Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Benjamin Long a prisoner at HMP Preston on 4 February 2017

A report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

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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 Benjamin Long, a prisoner at HMP Preston, died from a brain tumour on 4 February 2017. Mr Long was 37 years old. I offer my condolences to his family and friends.

I am satisfied that Mr Long received a very good standard of care at HMP Preston equivalent to that which he could have expected to receive in the community. Prison healthcare staff managed Mr Long's complex care needs diligently and provided a high standard of palliative care that enabled Mr Long to achieve a dignified death.

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 **October 2017**

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Summary

Events

1. Mr Benjamin Long was diagnosed with a slow growing brain tumour in 2011. He arrived at HMP Preston on 10 August 2015 and, apart from a three-week period in May 2016 when he was released on licence before being recalled, remained there until his death.

2. Upon arrival, Mr Long was admitted to the prison healthcare inpatient unit because of his social care and medical needs, resulting from his brain tumour. Healthcare staff developed appropriate care plans to address his needs.

3. Prior to Mr Long's release on licence in May 2016, prison healthcare staff put in place comprehensive arrangements so that his medical conditions and social care needs were addressed upon his release. Mr Long was recalled to prison three weeks later. His medical care was comprehensively reviewed and reinstated upon his return to Preston.

4. Between 6 January and 12 February 2016, Mr Long underwent a course of radiotherapy for his tumour and thereafter had MRI scans to monitor it. On 27 January 2017, Mr Long had his final MRI scan, which showed that the tumour had progressed to a stage where no further treatment could be offered. His life expectancy was estimated at six months.

5. On 30 January, Mr Long was moved into a nursing bed and staff began round the clock nursing. He continued to decline and died on the afternoon of 4 February. A prison GP certified his death at 6.05pm.

Findings

6. The clinical reviewer found that Preston provided outstanding care and planning for Mr Long, enabling early identification and proactive management of his complex care needs. The actions of healthcare staff at Preston demonstrated a positive approach to managing end of life care and enabled Mr Long to achieve a dignified death.

7. We agree with the clinical reviewer that Mr Long's care at Preston was very good and equivalent to that which he could have expected to receive in the community.

8. We found that the use of restraints on Mr Long during his transfers to hospital up to 15 January 2017 was proportionate. However, we are concerned that Preston was unable to locate the risk assessment for Mr Long's transfer to hospital on 27 January.

Recommendations

- The Governor should ensure that all documentation relating to a prisoner is stored securely and able to be retrieved as necessary during the course of the investigation.

The Investigation Process

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

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

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

12. We informed HM Coroner for Preston of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.

13. One of the Ombudsman's family liaison officers contacted Mr Long's named next of kin and mother to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Long's next of kin did not respond. Mr Long's mother raised a number of issues and those relevant to this investigation are addressed in this report. They included whether the prison had identified Mr Long's vulnerability and had responded appropriately, especially in the management of his healthcare. She also wanted to know whether her son had received care equivalent to that which he would have received in the community in relation to end of life and palliative care. She requested copies of Mr Long's prison records which were provided.

14. The investigation has assessed the main issues involved in Mr Long'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.

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

16. Mr Long's mother received a copy of the initial report. She pointed out some factual inaccuracies. This report has been amended accordingly.

Background Information

HMP Preston

17. HMP Preston is a Category B local prison serving the courts in Lancashire and Cumbria. It holds up to 811 adult male prisoners.

18. Lancashire Care NHS Foundation Trust provides primary healthcare services 24 hours a day, seven days a week. GPs provide daytime cover between 8.00am and 9.00pm Monday to Friday and 3.00pm to 5.30pm on Saturdays. Outside of these hours a Registered General Nurse is on duty. An out of hours service is provided by GTD Healthcare.

19. Preston is a regional healthcare facility taking patients from other prisons. The facility has a 10 bed physical care inpatient unit provided in two three bed dormitories and four single cells. Palliative care is provided within that setting.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Preston was in March and April 2014. Inspectors noted that there had been 11 deaths from natural causes and noted the prison was a resource to which many prisoners were transferred for end of life care. They reported that pre-release planning for prisoners' health needs was effective and that prisoners with palliative care needs received very good nursing care reflecting gold standard guidance.

