Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Clifford Ashbourne a prisoner at HMP Birmingham on 11 November 2016

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Clifford Ashbourne died on 11 November 2016 of pyelonephritis (a kidney infection) caused by his myelodysplastic syndrome (a life limiting blood disorder), while a prisoner at HMP Birmingham. He was 77 years old. I offer my condolences to Mr Ashbourne's family and friends.

I am satisfied that Mr Ashbourne received a good standard of care while at Birmingham, equivalent to the level of care he could have expected in the community. The prison implemented care plans that were reviewed regularly and, when the hospital cancelled blood transfusion appointments, the prison healthcare team ensured that Mr Ashbourne received the necessary treatment to prevent his health deteriorating. Mr Ashbourne's resuscitation wishes were also reviewed on a regular basis.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **May 2017**

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Summary

Events

1. On 11 April 2016, Mr Clifford Ashbourne was sentenced to 14 years for historic sexual offences and sent to HMP Birmingham. He had suffered poor health for a number of years and was diagnosed with myelodysplasia (a life limiting blood cancer which affects the bone marrow and the production of healthy red blood cells resulting in anaemia and breathlessness), chronic obstructive pulmonary disease (COPD) and an abdominal aortic aneurysm before coming to prison. Mr Ashbourne required blood transfusions every 21 days to manage his myelodysplasia.

2. On 14 April, Mr Ashbourne saw a specialist nurse practitioner for a chronic disease review. He told the nurse that he knew he was very unwell and had accepted the fact he was dying. Mr Ashbourne said that he did not want to be resuscitated if his heart or breathing stopped and a prison doctor completed an order to that effect.

3. Mr Ashbourne went to hospital for a blood transfusion on 20 April, his first while in prison. Due to a hospital error, the blood transfusions booked for 11 and 31 May were cancelled. To prevent deterioration in his health, the prison healthcare team took Mr Ashbourne to the accident and emergency department to receive the treatment required.

4. On 3 September, after complaining of breathlessness, Mr Ashbourne was taken to hospital. An ultrasound scan showed that his aneurism had grown and required treatment. After surgery, Mr Ashbourne was discharged back to the prison on 8 September. Mr Ashbourne's surgical wound became infected on 12 September. On 19 September, after antibiotics had no effect, he was taken back to hospital for further treatment. Mr Ashbourne returned to the prison on 20 October.

5. Eight days later, Mr Ashbourne's left hand was swollen with a rash on his hands, arms and legs. A blood test showed he had an infection. It was unclear where his infection was as other than his swollen hand and rash he had no other symptoms.

6. On 31 October, an officer found Mr Ashbourne unwell in his cell and he was taken to hospital for treatment for suspected pneumonia. Mr Ashbourne's health continued to deteriorate and, by 6 November, he was bedbound. Two days later, the prison released Mr Ashbourne on temporary licence, although an officer remained with Mr Ashbourne for support.

7. Mr Ashbourne was moved to a hospice on 10 November. He died the following day, on 11 November. The post-mortem indicated that Mr Ashbourne died from pyelonephritis (a kidney infection) caused by his myelodysplastic syndrome.

Findings

8. We are satisfied that Mr Ashbourne received good care while at Birmingham, equivalent to the level of care he could have received in the community. The prison implemented care plans that were reviewed regularly and when the hospital cancelled blood transfusion appointments, the prison healthcare team ensured that Mr Ashbourne received the necessary treatment to prevent his health deteriorating. Mr Ashbourne's resuscitation wishes were also reviewed on a regular basis.

9. While it is outside the Ombudsman's remit, we note that the clinical reviewer had concerns about the standard of clinical care Mr Ashbourne received towards the end of his life while in hospital.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Birmingham informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

11. The investigator obtained copies of relevant extracts from Mr Ashbourne's prison and medical records.

12. NHS England commissioned a clinical reviewer to review Mr Ashbourne's clinical care at the prison.

13. We informed HM Coroner for Birmingham and Solihull of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

14. The Mr Ashbourne's family received a copy of the initial report and indicated that they were satisfied with the findings.

15. The investigation has assessed the main issues involved in Mr Ashbourne's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.

16. The initial report was shared with the Prison Service. The Prison Service pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Birmingham

17. HMP Birmingham is a local prison, principally serving the West Midlands courts, and holds up to 1,450 men. It is managed by G4S Care and Justice Services. Birmingham and Solihull Mental Health Foundation Trust provides 24-hour healthcare services at the prison and sub-contract Birmingham Community Healthcare NHS Trust to provide primary care services, which includes two 15 bed healthcare units.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Birmingham was in February and March 2014. Inspectors noted that health services were generally very good and valued by most prisoners. Patients with complex, acute or chronic needs had access to well-organised inpatient units staffed by caring nurses and officers. External health appointments were rarely cancelled for security reasons. Inspectors noted that the healthcare centre had a new palliative care room and waiting times to see the doctor were less than 48 hours.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to June 2016, the IMB reported that healthcare staff sickness levels had had a negative impact on the prison regime, particularly when multiple unlock was required. However, there continued to be a high level of prisoner satisfaction with the service provided by the healthcare department.

