

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr William Burridge a prisoner at HMP Littlehey on 10 December 2017

A report by the Prisons and Probation Ombudsman

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*



© Crown copyright 2017

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 William Burridge died of end stage chronic obstructive airways disease (COPD) and a narrowing of the arteries to the heart (ischaemic heart disease) on 10 December 2017 while a prisoner at HMP Littlehey. He was 67 years old. I offer my condolences to his family and friends.

I am satisfied that the healthcare Mr Burridge received at Littlehey was good and equivalent to that which he could have expected to receive in the community.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman

May 2018

Contents

Summary	1
The Investigation Process	3
Background Information	4
Findings	5

Summary

Events

1. On 4 August 2016, Mr William Burrridge was sentenced to eight years in prison for sex offences. He had been at HMP Littlehey since 23 February 2017. At his initial health screen, a nurse noted that Mr Burrridge had a history of chronic obstructive airways disease (COPD).
2. On 24 February 2017, a prison GP saw Mr Burrridge and noted that because of his COPD, he was unable to walk around the wing. Mr Burrridge did not want to be treated if he was unwell again. The GP referred Mr Burrridge to the palliative care nurse. Mr Burrridge signed an order to say that he did not want anyone to resuscitate him if his heart or breathing stopped.
3. On 17 August, a palliative care consultant and nurse reviewed his palliative care. Mr Burrridge said that he did not want to have antibiotics if he got a chest infection and only wanted palliative care. However, he said that he wanted treatment, including in hospital, for any other illness. The consultant gave him oramorph, a morphine-based painkiller, and he had oxygen to use in his cell. The consultant added him to the end of life pathway under the care of the palliative care team. Mr Burrridge signed a document to refuse treatment.
4. On 17 October, a prison GP saw Mr Burrridge and told him the results of a CT scan (an imaging procedure that uses special x-rays to create detailed scans of areas inside the body) which showed he could have aspergillosis (a fungal condition of the lung). Blood test results confirmed this on 25 October.
5. On 14 November, Mr Burrridge was sent to the respiratory clinic at a hospital. He was aware that a chest infection might be fatal and said he did not want treatment, even though he was at risk of a fatal bleed from aspergillosis. On 26 November, Mr Burrridge had a pain in his upper left chest. Because he could not cough to clear his chest, he was sent to a hospital.
6. Mr Burrridge stayed in hospital. On 9 December, he was sent to a hospice, and died the next day. A post-mortem examination established that the cause of his death was end stage COPD. The pathologist concluded that a narrowing of the arteries to the heart (ischaemic heart disease) was a secondary factor.

Findings

7. We are satisfied that the healthcare department at Littlehey managed Mr Burrridge's COPD appropriately. A prison GP referred Mr Burrridge for a CT scan under the two-week wait rule and this identified he had aspergillosis. Mr Burrridge did not want treatment and he was appropriately given pain relief and palliative care.
8. While the healthcare team appropriately prepared to treat a potential bleed due to aspergillosis, Mr Burrridge went to hospital soon afterwards. Nurses regularly obtained updates about Mr Burrridge's condition and treatment from the hospital. He was transferred to a hospice the day before he died.

9. When Mr Burrige was sent to hospital on 26 November, he was not restrained and was not restrained while in hospital. Prison staff did not have the opportunity to start a compassionate release application before he died.
10. We make no recommendations.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Littlehey informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
12. The investigator obtained copies of relevant extracts from Mr Burridge's prison and medical records.
13. NHS England commissioned a clinical reviewer to review Mr Burridge's clinical care at the prison.
14. We informed HM Coroner for Cambridgeshire of the investigation who gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
15. One of the Ombudsman's family liaison officers contacted Mr Burridge's sister, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Burridge's sister gave the following information:
 - Mr Burridge had been unwell for a long time before he went to Littlehey and was under the care of the palliative care team, with an active order not to resuscitate him in the community.
 - When Mr Burridge went to hospital, with the family liaison officer (FLO) from Littlehey told her that he was in hospital. Mr Burridge's sister found the FLO to be very helpful and she gave her the relevant information to understand prison procedures and their responsibilities. She maintained regular contact with her, offering a visit to the prison if she wished.
 - She was aware that Mr Burridge was satisfied with the standard of care that he received throughout his time at Littlehey. After Mr Burridge died, the FLO contacted her to inform her and arranged for Mr Burridge's possessions to be returned to her. She was kept informed and updated about the process when someone dies in custody.
 - The Governor wrote to her to give her condolences and this was appreciated.
 - Mr Burridge's sister believed that he received the required care and she had no concerns about neglect.
16. Mr Burridge's sister received a copy of the initial report. She raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.
17. The investigation has assessed the main issues involved in Mr Burridge'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.
18. We shared the initial report with the Prison Service. There were two factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Littlehey

