during a prisoner's sentence. It is approved only in very exceptional circumstances and must be approved by the Secretary of State for Justice. It can be considered when a prisoner is terminally ill and death is likely to occur soon.

37. Bullingdon's governing Governor told my investigator that, following the man's diagnosis and his return to prison on 9 December, a brief meeting took place to discuss applying for compassionate release. At that point, the prison had not been given any prognosis regarding how long the man was likely to live. He was well enough to care for himself and was keen to move back to E wing. The governing Governor said the prison was alert to the possibility of applying for compassionate release at a later date but, at the time, it did not seem that the man's death was imminent and so he would not have qualified.

38. After the man's health deteriorated and he moved to the hospice, the possibility of release on temporary licence (ROTL) was discussed. This would have allowed him to be unaccompanied by prison officers whilst at the hospice. However, he died the morning after he moved to the hospice before a decision about ROTL was taken.

39. It is encouraging that compassionate release and ROTL were being considered by the prison governors. In the light of the man's rapid deterioration and sudden death, I accept that there was not sufficient time to implement either of these options.

Palliative care plans

40. The clinical reviewer reported in his clinical review that, because the man's health deteriorated so quickly, there was no time to put palliative care plans in place. He commented that this is also a common problem in the community. He went on to say that, when the man was admitted to hospital on 27 December, he was experiencing symptoms that would not normally have been possible to control in the community, and so his admission was appropriate.

41. The clinical record suggests that the man had been caring for himself until 27 December. There had been some concerns about his health in the preceding few days, but he was reluctant to go to the inpatient unit. When it became clear that he was no longer able to manage his health needs, the man moved to the inpatient unit and to hospital. After assessment by the palliative care team, he moved to a local hospice. Sadly, he died shortly thereafter.

Restraints, security and bed watch

42. Between 21 November and 9 December, the man was in hospital. During this time, according to the normal practice for category B prisoners, he was accompanied by prison officers and handcuffed to them. Two officers were present at all times. The officers accompanying prisoners during hospital visits are often referred to as bed watch officers. The risk assessments were carried out as appropriate, and the bed watch logs were fully completed. No concerns or issues were reported in these logs.

43. On 27 December, the man was taken back to hospital and was again accompanied by two officers and handcuffed. Two days afterwards, on 29 December, one of the bed watch officers contacted the duty governor at Bullingdon to report that the man's condition had deteriorated, and that handcuffs might no longer be necessary. The duty governor visited the hospital the same afternoon and agreed that the man no longer needed to be handcuffed to the officers. The man moved to the hospice the next day. Handcuffs were re-applied for the journey from the hospital to the hospice, but they were removed when he arrived.

44. I believe that restraints were used appropriately. During his first stay in hospital, the man was relatively well, and it certainly seemed that he was mobile. As a category B prisoner, it was therefore appropriate that he was handcuffed. When his health deteriorated to such an extent that he no longer had any means of escape, one of the bed watch officers alerted the duty governor, and the handcuffs were removed. I am pleased to see that a humane decision was taken quickly in response to the man's worsened

condition. Although he continued to be accompanied by prison officers, the man was not restrained, which gave him some dignity during the last two days of his life.

Support for staff and prisoners

45. In response to the draft version of this report, Bullingdon pointed out that staff and other prisoners were offered full pastoral support after the man's death. A memorial service, held in the prison's chapel shortly before the man's funeral, was well attended by prisoners who had known him during his time in custody.

CONCLUSION

46. The man was at Bullingdon when he sought the attention of medical staff. He was seen promptly, referred appropriately and diagnosed quickly. He spent time in hospital when necessary, but he also lived on a normal residential wing when he was well enough to do so. In late December 2010, his health deteriorated quickly and he moved to hospital and then to a hospice. A decision was made to remove the man's handcuffs.

47. I am satisfied that the man was treated appropriately at all stages. I was pleased to find that a humane decision was taken regarding his handcuffs, and that he was allowed some dignity during the last days of his life.