Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Baggaley a prisoner at HMP Lincoln on 24 September 2016

A report by the Prisons and Probation Ombudsman
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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.

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

Mr Michael Baggaley died on 24 September 2016 of bronchopneumonia caused by a brain tumour at HMP Lincoln. Mr Baggaley was 73 years old. I offer my condolences to Mr Baggaley's family and friends.

Mr Baggaley's health had deteriorated rapidly with his diagnosis of a brain tumour coming only a few days before he passed away. He received a standard of healthcare equivalent to that he could have expected in the community, though there were delays in arranging an MRI scan and in starting a social care package.

It is of concern that officers restrained Mr Baggaley until two days before his death, despite his reliance on a wheelchair and his deteriorating health.

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

Richard Pickering
Deputy Prisons and Probation Ombudsman **May 2017**

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Summary

Events

1. On 23 September 2015, Mr Michael Baggaley was remanded to HMP Lincoln following his conviction for sexual offences. He was sentenced to 24 years in prison the next day.

2. Mr Baggaley's initial medical screening revealed that he had previously had a splenectomy (a surgical procedure to remove your spleen) for Non-Hodgkin's lymphoma, but he was reasonably active and fit at that time.

3. In May 2016, Mr Baggaley began demonstrating unusual behaviour and developed urinal incontinence, though he denied this. His condition deteriorated and he became increasingly confused, disorientated and incontinent. Healthcare staff referred him for a mental health assessment, which Mr Baggaley did not attend.

4. Mr Baggaley was taken to hospital several times in June and July following falls. CT scans, blood tests and an echocardiogram failed to reveal anything. On 18 August, Mr Baggaley suffered another fall and was taken to hospital. A CT scan showed that Mr Baggaley had a 'non specific grey white matter differentiation'. Hospital doctors requested an MRI scan in July, which was delayed due to concern that Mr Baggaley had 'metal work' in him, and August, which the prison eventually booked for 27 September.

5. At a review into Mr Baggaley's condition on 13 September, a prison GP arranged for his immediate transfer to hospital, as he feared a malignancy (a tumour) in Mr Baggaley's brain.

6. While in hospital, Mr Baggaley's health deteriorated rapidly and he had an emergency MRI scan on 19 September. The results indicated a frontal lobe tumour but hospital doctors could not determine whether it was treatable because they considered that Mr Baggaley was not fit enough for a biopsy. Mr Baggaley's health declined further and he died at 5.06am on 24 September.

Findings

7. Overall, we are satisfied that the clinical care Mr Baggaley received at Lincoln was equivalent to what he could have expected to receive in the community. As Mr Baggaley's condition deteriorated, the prison made regular referrals to specialists, though nothing was detected until a CT scan on 18 August and an MRI scan on 19 September. While overall care was appropriate, we are concerned that there were missed opportunities to perform MRI scans because healthcare staff did not chase up Mr Baggaley's community GP records to ascertain whether he had 'metal work' in him and overlooked the hospital's recommendation that he be referred for an MRI.

8. We consider that healthcare staff and prison staff appropriately cared for Mr Baggaley's social care needs when he began to suffer from falls and incontinence, though we are concerned at the delays in the local authority providing this social care.

9. Mr Baggaley was restrained during his time in hospital until 22 September despite being elderly and in very poor health. The risk assessments that were completed failed to address Mr Baggaley's risk of escape given his condition and mobility at the time. We were not satisfied that prison staff followed, or were aware of, legal guidance for using restraints as a prisoner's health deteriorates.

Recommendations

- The Head of Healthcare should ensure that community GP records and other relevant records are routinely requested and chased up to ensure continuity of healthcare in line with PSO 3050.
- The Head of Healthcare should ensure that, in line with information from hospital discharge summaries, urgent referrals for investigative tests are made within 24 hours.
- The Governor and the Head of Healthcare should liaise with the local authority to ensure that prisoners' social care needs are promptly assessed and that care packages are quickly started.
- The Governor and the Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Lincoln informing them of the investigation and asking anyone with relevant information to contact him. Two prisoners responded.

11. The investigator obtained copies of relevant extracts from Mr Baggaley's prison and medical records. He and another investigator interviewed a member of staff and two prisoners at HMP Lincoln on 5 October 2016. He also spoke to another member of staff on the telephone on 13 October.

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

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

14. One of the Ombudsman's family liaison officers contacted Mr Baggaley's wife, to explain the investigation and to ask if she had any matters they wanted the investigation to consider. Mr Baggaley's wife asked us to consider the level of personal care that he received.

