

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Christopher Bates a prisoner at HMP Buckley Hall on 28 April 2017

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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*



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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 Christopher Bates died in hospital on 28 April 2017 of lung cancer, while a prisoner at HMP Buckley Hall. He was 54 years old. I offer my condolences to Mr Bates' family and friends.

I agree with the clinical reviewer that the healthcare Mr Bates received at Buckley Hall was of a good standard and was equivalent to the care he could have expected to receive in the community. I am satisfied that prison healthcare staff treated Mr Bates' health concerns appropriately. Although there was a short delay in arranging a blood test, the result of which led to Mr Bates' hospital admission and cancer diagnosis, the delay did not affect the eventual outcome.

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 Christopher Bates was serving a life sentence and had been at HMP Buckley Hall since 10 June 2014. He had a history of low back pain following a fall from a ladder in 2009, but he did not declare this at his reception health screen when he arrived at Buckley Hall. He presented with no physical health concerns at that time.
2. In October 2016, Mr Bates told his IT tutor that he was suffering with back pain but he did not seek healthcare advice until 5 December 2016. He had no other symptoms so was given paracetamol and ibuprofen. A prison doctor reviewed Mr Bates' back on 16 December and diagnosed muscular pain.
3. On 11 January 2017, due to aggressive and threatening behaviour, Mr Bates was moved to the care and separation unit (CSU). Mr Bates spent a total of 15 days in CSU and was seen daily by healthcare. He continued to take pain relief for his back and did not report any other health concerns.
4. On 14 April, Mr Bates developed fluid retention in his feet. A prison doctor asked for a blood test, but this was not carried out until 18 April.
5. Mr Bates' blood test results were reviewed on 21 April and showed acute liver failure. He was admitted to hospital for further examination. On 26 April, Mr Bates was told by a hospital consultant that he had liver, bone and lung metastatic cancer (metastatic cancer is a cancer that has originated from another part of the body). Mr Bates was told that with palliative chemotherapy he might have a life expectancy of 12 months. However, his health deteriorated unexpectedly and he died two days later on 28 April. Mr Bates' family were with him when he died.

Findings

6. Mr Bates delayed reporting his back pain to healthcare. When he did seek medical advice, the clinical assessment and treatment was appropriate and in line with NICE (National Institute for Health and Care Excellence) guidance. Mr Bates did not attend healthcare on a regular basis and did not report any other symptoms that could have led to an earlier cancer diagnosis.
7. We found that the healthcare Mr Bates received was of a good standard and equivalent to that which he could have expected to receive in the community. Although the delay in carrying out a blood test did not affect the eventual outcome for Mr Bates, it may have delayed his hospital admission.

Recommendations

- The Head of Healthcare should ensure there are robust procedures in place to ensure that investigations are undertaken, followed up and actioned in a timely manner.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Buckley Hall 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 Mr Bates' prison and medical records. She interviewed Mr Bates' IT Tutor at HMP Buckley Hall on 13 June 2017.
10. NHS England commissioned a clinical reviewer to review Mr Bates' clinical care at the prison.
11. We informed HM Coroner for Greater Manchester North District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
12. One of the Ombudsman's family liaison officers contacted Mr Bates' daughter to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Ms Bates' asked for information about her father's diagnosis, treatment and medication while in prison.
13. The investigation has assessed the main issues involved in Mr Bates' 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.
14. Mr Bates' daughter received a copy of the initial report. She did not make any comments.
15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out a factual inaccuracy and this report has been amended accordingly.

Background Information

HM Prison Buckley Hall

16. HMP Buckley Hall is a medium security prison holding just over 400 men. There are four residential blocks, one of which is a dedicated drug recovery wing. Greater Manchester Mental Health NHS Foundation Trust provide healthcare seven days a week with a multidisciplinary team of GPs, general and mental health nurses.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Buckley Hall was in June 2016. Inspectors reported that an advanced nurse practitioner was the Head of Service and provided effective leadership to a small team of healthcare professionals with a reasonable range of competencies. Not all healthcare staff were in date for mandatory training, and not all received regular, documented clinical supervision. Primary care services were appropriate for the prison population and met their needs.
18. The prison had recently introduced a well man screening clinic to attract new patients. Access to the GPs had improved since the last inspection and was similar to that in the community with out-of-hours cover. Patients in the segregation unit were visited daily by healthcare staff. The prison had developed palliative care policies but these were rarely required.