Previous deaths at HMP Birmingham

20. Mr Ashbourne was the fifth prisoner to die of natural causes at Birmingham since January 2016. There have been two subsequent natural cause deaths. There were no similarities between the circumstances of Mr Ashbourne's death and previous deaths at the prison.

Findings

The diagnosis of Mr Ashbourne's terminal illness and informing him of his condition

21. On 11 April 2016, Mr Clifford Ashbourne was sentenced to 14 years for historic sexual offences and was sent to HMP Birmingham. He had suffered poor health for a number of years and was diagnosed with myelodysplasia (a life limiting blood cancer which affects the bone marrow and the production of healthy red blood cells resulting in anaemia and breathlessness), chronic obstructive pulmonary disease (COPD) and an abdominal aortic aneurysm before coming to prison. Mr Ashbourne required blood transfusions every 21 days to manage his myelodysplasia.

22. Mr Ashbourne saw a nurse on reception to prison. She noted that Mr Ashbourne was physically unwell; he had trouble breathing (due to his COPD) and had reduced mobility. She referred Mr Ashbourne for a chronic disease review and to the prison's respiratory nurse for further assessment and asthma management. Mr Ashbourne did not smoke.

23. On 14 April, Mr Ashbourne saw a specialist nurse practitioner for a chronic disease review. Mr Ashbourne told her that his consultant had told him, before coming to prison, that with his COPD, myelodysplasia and his aneurysm, he could die suddenly without warning. He said that he had accepted the fact of dying and had already made funeral arrangements and paid for his cremation.

24. We note that Mr Ashbourne entered Birmingham with a terminal condition and that healthcare staff took appropriate steps to assess his chronic diseases.

Mr Ashbourne's clinical care

25. During the chronic disease review with the specialist nurse practitioner, Mr Ashbourne said that he did not want staff to resuscitate him if his heart or breathing stopped. She created care plans to treat Mr Ashbourne's myelodysplasia with regular transfusions and to treat his COPD.

26. A prison GP spoke to Mr Ashbourne the same day about his resuscitation wishes. After discussion, he agreed to Mr Ashbourne's request and completed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order. Healthcare staff continued to check Mr Ashbourne's resuscitation wishes, and he reiterated that he did not want to be resuscitated.

27. Mr Ashbourne was sent to hospital for a blood transfusion on 20 April, his first while in prison.

28. On 5 May, Mr Ashbourne saw a physiotherapist, who noted that he was independently mobile with two walking sticks, but struggled with stairs.

29. The hospital cancelled Mr Ashbourne's blood transfusions on 11 and 31 May. On both occasions, healthcare staff sent him to the hospital's accident and emergency department so that he could get a blood transfusion. After this, Mr Ashbourne continued to receive blood transfusions at hospital every 21 days.

30. On 3 September, Mr Ashbourne told a nurse that he was experiencing breathlessness. As he was due a blood transfusion, she sent him to another hospital. Mr Ashbourne was admitted to the vascular ward on 4 September where he had an MRI and ultrasound scan. The results of these scans showed that his aneurysm had grown. Mr Ashbourne had surgery on his enlarged abdominal aortic aneurism on 5 September.

31. Mr Ashbourne was discharged back to the prison's inpatient unit on 8 September. The following day, an occupational therapist completed a personal care assessment for Mr Ashbourne.

32. Mr Ashbourne's surgical wound became infected on 12 September and healthcare staff treated it with antibiotics. On 19 September, as antibiotics had had no effect, he was taken to hospital. Mr Ashbourne was given intravenous antibiotics and a drain was inserted into his wound. One month later, on 20 October, when his wound appeared healthy with no obvious signs of infection he was discharged back to the prison's inpatient unit.

33. On 28 October, a nurse noticed that Mr Ashbourne's left hand was swollen with a rash on both his hands, arms and legs. A prison GP diagnosed vasculitis and ordered an urgent blood test. (Vasculitis is an inflammation in the immune system's response to injury or infection. It can range from a minor skin problem to a more serious illness that can cause problems with organs such as the heart or kidneys.)

34. Mr Ashbourne's blood results, received on 30 October, showed he had an infection. Healthcare staff could not tell the location of the infection because apart from his swollen hand and rash, he had no other symptoms.

35. At 8.13am on 31 October, an officer found Mr Ashbourne unwell in his cell and asked for healthcare assistance. Healthcare staff attended and they asked for an emergency ambulance. The specialist nurse practitioner examined Mr Ashbourne and found his skin was mottled and his oxygen levels were low at 89%. He was pale and complained of being cold. Mr Ashbourne was taken to hospital at 9.25am.