15. Mr Baggaley's wife received a copy of the initial report. She raised a number of questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

16. We shared the initial report with the prison service. We are disappointed they have not responded in time. They have not submitted an action plan addressing our recommendations or detailed any factual inaccuracies.

Background Information

HMP Lincoln

17. HMP Lincoln houses up to 738 remand and convicted men. It serves the courts of Lincolnshire, Nottinghamshire and Humberside. It has four residential wings, which includes a vulnerable prisoners unit. Nottingham Healthcare NHS Trust provides health services and there is 24-hour nursing cover. There is no inpatient unit at Lincoln; social care is organised externally with Lincolnshire County Council.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Lincoln was in November 2013. Inspectors reported that health services had improved overall since the previous inspection. The health services team delivered a wide range of chronic disease clinics, with reasonable waiting lists. Inspectors noted that disabled prisons received good clinical support, but that their social care needs were not adequately met. Although there were no formal prisoner carers, some prisoners received informal help from cellmates and friends. Inspectors recommended that social care plans should be developed for all prisoners with disabilities who require additional help with everyday tasks.

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 January 2016, the IMB reported concerns about the lack of facilities for prisoners with a physical disability or reduced mobility. It also noted that the special accommodation cell remained unavailable having been deemed unfit for purpose throughout the year.

Previous deaths at HMP Lincoln

20. Mr Baggaley was the second person to die from natural causes at HMP Lincoln since January 2015. There have been three deaths subsequently. There were no similarities between the circumstances of Mr Baggaley's death and the previous death at the prison.

Key Events

21. Mr Michael Baggaley was convicted of historic sex offences on 23 September 2015 and remanded to HMP Lincoln. He was sentenced to 24 years in prison the following day. He was 72 years of age when he first arrived at Lincoln.

22. When he arrived at Lincoln, a nurse reviewed Mr Baggaley at an initial health screen. Mr Baggaley said that he had had a splenectomy (a surgical procedure to remove the spleen) for Non-Hodgkin's lymphoma (a group of blood cancers that develops from lymphocytes). She considered that Mr Baggaley was mobile and suitable for a multi cell location. Staff and fellow prisoners said he was active and alert during his first few months at Lincoln.

23. There was no record of other serious treatment, but, in June 2016, Mr Baggaley's wife told healthcare staff that he had two bone marrow transplants and chemotherapy, though he had not been treated since 2002.

24. Shortly after Mr Baggaley arrived at Lincoln, a number of entries in his medical record show requests that his community GP confirm his current medication and whether he had any outstanding hospital appointments. On 28 September, the prison received a fax from Mr Baggaley's community GP that confirmed his medications, though there was nothing to suggest his full notes had been received at this stage.

25. Between September 2015 and May 2016, healthcare staff saw Mr Baggaley occasionally for minor health issues.

26. On 12 May 2016, Mr Baggaley's cellmate told prison staff that Mr Baggaley was having strange conversations and was incontinent, though Mr Baggaley denied this. Healthcare staff referred Mr Baggaley for a mental health assessment; he did not attend the appointment as he felt he did not need any support.

27. On 25 May, healthcare staff attended to Mr Baggaley after he fell while working in the textile workshop. He denied being unconscious and said he had fallen; he told a prison GP that he had been feeling light headed for the past four weeks. The GP diagnosed the fall as a collapse and asked staff to keep him under observation for two days.

28. Later that day, a nurse saw Mr Baggaley for a mental health review. She did not notice anything odd during the review though she noted that Mr Baggaley was vague at times. Mr Baggaley said that he did not have a problem with his memory and there was no family history of dementia.

29. On 2 June, a prison GP referred Mr Baggaley to healthcare for the elderly at the hospital, as he was concerned that he was unsteady and incontinent. The hospital arranged an appointment for 21 September.

30. On 19 June, Mr Baggaley collapsed in the exercise yard and a nurse sent him to hospital for observations. A week later, another nurse sent him to hospital as he had a low oxygen saturation level and low blood pressure. On both occasions, hospital doctors performed CT scans that showed nothing abnormal. Following

the second admission, blood test results and an echocardiogram were also normal.

31. On 29 June, a prison GP reviewed Mr Baggaley, noted that he was very vague and suspected that he had dementia. The GP referred Mr Baggaley to a psychiatrist.

32. On the same day, a member of Lincolnshire County Council assessed Mr Baggaley for adult social care but decided that he did not fit the criteria at that time, as his needs were health related.