21. Inspectors also reported that a prisoner had died of natural causes in hospital while handcuffed. They noted that practices had been introduced to address the issues identified by the Prisons and Probation Ombudsman and the Coroner.

Independent Monitoring Board

22. 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.

23. In its latest annual report, for the year to 31 March 2016, the IMB reported that Preston operates a regional hospital facility and has a in-patient capability and a palliative care role. During that period three deaths from natural causes had occurred.

24. The IMB also noted that the chaplaincy has a role when prisoners are admitted to the palliative care facility, making contact and supporting families and arranging unrestricted access to the bedside of their relative.

Previous deaths at HMP Preston

25. Mr Long was the fourth prisoner to die at Preston since October 2015. Of the previous three deaths, one prisoner took his own life and the other two died of natural causes. There were no similarities between the circumstances of these deaths and Mr Long's.

Findings

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

26. On 10 August 2015, Mr Benjamin Long was convicted of causing grievous bodily harm and possession of a weapon in a public place. He was remanded in custody to HMP Preston and on 21 December, was sentenced to 18 months in prison. He was released on licence on 9 May 2016 but was recalled to prison on 30 May 2016 and was returned to Preston.

27. Mr Long had been diagnosed with a slow growing brain tumour in 2011, before his arrival at Preston. On 6 January 2016, he began a course of radiotherapy, which finished on 12 February. He underwent regular magnetic resonance imaging (MRI) scans (a scan that produces detailed images of the inside of the body) to ascertain the size and growth of his brain tumour. His last MRI scan was on 27 January 2017, which showed that his tumour had progressed to a stage that, in the oncologist's opinion, meant that no further active treatment could be offered. The oncologist estimated that Mr Long had a life expectancy of six months.

28. On 28 January, the prison's Clinical Team Leader spoke to a prison GP about completing a Do Not Attempt Resuscitation order (DNAR) (an instruction not to attempt resuscitation should the heart or breathing stop) for Mr Long. The GP suggested this should be discussed with Mr Long and his next of kin. On 30 January, the Clinical Team Leader and the GP discussed the implications of a DNAR with Mr Long and he decided he wanted to be resuscitated. Mr Long was considered to have full mental capacity and his decision was recorded.

29. By 2 February, Mr Long's condition had deteriorated. He was assessed by a palliative care nurse and a consultant in palliative care, both from St Catherine's Hospice in Preston, who recommended a DNAR order be put in place. The decision was discussed by the Clinical Team Leader and a prison GP and discussed and agreed with Mr Long's named next of kin when she visited that day. The order was signed by a prison GP. Mr Long continued to deteriorate and he died on 4 February.

30. Mr Long was diagnosed with his brain tumour before he arrived in prison. We are satisfied that his condition was monitored appropriately and that staff engaged with Mr Long on decisions affecting his end of life care.

Mr Long's clinical care

31. Mr Long had been diagnosed with diabetes in 1986, epilepsy in 2002 and a slow growing brain tumour in 2011. Upon reception to Preston, Mr Long was referred to a prison GP for a review of his health. He was seen immediately by the doctor who, after contacting Mr Long's GP, prescribed medication in line with his advice and a recent hospital discharge summary.

32. Mr Long was often non-compliant with his diabetic treatment and so his blood sugars were monitored frequently, day and night.

33. On 12 September 2015, the Clinical Team Leader made a comprehensive assessment of Mr Long's physical health needs and developed appropriate care plans to address his ongoing needs. The Clinical Team Leader and the nursing team reviewed these care plans on a monthly basis and updated them as Mr Long's needs changed.

34. Over the following year, Mr Long's disease progressed and he became more unsteady and increasingly prone to injury.

35. On 2 February, the Clinical Team Leader started planning for Mr Long's release on licence, due on 9 May. Over the next three months, she made extensive discharge arrangements so that Mr Long's medical conditions and social care needs were addressed upon his release on licence.

36. Mr Long was recalled to prison on 30 May. His medical care was comprehensively reviewed and reinstated on his return to Preston.