19. HMP Littlehey in Cambridgeshire is a medium security prison holding approximately 1,200 men. A large proportion of the prison's population have been convicted of sexual offences.
20. Northamptonshire Healthcare NHS Foundation Trust commissions healthcare services at Littlehey. The prison healthcare centre is open from 7.30am to 7.30pm, Monday to Friday, and from 8.00am to 5.30pm at weekends. A local practice provides GP services, and there is a range of nurse-led clinics. There are no inpatient beds at the prison.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Littlehey was in March 2015. Inspectors reported that a small group of GPs who regularly attended the prison had significantly improved patient care. Lifelong conditions were effectively identified and there was an appropriate range of clinics, led by specialist nurses. Inspectors found that hospital appointments for prisoners were rarely cancelled but that risk assessments for keeping medications in-possession were not always reviewed and recorded correctly.

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. In its latest annual report for the year to January 2017, the IMB reported that the prison's working agreement with the local hospice to provide decent and dignified end of life care was recognised in the local hospital's Care Quality Commission report as an outstanding initiative. The IMB noted that end of life and audiology clinics had been introduced at Littlehey. They reported that the End of Life suite, completed in 2013, continued to be unused due to a lack of funding.

Previous deaths at HMP Littlehey

23. Mr Burridge was the eighth prisoner to die of natural causes at HMP Littlehey since December 2016. There were no significant similarities between the deaths.

Findings

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

24. On 4 August 2016, Mr William Burridge was sentenced to eight years in prison for sex offences. He had been at HMP Littlehey since 23 February 2017.
25. At his initial health screen, a nurse noted that Mr Burridge had a history of COPD, restricted mobility and poor vision. She noted that Mr Burridge had multiple medications for osteoporosis, high blood pressure, chest pain and heart failure, lung disease, asthma and depression, along with folic acid, aspirin and paracetamol.
26. On 24 February, a prison GP saw Mr Burridge. She noted that because of his COPD, he was unable to walk around the wing. Mr Burridge had an advance directive (a legally binding document), which said that he did not want treatment if he was unwell again. The prison GP referred Mr Burridge to the palliative care nurse. Mr Burridge said that he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect.
27. On 19 April, a nurse saw Mr Burridge for his annual COPD review. He said that he was aware that his condition was getting worse and that he had the medication to manage his condition.
28. On 3 May, a nurse saw Mr Burridge for his annual heart disease review.
29. A prison GP, saw Mr Burridge on 25 May because he had swollen lower legs and his shortness of breath was worse. He gave him furosemide, used to treat fluid retention.
30. On 28 May, a palliative care nurse created a palliative care plan for Mr Burridge.
31. On 14 June, a prison GP saw Mr Burridge because he said that his breathing was getting worse. He thought that the symptoms were caused by angina so he gave him GTN, (used for chest pain and angina). He also gave him a tiotropium bromide inhaler for COPD.
32. On 27 June, a prison GP referred him to the respiratory team at a hospital for a COPD review.
33. On 15 August, Mr Burridge went to the GP surgery because he said that he had had abdominal pain for two to three days and was bloated. A prison GP gave him omeprazole (used to reduce acid in the stomach).
34. On 17 August, a palliative care consultant and a nurse reviewed Mr Burridge's palliative care. Mr Burridge said that he did not want to have antibiotics if he got a chest infection and only wanted palliative care. However, he said he wanted treatment, including in hospital, for any other illness. The palliative care consultant gave him oramorph, a morphine-based painkiller, and he had oxygen to use in his cell. She added him to the end of life pathway under the care of the palliative care team. Mr Burridge signed an advanced decision to refuse treatment.