33. A psychiatrist saw Mr Baggaley, on 4 July, and recommended that a full medical assessment be carried out to explore other possible causes before a diagnosis of dementia was considered. In particular, she suggested that brain metastases (cancer cells that have spread to the brain from primary tumours in other organs in the body) needed to be discounted, though she noted that this diagnosis was unlikely in light of recent, normal CT scans of his head.

34. On 8 July, Mr Baggaley collapsed on the wing, cut his head and was taken to hospital. Hospital doctors wanted to perform an MRI scan but could not due to fears that he had 'metal work' in him from a previous procedure. Three days later, the prison sent a letter to his community GP requesting his full medical notes and whether he had any metal in his body. There was no record that the prison received Mr Baggaley's full medical notes or chased up a response, though his community GP confirmed, on 16 September, that he did not have any metal in his body.

35. On 22 July, a member of Lincolnshire County Council arranged for Mr Baggaley to receive daily social care. By 10 August, he confirmed that carers would support Mr Baggaley for 15 hours a week.

36. On 18 August, a nurse reviewed Mr Baggaley after he sustained a cut to the head. She noted that his oxygen saturation level was low and he had a slight droop to his mouth, so sent him to hospital for assessment. Hospital doctors performed a CT scan, which showed a 'non specific grey white matter differentiation', and recommended prison healthcare staff request an outpatient MRI scan for Mr Baggaley. Upon his return to the prison, healthcare staff started hourly welfare checks.

37. Ten days later, a nurse reviewed Mr Baggaley after he collapsed. She noted that his oxygen saturation level was low, so sent him to hospital for assessment. A CT scan revealed that Mr Baggaley had not suffered an acute injury but it detected 'diffuse changes in the white matter of the frontal cortex'. A hospital doctor recommended an MRI scan as soon as possible.

38. On 2 September, the prison made a referral for Mr Baggaley to have an MRI scan, which the hospital arranged for 27 September.

39. A letter from a worker from Lincolnshire County Council to Mr Baggaley, dated 14 September, confirmed his eligibility for personal social care following an assessment on 8 August. He confirmed that an agency had been commissioned to perform this role. A week earlier, a member of healthcare staff complained to

Lincolnshire County Council about the delays in starting Mr Baggaley's social care.

40. Two days later, a nurse created a falls care plan to reduce the number of falls that Mr Baggaley had experienced. She also arranged for Mr Baggaley to move to a single cell and approached HMP Whatton to see whether he could be admitted to their inpatient unit.

41. A multi-disciplinary meeting was held on 13 September to discuss Mr Baggaley's condition and care. It was noted that a social care plan was due to start on 23 September. A prison GP stated that he now suspected a possible malignancy (a tumour) in his brain and it was agreed that Mr Baggaley should be admitted to hospital as soon as possible for specific investigations including an MRI scan. Mr Baggaley was sent to hospital that day. Two officers accompanied Mr Baggaley and restrained him with an escort chain.

42. Following his admission to hospital, Mr Baggaley's condition deteriorated rapidly. On 19 September, Mr Baggaley had an emergency MRI scan, which revealed a sizeable shadow consistent with a malignancy on the brain. Hospital doctors decided that he needed a biopsy to determine whether this was treatable but were unsure whether Mr Baggaley would recover from it.

43. At 11.45pm on 23 September, Mr Baggaley went into respiratory arrest. Hospital doctors attempted to resuscitate him but they were unsuccessful and his death was confirmed at 5.06am on 24 September.

Contact with Mr Baggaley's family

44. On 14 September 2016, the prison appointed a senior officer as the Family Liaison Officer due to the deterioration in Mr Baggaley's condition and to ensure better communication. He contacted Mr Baggaley's wife that day to update her on his condition and agreed to talk with her on a weekly basis.

45. At 0.45am on 24 September, the senior officer contacted Mr Baggaley's wife to inform her that he had gone into respiratory arrest. Mr Baggaley's family went to the hospital and he met them to offer his support. Mr Baggaley's family remained with him until after he passed away.

46. On 26 September, the senior officer visited Mr Baggaley's wife to return his possessions and to offer ongoing support.

47. Mr Baggaley's funeral was held on 14 October, and the prison contributed to the funeral costs in line with national guidance.

Support for prisoners and staff

48. After Mr Baggaley's death, the staff care team offered support to the staff involved in the bed watch.

49. The prison posted notices informing other prisoners of Mr Baggaley's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm prevention in case they had been adversely affected by Mr Baggaley's death.

Post-mortem report

50. The post mortem report concluded that the immediate cause of Mr Baggaley's death was pneumonia caused by a recurrent lymphoma within the brain.

