Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr James Bronson at a hospice on 19 January 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.

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 James Bronson died of lung cancer at a hospice on 19 January 2016. He had been released on licence from HMP Wayland the day before. Mr Bronson was 61 years old. I offer my condolences to those who knew him.

I am satisfied that Mr Bronson received a good standard of care at Wayland during his terminal illness and healthcare staff were compassionate and sensitive to his needs. As his condition deteriorated, he was moved to a hospice, where he was able to die with dignity.

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 **June 2016**

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Summary

Events

1. In December 2009, Mr James Bronson was recalled to prison for a breach of his licence. He had been at HMP Wayland since April 2011.

2. In June 2014, Mr Bronson reported a persistent cough, which was treated as a symptom of longstanding asthma. By December, his condition had not improved and he had lost weight. A prison GP referred him for a chest X-ray, which showed some abnormalities and referred him urgently to a specialist. In January 2015, Mr Bronson was diagnosed with lung cancer.

3. In March, after further investigations, doctors indicated that Mr Bronson might live one to two years. Between April and November, Mr Bronson received chemotherapy and radiotherapy aimed at prolonging his life but further tumours developed. In December, doctors revised Mr Bronson's prognosis to a few months.

4. Mr Bronson was admitted to a hospice on 30 December. On 18 January, he was released on licence. The next day, he died at the hospice.

Findings

5. Prison doctors appropriately considered Mr Bronson's symptoms and his diagnosis was prompt. Healthcare staff developed appropriate care plans, held case management meetings and liaised effectively with community palliative care services to help ensure Mr Bronson received a good standard of care.

6. We are satisfied that Mr Bronson's care at Wayland was equivalent to that he could have expected to receive in the community. The prison took appropriate steps to pursue his release on licence and although he was not formally released until the day before he died, he had good end of life care and was able to die with dignity, in a caring environment.

The Investigation Process

7. Mr Bronson was no longer a serving prisoner at the time of his death. When we were notified of his death, we were not informed that he had been released. Subsequently, we decided to investigate the circumstances of his death, at the Ombudsman's discretion, as he had died within 24 hours of being released on licence. Until that point, the prison had overall responsibility for his care.

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

9. The investigator obtained copies of relevant extracts from Wayland's prison and medical records.

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

11. We informed HM Coroner for Greater Norfolk of the investigation, who gave us the cause of death. We have sent the coroner a copy of this report.

12. Mr Bronson had not named any next of kin and had not been in contact with members of his family for many years. Enquiries by the Salvation Army, the prison chaplain and the police were not able to trace any family.

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

14. The initial report was shared with the Prison Service. There were no factual inaccuracies. Mr Bronson did not have any next of kin to share the report with.

Background Information

HMP Wayland

15. HMP Wayland is a medium security prison, near Thetford in Norfolk, holding over 1,000 men in thirteen residential units. Virgin Care provides healthcare services.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Wayland was in August 2013. Inspectors reported that healthcare had improved since the last inspection. Prisoners had access to a range of well-run clinics, including an older persons' clinic. There was very good access to nurse practitioner services, with prisoners seen within 48 hours. Prisoners over the age of 44 had routine annual health checks.

Independent Monitoring Board

17. 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 May 2015, the IMB reported that Virgin Care delivered a sustainable, reliable service, although the IMB was concerned about the high numbers of temporary healthcare staff.

Previous deaths at HMP Wayland

18. Mr Bronson was the third man from Wayland to die from natural causes since October 2012. There were no significant similarities with the circumstances of the previous deaths.

Findings

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

19. On 22 October 2004, Mr James Bronson was sentenced to 15 years in prison for wounding with intent to cause grievous bodily harm. On 29 October 2009, he was released on conditional licence but his licence was revoked on 31 December and he was recalled to prison. He had been at Wayland since April 2011.

20. In June 2014, Mr Bronson reported having a tickly cough and that he had been sneezing for a few weeks. A nurse noted that he had a history of asthma, which was aggravated by pollen. Healthcare staff treated Mr Bronson's cough as asthma for the next few months.

21. On 4 December 2014, a nurse practitioner diagnosed severe asthma, and prescribed prednisolone (a steroid drug). She planned to refer Mr Bronson for a chest X-ray if his cough did not improve. On 8 December, she reviewed Mr Bronson and noted there had been very little improvement. She prescribed another course of prednisolone, and referred him to a GP.

22. On 11 December, a prison GP noted that the steroids had not helped Mr Bronson and he had lost weight. She noted that he had been a heavy smoker, but had stopped smoking nine years before. She referred Mr Bronson for a chest X-ray at hospital.

23. On 23 December, Mr Bronson had the X-ray and the next day the prison GP reviewed the results, which indicated abnormalities. She referred him urgently to a specialist under the NHS pathway that requires patients with suspected cancer to be seen within two weeks.