37. On 28 September, the Clinical Team Leader, with Mr Long's agreement, referred him to St Catherine's Hospice in anticipation of his release in February 2017.

38. On 15 January, Mr Long was taken to hospital because staff were concerned that he was very drowsy and unsteady on his feet. Mr Long self-discharged from the Accident and Emergency (A&E) department as he did not want to wait to be seen. The doctor in A&E considered that Mr Long had the mental capacity to make that decision.

39. On 18 January, a prison GP assessed that Mr Long's condition had deteriorated rapidly over the previous five days and he needed constant care. The doctor referred him back to the oncologist.

40. On 26 January, Mr Long began choking on his food. Staff Nurses used first aid techniques to dislodge the food from Mr Long's throat. As a result, on the same day, a prison GP placed Mr Long on a pureed diet until an urgent speech and language therapy assessment of his swallowing ability could be made. The GP made the referral the same day and an assessment was listed for 6 February. His medication was also altered to liquid dosage.

41. On 27 January, after a series of falls, Mr Long was taken to hospital. He underwent an MRI scan which showed that his brain tumour had progressed to a terminal stage. He was returned to Preston the same day.

42. An open door policy for Mr Long was impractical because of his unpredictable behaviour but on 29 January, the Governor authorised healthcare staff to access Mr Long's ward whenever necessary.

43. On 30 January, Mr Long was moved into a nursing bed and staff started round the clock, one-to-one nursing.

44. Mr Long continued to decline and he died on 4 February at around 5.35pm. A prison GP confirmed his death at 6.05pm.

45. The Coroner decided that a post mortem examination of Mr Long was not required. He accepted statements from prison GPs that on the balance of probabilities Mr Long died from a brain tumour.

46. The clinical reviewer found there was outstanding care planning by the Clinical Team Leader. Regular assessment enabled the proactive management of Mr Long's complex care needs. The clinical reviewer also commented that the actions of healthcare staff demonstrated a positive approach to managing end of life care and shows appropriate planning for a dignified death. We agree with these findings.

Mr Long's location

47. Upon arrival at Preston, Mr Long was located in a cell on the healthcare wing because of his complex healthcare and social care needs. He had limited mobility caused by his brain tumour and needed assistance with washing and dressing.

48. On 30 January 2017, he was moved from a healthcare cell into a three bedded ward where clinical care could be more easily given. He remained there until his death.

49. We are satisfied that Mr Long's accommodation at Preston was appropriate to his needs.

Restraints, security and escorts

50. 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.

51. Mr Long was a Category C prisoner (prisoners who cannot be trusted in open conditions but who do not have the resources and will to make a determined escape attempt). He went to hospital often for scheduled treatment and emergency admissions. Mr Long's medical condition made him unpredictable, abusive and at times violent.

52. Mr Long's escort risk assessments showed that he had the ability to escape. No objections were raised by medical staff about the use of restraints during transfers to hospital.

53. During hospital transfers, Mr Long was escorted by two officers and restrained with a single handcuff (attached to both the prisoner and a prison officer). Exceptionally, on 5 September 2016, because Mr Long had been unpredictable and was on a "caution unlock" (unlocking staff must be aware of the prisoner's

unpredictability) the risk assessment recommended single cuffing with up to three escorting officers. In the event, the Head of Security authorised that Mr Long go to hospital as normal with two officers and be single cuffed. The escort was concluded without incident.

54. As the effects of his brain tumour progressed, Mr Long became less mobile but he remained unpredictable. By mid-December 2016, the level of restraints used was reduced to an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer).

55. Mr Long was taken to hospital for the final time on 27 January, after a series of falls. The medical records show that he needed the help of four members of staff to stand up and return to his bed. Despite requesting the escort paperwork from the prison to show whether or not Mr Long was restrained on this occasion, and the justification for that decision, the prison was unable to locate any of the paperwork. Therefore, we were unable to establish whether Mr Long was restrained or not and the reasoning for that decision.