Findings

Clinical care

51. The clinical reviewer noted that the deterioration in Mr Baggaley's health and mental state occurred over a three-month period. During that time, healthcare staff made a number of referrals to external medical professionals and Mr Baggaley went to hospital a number of times for tests. After two normal CT scans, hospital doctors diagnosed Mr Baggaley with a malignancy on the brain after a CT scan in August and an MRI scan in September.

52. As the MRI scan led to detection of the malignancy, we are concerned that there were missed opportunities to perform an earlier scan in July and August. On 8 July, hospital doctors wanted to perform an MRI scan but could not due to fears that Mr Baggaley had 'metal work' in him. Despite requesting his community GP records, healthcare staff failed to chase up the records to provide confirmation to the hospital.

53. Prison healthcare staff also overlooked the hospital's recommendation that an MRI scan was arranged on 18 August, and did not request one until 2 September, following a second request on 28 August. While an earlier scan was unlikely to have affected the outcome for Mr Baggaley, we consider that quicker referrals and promptly obtaining a prisoner's community GP records could make a difference in the future. We make the following recommendations:

    The Head of Healthcare should ensure that community GP records and other relevant records are routinely requested and chased up to ensure continuity of healthcare in line with PSO 3050.

    The Head of Healthcare should ensure that, in line with information from hospital discharge summaries, urgent referrals for investigative tests are made within 24 hours.

54. As his health deteriorated, Mr Baggaley became incontinent, increasingly prone to falls and unable to care properly for himself. Initially, in June, Lincolnshire County Council assessed that Mr Baggaley did not require adult social care but decided on 8 August that he fitted the criteria, though his care was not scheduled to start until 23 September. As a result, healthcare staff, prison staff and fellow prisoners provided Mr Baggaley social and personal care to the best of their ability.

55. While we agree with the clinical reviewer that the prison cared for Mr Baggaley's social care needs appropriately, we are concerned that the local authority had not started this care by the date of his death, despite having assessed him as needing it six weeks earlier. We believe that there needs to be a greater level of liaison between the prison and the local authority to ensure that similar circumstances do not arise in the future. We make the following recommendation:

    The Governor and the Head of Healthcare should liaise with the local authority to ensure that a prisoner's social care needs are promptly assessed and that care packages are quickly started.

56. Overall, we agree with the clinical reviewer that, despite delays arranging an MRI scan and securing social care from Lincolnshire County Council, that healthcare staff had taken appropriate steps to obtain a diagnosis and care for Mr Baggaley. We agree that the care Mr Baggaley received was equivalent to that he could have expected to receive in the community.

Restraints, security and escorts

57. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

58. When Mr Baggaley was first admitted to hospital on 13 September, a nurse decided that there were no medical objections to the use of restraints, though she noted that he used a wheelchair. A security analyst confirmed that Mr Baggaley presented a high risk to the public and to females, and a medium risk of escape so recommended that double cuffs should be used while he was in transit and an escort chain while in hospital. (Double cuffing is when the prisoner's hands are handcuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs and an escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.) The documentation we have reviewed is incomplete and does not record who authorised this decision.

59. This risk assessment was reviewed on 16 September, and a senior prison manager authorised the same level of restraint. However, a security analyst confirmed that Mr Baggaley's risk levels had deceased as he presented a medium risk to females and children, and a low risk to the public and of escape.

60. At 3.39pm on 19 September, a nurse emailed a senior prison manager and requested that the use of restraints was reviewed. She pointed out that Mr Baggaley's condition had deteriorated and that he was sedated, lacked mobility and could only communicate by nodding his head. The following day, the risk assessment was reviewed again and it was decided that the escort chain should be switched to alternate wrists every two hours to prevent irritation.

61. On 22 September, the senior prison manager reviewed the risk assessment and decided that, due to Mr Baggaley's ill health, no restraints should be used. Officers removed the restraints and there were not reapplied.

62. While we are satisfied that the prison continually reviewed the use of restraints and decided to remove them on 22 September, we are concerned about the decision to use restrain him when he went to hospital. The risk assessment appears to have been based primarily on Mr Baggaley's offence, with little

consideration of his actual risk or how his health affected this risk, as the 2007 High Court judgment requires. We are also concerned that the escort chain continued to be used despite information from the nurse that reflected the extent of his deterioration. Whenever restraints are used the risk assessments must accurately reflect the risk posed at that time to ensure proportionality and to maintain human dignity. We make the following recommendation:

The Governor and the Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

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