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 ending 31 July 2016, the IMB reported that primary care services were considered generally good. It noted the waiting time for prisoners to see a doctor or dentist was now low and much improved compared to the figures recorded in the Board's previous Annual Report. The healthcare department has policies in place for adult safeguarding and for managing prisoners requiring palliative care.

Previous deaths at HMP Buckley Hall

20. Mr Bates was the fourth person to die from natural causes since 2015, the second from cancer. There are no other similarities.

Findings

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

21. Mr Bates was serving a life sentence and was transferred to HMP Buckley Hall on 10 June 2014. During an initial health screen, Mr Bates told a nurse that he had a family history of cancer and smoked roughly ten cigarettes a day. Mr Bates had a history of lower back pain following a fall from a ladder in 2009, but he did not declare this at his initial health screen. He had no physical health concerns at that time.
22. In October 2016, Mr Bates told his IT Tutor that he had back pain. They thought the classroom chairs could be the cause of his pain as they were quite old and uncomfortable.
23. On 5 December 2016, a nurse attended Mr Bates' cell after he complained of back pain. She was unable to examine him because he refused to have the light on and his door open, in line with prison safety rules. She noted that Mr Bates could move freely around his bed and told him he would need to go to healthcare to be seen.
24. Mr Bates attended healthcare on 7 December, complaining of lower back pain. He had no other symptoms. He was able to walk normally and had a good posture. A nurse gave paracetamol and ibuprofen and an appointment was requested for a review with the prison doctor.
25. A prison doctor examined Mr Bates on 16 December. Mr Bates told the doctor that the paracetamol and ibuprofen were helping with his back pain and he was able to work in the prison's pallet workshop. Mr Bates had no other symptoms and the doctor diagnosed muscular pain. The doctor told Mr Bates he would review him in three to four weeks if his back had not improved.
26. On 11 January 2017, due to aggressive and threatening behaviour, Mr Bates was moved to the care and separation unit (CSU). Mr Bates spent a total of 15 days in CSU and was seen daily by someone from the healthcare department. Prison records show that he continued to take pain relief but did not report any other health concerns. Mr Bates returned to a normal wing on 26 January.
27. An officer spoke to Mr Bates on 28 February after the IT Tutor reported that he appeared withdrawn in class and not his normal self. Mr Bates said he was okay.
28. At interview, the IT Tutor said when Mr Bates returned to class following his period in CSU she noticed a decline in his health. He appeared to have lost weight and his face was pasty in colour. He would fall asleep in class and was generally quiet. She advised Mr Bates on a number of occasions to see a doctor but he said he was fine and did not need to be seen.
29. A prison doctor examined Mr Bates on 14 April when he complained of swelling to both feet. His chest was clear, he was not short of breath and not in any pain.

The doctor diagnosed dependent oedema (fluid retention) and advised Mr Bates to elevate his feet to reduce the swelling. He asked for a blood test to be carried out.

30. Mr Bates did not have a blood test until 18 April. His symptoms had worsened. The swelling in his feet had spread to his lower thighs and the doctor noted what appeared to be mild jaundice (yellowing in the whites of his eyes). Mr Bates was not in pain and did not have a temperature. The doctor ordered an urgent blood test and an electrocardiogram (ECG – a test to check the heart’s electrical activity). (Mr Bates did not attend his ECG appointment.)
31. A prison doctor reviewed Mr Bates on 21 April. Mr Bates’ abdomen and testicles were swollen and the swelling to his legs had now spread to his mid thigh. He complained of mild shortness of breath but nothing abnormal could be found when the doctor listened to his chest.
32. Mr Bates’ blood test results were reviewed later that day and showed acute liver failure. Mr Bates was taken to hospital at 2.49pm that day. On 26 April, after further investigation, Mr Bates was told by a hospital consultant that he had liver, bone and lung metastatic cancer (metastatic cancer is a cancer that has originated from another part of the body).
33. Mr Bates delayed seeking treatment for his back pain. The clinical reviewer found that once Mr Bates had sought medical advice, the clinical assessment and treatment was appropriate and in line with NICE (National Institute for Health and Care Excellence) guidance. The medical records show that Mr Bates did not attend healthcare on a regular basis and did not report any other symptoms that could have led to an earlier diagnosis of his cancer. The four day delay in carrying out a blood test would not have affected the eventual outcome for Mr Bates, but had this been more timely and the results followed up sooner, this may have resulted in an earlier diagnosis of liver failure and admission to hospital. In light of this we make the following recommendation:

The Head of Healthcare should ensure there are robust procedures in place to ensure that investigations are undertaken, followed up and actioned in a timely manner.