56. Mr Long had a history of violence and unpredictable behaviour. The escort risk assessment completed on 15 January, his penultimate visit to hospital, showed that he was assessed as having the ability to escape, albeit his mobility was impaired. We consider that the use of restraints up to this time was proportionate. However, we are concerned that we were not provided with the escort paperwork for Mr Long's final visit to hospital on 27 January. We consider that the use of restraints, were they applied on that occasion, would have been disproportionate given Mr Long's rapidly failing health and very poor mobility. In the absence of the documentation we make no finding or recommendation on the question of restraints. We do, though, make the following recommendation:

The Governor should ensure that all documentation relating to a prisoner is stored securely and able to be retrieved as necessary during the course of the investigation.

Liaison with Mr Long's family

57. Mr Long did not name a next of kin when he arrived at Preston on 10 August 2015. Nine days later, following Mr Long's admission to hospital, a governor at HMP Preston contacted his girlfriend to inform her. She visited him often thereafter and was known as his next of kin. Mr Long had no contact with his family during his time in prison.

58. On 25 April 2016, Mr Long's girlfriend attended a multi-disciplinary team meeting at the prison and took part in the planning of a comprehensive care package in support of his discharge on licence the following month. He was recalled to prison three weeks after his release.

59. A Parole Board hearing on 6 January 2017 decided that Mr Long should remain in prison until his discharge date of 7 February. Following that decision, the Clinical Team Leader began planning a care package for his release. Both she and Mr Long's probation officer experienced some difficulty contacting his girlfriend to involve and update her.

60. On 1 February, the family liaison officer, who was a prison chaplain, contacted Mr Long's girlfriend and arranged for her to visit him in the healthcare unit the next day. Before the visit the Clinical Team Leader and a palliative care nurse updated her on his deteriorating condition. Discussions also took place later about his DNAR and the care package to be put in place for when Mr Long was released on 7 February.

61. A bed at St Catherine's Hospice for Mr Long was offered and declined by his girlfriend because of difficulties in her being able to visit him there. An alternative, St John's Hospice, Lancaster, was agreed and the Clinical Team Leader made the necessary referral. A further visit for her to see him was arranged for 3 February.

62. During that visit, Mr Long's girlfriend was informed that if St John's Hospice had a bed available prior to his release date, the Governor would authorise a Release on Temporary Licence (RoTL) (a mechanism that allows prisoners to be temporarily released in exceptional circumstances) to allow his immediate transfer there.

63. Mr Long's condition deteriorated further during 4 February but despite several attempts, the prison was unable to make contact with his girlfriend.

64. In the late afternoon of 4 February, a prison GP saw Mr Long and believed his life was ending. The duty governor requested that the family liaison officer try again to contact Mr Long's girlfriend and, as she had no transport, sanctioned a taxi at prison expense to pick her up from her home. The family liaison officer telephoned and sent text messages to her without success.

65. Mr Long continued to deteriorate and died at around 5.35pm on 4 February. His death was confirmed by a prison GP at 6.05pm.

66. Mr Long's girlfriend telephoned the prison healthcare unit at around 7.00pm after realising she had missed calls. Around 8.30pm, the duty governor and the family liaison officer visited her at the home of a friend where they broke the news of his death and offered their condolences.

67. On 8 February, the Coroner's office informed Preston that they would be contacting Mr Long's mother. Two police officers visited Mr Long's mother on 10 February and informed her of her son's death. The family liaison officer contacted Mr Long's mother by telephone on 11 February and offered his condolences.

68. The family liaison officer remained in contact with Mr Long's girlfriend continuing to support her until after the funeral.

69. Mr Long's property was returned to his girlfriend on 20 February. Mr Long's funeral, arranged by the prison, took place on 22 February and Preston met the cost in line with national policy.

Compassionate release

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

71. On 27 January 2017, Mr Long's oncologist confirmed that no further treatment could be offered for his brain tumour and he estimated that he had a life expectancy of about six months. At that time, there was no suitable place for him to be discharged to, and so an application for compassionate release could not be made.

72. On 3 February, in view of the rapid deterioration in Mr Long's health, a RoTL board sanctioned his release on the basis that he would be discharged to a hospice bed. The hospice deemed it unlikely that a bed would become available before 6 February. Sadly Mr Long died on 4 February before the bed became available.

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