24. On 14 January 2015, doctors at the hospital told Mr Bronson it was likely that he had lung cancer and they arranged a CT scan for 19 January. When he got back to the prison, a nurse reassured him that the hospital would tell him the results as soon as they had a clear diagnosis.

25. On 29 January, hospital doctors confirmed that Mr Bronson had lung cancer, and his prognosis was poor.

26. We are satisfied that healthcare staff at Wayland reviewed Mr Bronson frequently, and considered his symptoms appropriately. A doctor referred him to a specialist promptly when she identified concerns that might indicate cancer and there was no delay in his diagnosis.

Mr Bronson's clinical care

27. From the end of December, Mr Bronson told a nurse that his symptoms were getting worse and he found it difficult to eat. She booked a full physical health check with a nurse practitioner, who examined him the same day. She prescribed amoxicillin (an antibiotic) and ordered a food replacement drink. A week later, the nurse requested a soft diet for Mr Bronson and the kitchen continued to provide him with appropriate meals for the rest of his time at Wayland.

28. On 8 February, Mr Bronson refused to attend a hospital appointment for a bronchoscopy and biopsy. He said that he suffered from panic attacks and wanted the officers who usually escorted him. The hospital re-arranged the appointment and he attended on 21 February.

29. Mr Bronson attended two hospital appointments in March to discuss his diagnosis and treatment plan. Doctors planned a course of chemotherapy, followed by radiotherapy to shrink the tumour. His life expectancy was estimated at one to two years. On 10 April, Mr Bronson transferred to HMP Norwich where he could receive 24-hour healthcare support during his chemotherapy treatment.

30. On 20 April, Mr Bronson refused to go to hospital for treatment because he was unfamiliar with the escort officers. He would not change his mind, said he was dissatisfied with his care at Norwich and refused to comply with his treatment. Healthcare staff considered he did not need the level of care Norwich offered because he was independent and able to care for himself, so he was sent back to Wayland on 7 May. Mr Bronson then continued chemotherapy.

31. Between May and September, Mr Bronson frequently refused to attend hospital appointments because he did not know the escort staff. On 29 July, this was discussed at a multidisciplinary team meeting. The meeting agreed that, where possible, the prison would arrange an officer he knew, to take him to hospital appointments.

32. On 11 September, Mr Bronson refused to attend his first radiotherapy appointment because he did not know the escort officers. Mr Bronson said he was happy to have one officer he knew, paired with a new officer who he would learn to trust. This would allow the prison to have a pool of officers to escort him. On 17 September, Mr Bronson told a nurse that he wanted healthcare staff to resuscitate him if his heart or breathing stopped.

33. By 6 November, Mr Bronson completed chemotherapy and radiotherapy. On 2 December, a CT scan showed that his original tumour had shrunk, but others had developed. A prison GP made plans for Mr Bronson's palliative care. On 14 December, hospital doctors explained that they would treat the new tumours to help manage his pain and make him comfortable, but they did not expect him to live more than two to three months.

34. On 23 December, Mr Bronson had a further discussion about resuscitation with the Head of Healthcare. He decided that he did not want anyone to try to resuscitate him and a doctor formally recorded this decision.

35. On 30 December, Mr Bronson was admitted to a hospice for a pain control assessment. While at the hospice, Mr Bronson's health deteriorated and he remained there for intravenous antibiotics. Mr Bronson died at the hospice at 4.00am on 19 January.

36. A post-mortem examination found that Mr Bronson had died from metastatic lung carcinoma (cancer that had spread), bronchopneumonia (inflammation of the lungs) and heart disease.

37. This was the first time that healthcare staff at Wayland had managed a prisoner's end of life care. They created appropriate care plans and worked collaboratively

with community palliative care specialists. After his diagnosis, Mr Bronson could be difficult and often refused to attend hospital appointments with unfamiliar officers. Senior managers were flexible and sympathetic to his request for escort staff he knew and accommodated this where possible. We are satisfied that Mr Bronson received a good standard of healthcare at the prison.

Mr Bronson's location

38. Mr Bronson lived in a single cell at Wayland. In September 2015, a nurse requested that social services assess his needs. On 8 October, a social worker and occupational therapist visited and recommended a rail over his bed and near the toilet, a fold up seat in the shower, and a repose mattress to reduce pressure sores. Mr Bronson's cell was altered accordingly. They also recommended that staff unlock Mr Bronson an hour earlier than other prisoners, to allow him to shower in peace.

39. On 20 October, a nurse and a prison GP referred Mr Bronson for a hospice bed. On 11 December, the Head of Healthcare told Mr Bronson that a transfer plan had been arranged. He would remain at Wayland for as long as he was comfortable, but when his health deteriorated, he would have to move to Norwich, or a hospice. Mr Bronson said that he did not want to go to Norwich. On 30 December, a bed became available at the hospice for a pain control assessment and Mr Bronson was moved there.