36. Mr Ashbourne was admitted to hospital and given strong intravenous (IV) antibiotics for suspected pneumonia. Mr Ashbourne's health continued to deteriorate so, on 4 November, a prison nurse made a referral to a hospice. Two days later, Mr Ashbourne was bedbound but requested that all active treatment be continued at that time.

37. Prison escort records show that, on 8 November, Mr Ashbourne did not receive sufficient pain relief from hospital staff. Escort records show that Mr Ashbourne asked for pain relief at 6.20pm, but it was not provided until 7.41pm. While hospital care is outside of the Ombudsman's remit, we note that the clinical reviewer has commented on this incident in his report and made a recommendation for improvement.

38. Mr Ashbourne declined any further treatment on 9 November. He was unable to swallow and asked to receive oxygen and pain relief only. The following day, the

specialist nurse practitioner arranged for Mr Ashbourne to be transferred to the hospice in the course of the day.

39. Mr Ashbourne's condition to deteriorate and he died at 10.50pm on 11 November. Hospice staff contacted Mr Ashbourne's daughter to inform her of the news.

40. The post mortem indicated that Mr Ashbourne died from pyelonephritis (a kidney infection) caused by his myelodysplastic syndrome.

41. We are satisfied that Mr Ashbourne received good care while at Birmingham, equivalent to the level of care he could have received in the community. The prison implemented care plans that were reviewed regularly and when the hospital cancelled blood transfusion appointments, the prison healthcare team ensured that Mr Ashbourne received the necessary treatment to prevent his health deteriorating. Mr Ashbourne's resuscitation wishes were also reviewed on a regular basis.

Mr Ashbourne's location

42. Mr Ashbourne lived on the older persons' wing and when required spent time in the prison's inpatient unit.

43. When Mr Ashbourne's health began to deteriorate, healthcare staff sent him to hospital and then onto the hospice.

44. We are satisfied that Mr Ashbourne was appropriately located throughout his illness.

Restraints, security and escorts

45. When prisoners have to travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk taking into account factors such as the prisoner's health and mobility.

46. Mr Ashbourne attended hospital every 21 days for a blood transfusion. He was mobile and escorting records show that prison managers authorised that he be restrained with a single handcuff. While Mr Ashbourne's escort risk assessment confirmed that restraints could be removed for emergency treatment with the authority of the duty governor, the handcuff was not removed for his blood transfusions.

47. When Mr Ashbourne was taken to hospital on 31 October. Due to his reduced mobility, a prison security manager authorised officers not to restrain him. Mr Ashbourne was not restrained before his death.

48. We are satisfied that the level of restraints used on Mr Ashbourne was appropriate and that prison managers reviewed his risk as his condition deteriorated.

Liaison with Mr Ashbourne's family

49. When Mr Ashbourne was taken to hospital by emergency ambulance on 31 October, a PCO (Prison Custody Officer) who is also a trained family liaison officer, telephoned his daughter to tell her that her father was in hospital. Prison bedwatch records show that escorting staff were told that Mr Ashbourne's daughter could visit during hospital visiting times and that privacy must be afforded to her.

50. The PCO kept in regular contact with Mr Ashbourne's daughter and she confirmed that if her father died during the day she was happy to be contacted by phone. A visit to her home could take place if he died during the night.

51. Mr Ashbourne died at 10.50pm on 11 November. The PCO was notified of the death by the prison Director approximately two hours later. She telephoned the hospice to speak to Mr Ashbourne's daughter to offer her support. She followed up this call by visiting Mr Ashbourne's daughter's home two days later, on 14 November.

52. The PCO continued to offer support and attended Mr Ashbourne's funeral on 9 December. The prison offered a contribution towards the cost of the funeral in line with national policy. However, Mr Ashbourne had a funeral care policy in place which covered the cost of the funeral. The prison paid for the Order of Service leaflets, which was not covered by this policy.

Release on temporary licence

53. Release on temporary licence (ROTL) can be granted for precisely defined and specific activities which cannot be provided in the prison. A risk assessment is completed to ensure that the prisoner's temporary release does not present unacceptable risks. The Director and Controller of a privately operated prison is able to grant the temporary licence and will decide on whether the prisoner is to be accompanied by staff.

54. Mr Ashbourne was granted release on temporary licence (special purpose license) on 8 November 2016. An officer remained with Mr Ashbourne to support him while at the hospital and hospice. Mr Ashbourne was not restrained and the accompanying officer was allowed to leave the room to provide Mr Ashbourne and his family with the privacy required.

55. We are satisfied that the prison appropriately granted ROTL, which allowed Mr Ashbourne to die with dignity.

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