Mr Bates’ clinical care

34. Mr Bates discussed his diagnosis with a hospital consultant on 26 April. He was told that with palliative chemotherapy he may have a life expectancy of 12 months. Mr Bates signed a DNACPR (Do Not Resuscitation Order), confirming that he did not wish anyone to resuscitate him if his heart or breathing stopped.
35. The Deputy Governor visited Mr Bates and his family in hospital on 27 April. Mr Bates’ health had deteriorated and was now only expected to live for a matter of weeks.
36. A Macmillan nurse contacted the Deputy Governor at 12.30pm on 28 April. An End of Life Pathway had commenced and, due to Mr Bates’ rapid decline in

health, a hospice bed had been arranged. Mr Bates died at 3.50pm that day, before he could be transferred to a hospice.

37. Having reviewed the clinical care extended to Mr Bates, we consider that the care he received was of a good standard and was equivalent to that which he could have expected to receive in the community.

Mr Bates' location

38. The Deputy Governor made enquires with HMP Preston and Manchester (who have inpatient facilities) when she was told that Mr Bates required a hospital bed for palliative care. Mr Bates was moved to a private room in the hospital and prison staff were told to position themselves outside to allow Mr Bates to spend time with his family. A hospice bed was arranged for 29 April, but he died before he could be transferred.
39. When Mr Bates' health deteriorated healthcare staff took the appropriate decision to send him to hospital. This ultimately enabled Mr Bates' to die in comfort, within an appropriate environment and with dignity.

Restraints, security and escorts

40. When prisoners have to travel outside 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.
41. Mr Bates was taken to hospital on 21 April. He was escorted by two officers and, due to previous threatening behaviour, was restrained by a single hand cuff. Healthcare advice was sought and no medical objections were given to the use of restraints. When the hospital confirmed that evening that Mr Bates would be staying overnight, the hand cuffs were removed and replaced by 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).
42. Mr Bates' restraints were reviewed by the prison on 22 and 23 April. It was decided, due to previous threatening and intimidating behaviour, the escort chain should remain.
43. Mr Bates was diagnosed with cancer on 26 April. The Deputy Governor visited the hospital the following day, 27 April, to carry out a risk assessment. The restraints were removed during this visit.
44. While in hospital, healthcare advice was sought and restraints were reviewed regularly. We consider the level of restraints used was appropriate.

Liaison with Mr Bates' family

45. The Deputy Governor visited the hospital on 26 and 27 April to meet with Mr Bates' family and hospital consultant. She authorised for prison escorting staff to position themselves outside the room and they were told to maintain a discreet presence. On 26 April, the family liaison officer telephoned Mr Bates' partner to introduce herself and make her aware of the support available. Mr Bates' son stayed with him at the hospital overnight.
46. At the families' request, on 28 April Mr Bates was allowed to wear his own pyjamas, as the clothing issued by the hospital was becoming uncomfortable due to his swollen legs. Mr Bates' family were with him when he died later that day. The family liaison officer visited the hospital that afternoon to meet with the family to answer any questions they had.
47. Mr Bates' funeral was held on 19 May. The prison contributed towards the cost of the funeral in line with national policy.

Compassionate release

48. Prisoners can be released from custody 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.
49. A hospital doctor told the Deputy Governor on 26 April that with chemotherapy Mr Bates may have a life expectancy of 12 months. However, when she visited the hospital the following day, 27 April, she was told that Mr Bates' health had declined overnight and he now had 'a matter of weeks to live'. She started early release paperwork the same day. Mr Bates' died at 3.50pm on 28 April, before the early release paperwork could be processed.

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