35. On 11 September, a prison GP saw Mr Burridge because he had difficulty swallowing and had a swollen abdomen. She thought that he might have ascites (fluid in the space surrounding the organs). She referred Mr Burridge to gastroenterology under the two-week suspected cancer pathway, which requires patients with suspected cancer to be seen by a specialist within two weeks.
36. On 13 September, Mr Burridge went to the gastroenterology clinic at hospital, and hospital staff suspected that he had a tumour and ascites in the upper gastrointestinal. They arranged a CT scan.
37. On 28 September, Mr Burridge went to hospital for the CT scan of his chest, abdomen and pelvis.
38. On 17 October, a prison GP gave Mr Burridge the results of the CT scan which showed that he might have aspergillosis, tuberculosis or gallstones. He told her that he was very breathless and had swollen ankles. Mr Burridge told her that he was fed up and wanted to die. She gave him spironolactone to treat fluid build-up. On 25 October, the blood results showed that he had aspergillosis.
39. On 9 November, a prison GP saw Mr Burridge who confirmed that he did not want any more treatment for his chest, including the aspergillosis. He said that he had aches across his body and chest. She arranged for Mr Burridge to have buprenorphine patches to relieve pain and gaviscon for indigestion.
40. On 14 November, Mr Burridge went to the respiratory clinic at a hospital. Hospital staff noted that he was chronically breathless, used a wheelchair to get around and used oxygen when he exerted himself. Mr Burridge was aware that a chest infection may be terminal and again said that he did not want treatment, even though he understood he was at risk of a fatal bleed from the aspergillosis.
41. We are satisfied that Mr Burridge's COPD was appropriately managed by the healthcare department while at Littlehey. A prison GP referred Mr Burridge for a CT scan under the two-week wait rule which identified that he had aspergillosis. The healthcare department accepted that Mr Burridge did not want treatment and appropriately gave him pain relief and palliative care.

Mr Burridge's clinical care

42. On 14 November, a nurse told the healthcare team that Mr Burridge had aspergillosis and was at risk of a fatal bleed. She made sure that he had midazolam in case his condition deteriorated further. Mr Burridge was reassured that medication to control anxiety and help calm him could be given and it would be a medical decision to give the medication should it arise.
43. On 26 November, Mr Burridge went to the healthcare unit and told a nurse that he had a pain in his upper left chest. Because he could not cough to clear his chest, he went to hospital.
44. The healthcare team appropriately prepared to treat a potential bleed due to aspergillosis but Mr Burridge went to hospital soon afterwards. Nurses regularly obtained updates of Mr Burridge's condition and treatment.

Mr Burridge's location

45. While at Littlehey, Mr Burridge had a locked cabinet for his in-possession medication, which included oramorph in his cell. He also had oxygen and a nebuliser (a device that changes liquid medicine into a fine mist, which is breathed in through a mask) in his cell.
46. On 26 November, when Mr Burridge was very ill, he was sent to hospital, where he stayed until 9 December. He then was sent to a hospice. The hospice has 15 beds and cares for people with progressive conditions who are approaching the end of their lives.
47. Mr Burridge died on 10 December. A post-mortem examination established that the cause of his death was end stage COPD. The pathologist concluded that a secondary factor was a narrowing of the arteries to the heart.
48. Mr Burridge was sent appropriately to hospital when his chest pain got worse, and to a hospice (organised by the healthcare department) the day before he died.

Restraints, security and escorts

49. When prisoners 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 must 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 considering factors such as the prisoner's health and mobility.
50. On 26 November, Mr Burridge went to hospital. The governor said that two officers must escort Mr Burridge without using restraints because of his age and lack of mobility. While at the hospital and after his transfer to the hospice, Mr Burridge was not restrained.

Liaison with Mr Burridge's family

51. On 14 September 2017, Littlehey appointed an officer as the family liaison officer (FLO) and the prison chaplain, as the deputy family liaison officer.
52. On 11 October, the FLO saw Mr Burridge and told him that she was the family liaison officer. He said that he had already paid for his funeral and told her that his next of kin was his sister.
53. On 27 November, because Mr Burridge was not well and went to hospital, the FLO spoke to Mr Burridge's sister. She arranged for her to visit the hospital.
54. The FLO remained in contact with Mr Burridge's sister and updated her about his condition and location.
55. On 10 December, the FLO spoke to an officer at HMP The Mount to arrange for a family liaison officer to visit Mr Burridge's sister to break the news of his death. Because of bad weather, they were unable to do so. At 10.20am, the FLO telephoned Mr Burridge's sister and told her that he had died. She offered her condolences and support.

56. The FLO and the deputy FLO remained in contact with Mr Burridge's sister. Mr Burridge's funeral was held on 29 January. The prison did not contribute to the costs because Mr Burridge had paid for his own funeral.

Compassionate release

57. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they have a terminal illness and a life expectancy of less than three months.
58. A prison manager and the Acting Head of Safer Custody, said that Littlehey had an agreement with the healthcare department that they would inform the Head of Safer Custody as soon as a prisoner was diagnosed with a terminal illness. She said that they tell the Offender Management Unit who start the compassionate release paperwork.
59. She said that while Mr Burridge was poorly, there was no indication that his health would deteriorate as quickly as it did and the compassionate release application was never started.
60. We are satisfied that Littlehey did not start a compassionate release application because they did not have an accurate prognosis about Mr Burridge's life expectancy.

**Prisons &
Probation**

Ombudsman
Independent Investigations