40. On 12 January, a nurse and a senior manager visited Mr Bronson and noted that his condition had improved slightly. A hospice doctor told the nurse that Mr Bronson would need to stay at the hospice for another week. If he remained stable, he would move to Norwich, but if his health deteriorated, he would stay at the hospice for end of life care. Mr Bronson remained at the hospice until he died.

41. We are satisfied that the prison appropriately took account of Mr Bronson's needs and that he was appropriately located throughout his terminal illness.

Restraints, security and escorts

42. When prisoners have to travel outside of the prison to a hospital or hospice, a risk assessment determines the nature and level of any security arrangements, including any 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 take into account factors such as the prisoner's health and mobility.

43. Between April and December 2015, Mr Bronson attended 19 hospital appointments. All but three of the escort risk assessments had a medical opinion of Mr Bronson's health, but the medical input into the last four assessments was very vague. For each journey, security staff assessed that Mr Bronson was still physically able to escape and a risk to the public. Prison managers decided that officers should restrain Mr Bronson, with either an escort chain or handcuffs.

44. On 1 October, a prison manager noted that Mr Bronson's health had deteriorated but he remained mobile. Although he was not as strong as a well man of comparable age, he was able to participate fully in prison activities and walked

from the prison transport into the hospital for his weekly radiotherapy treatment. He decided that officers should continue to restrain Mr Bronson.

45. No restraints were used when Mr Bronson was taken to the hospice at the end of December but the intravenous drugs he received improved his mobility. On the evening of 2 January, a prison manager noted in the escort log that Mr Bronson had been rude and aggressive to hospice staff and had repeatedly wandered into other patients' rooms.

46. The next day, the Head of Security reviewed Mr Bronson's risk assessment, based on the prison manager's entry in the log. A nurse had noted that doctors at the hospice had advised that Mr Bronson's behaviour was due to delirium as a result of sepsis and that he should not be restrained unless absolutely necessary. However, the Head of Security concluded that officers should use an escort chain to restrain Mr Bronson. She noted that if his medical condition, attitude and/or mobility changed, escort staff should contact the prison's duty manager to review the risk assessment. She planned to review this again after prison healthcare staff visited him on 4 January.

47. On 5 January, a hospice doctor queried the use of restraints with the Head of Security. She agreed that a manager would review the risk when he visited Mr Bronson that afternoon. The manager consulted the medical staff at the hospice, who said that Mr Bronson was not aggressive. He therefore agreed that the escort chain should be removed and he was not restrained again.

48. We are concerned that restraints appear to have been used to control Mr Bronson's behaviour, which was a symptom of his medical condition, rather than because he was assessed as a risk to the public. We consider prison staff should have accepted the view of hospice staff on 3 January that restraints should be used only if absolutely necessary. It is difficult to see that this was the case, especially as there were two escort officers with him at all times. The prison needs to follow the legal guidance for the use of restraints for terminally prisoners and ensure that risk assessments take full account of medical opinion and that restraints are used in such circumstances, only when there are genuine overriding security considerations. As the escort chain was removed on 5 January, and Mr Bronson was not restrained for the last two weeks of his life, we do not make a formal recommendation.

Liaison with Mr Bronson's family

49. After his diagnosis, Mr Bronson told several members of staff that he wanted to find his two children and two sisters. However, he had not been in contact with any of them for 30 years and had only limited information about them. Even with the help of the Salvation Army, the prison chaplain and the police, it was not possible to trace any of Mr Bronson's family members before he died. All subsequent efforts to trace them were unsuccessful.

50. Mr Bronson asked the prison's family liaison officer to notify two of his friends after he died, which he did. The prison arranged and paid for Mr Bronson's funeral, which was held on 10 February.

Compassionate release

51. Prisoners can be released before their sentence has expired, on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.

52. On 23 July 2015, the Parole Board considered Mr Bronson's suitability for release but asked for further information about his risk management plan. Mr Bronson's offender manager and his offender supervisor tried to find suitable accommodation for Mr Bronson in his area of choice, but he had no ties there. A friend of Mr Bronson offered independent accommodation, but then withdrew the offer.

53. In the meantime, Mr Bronson's mobility declined and he needed a ground floor room. Suitable accommodation was identified at a Probation Service Approved Premises, but a room was not available. Staff explored local housing providers, but social services assessed Mr Bronson and said they could not provide the level of support he needed.

54. On 31 December, the prison informed the Parole Board of Mr Bronson's revised prognosis and, on 9 January 2016, the Parole Board decided that he should be released on licence. As Mr Bronson's bed at the hospice was only temporary, his offender supervisor asked for a revision of his licence conditions to reflect that his release was subject to suitable accommodation. This delayed his release further.

55. By 18 January, Mr Bronson's condition had deteriorated significantly. The hospice guaranteed his bed for end of life care and the Parole Board released him on licence. The delays in finding suitable accommodation were unfortunate, but this meant Mr Bronson was no longer a serving prisoner when he died at the hospice the next day.

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