Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Francis Cullen a prisoner at HMP Oakwood on 24 June 2018

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 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 I oversee can improve their work in the future.

Mr Francis Cullen died on 24 June 2018 while a prisoner at HMP Oakwood. He died of frailty brought on by Alzheimer's disease and heart disease. He was 89 years old. I offer my condolences to Mr Cullen's family and friends.

Mr Cullen had a number of health issues. Healthcare staff regularly reviewed him and formulated care plans to ensure they monitored his situation and provided assistance when necessary.

We are satisfied that the physical care Mr Cullen received was equivalent to that which he could have expected to receive in the community.

However, the care provided to Mr Cullen in relation to his mental health was not equivalent to the care he could have expected to receive in the community. There was a delay in his referral to a consultant psychiatrist, and a delay in his assessment and diagnosis of Alzheimer's.

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

Sue McAllister, CB
Prisons and Probation Ombudsman **November 2018**

Contents

Summary 1
The Investigation Process 3
Background Information 4
Key Events 5

Summary

Events

1. On 24 March 2014, Mr Cullen was sentenced to 15 years imprisonment. He transferred to HMP Oakwood on 14 March 2017. Prior to this he had been at HMP Rye Hill, where he was diagnosed with atrial fibrillation (an irregular heart rate) in 2014, an enlarged prostate in 2015 and had a pacemaker inserted in August 2016.

2. At his reception screening at Oakwood, Mr Cullen was referred for assessment by the mental health team as he was being monitored for dementia.

3. On 30 March 2017, Mr Cullen was discussed at a mental health multi-disciplinary team meeting. The meeting concluded that Mr Cullen needed to be referred by a GP to external healthcare services to assess his memory The referral to a GP was not made for almost three months, so Mr Cullen was not referred to external memory services until 17 August.

4. On 6 June 2018, Mr Cullen was assessed by a psychiatrist and diagnosed with cognitive moderate-severe Alzheimer's disease.

5. Throughout his time at Oakwood, healthcare staff monitored Mr Cullen's needs. He became increasingly frail and his memory became progressively worse. Mr Cullen's care plan was updated as need arose, and appropriate referrals were made to social services for support. On 7 June, Mr Cullen's needs were reassessed following a fall in his cell and his social care visits were increased to three per day.

6. On 14 June, a GP assessed Mr Cullen and concluded that he had now reached the end of life. Mr Cullen wanted to remain at Oakwood so his care plan was updated to allow this.

7. On 23 June, at approximately 12.30pm, a nurse went to Mr Cullen's cell and found him unresponsive and lying on his back; his breathing was laboured. Mr Cullen's cell door was then left unlocked to allow healthcare staff to sit with him. Mr Cullen died on 24 June 2018.

Findings

8. The clinical reviewer found that the care Mr Cullen received in relation to his physical and spiritual needs was equivalent to that which he could have expected to receive in the community. An individualised care package was managed between prison, medical, nursing and social care staff, particularly as he deteriorated over the final five months of life.

9. However, the clinical reviewer concluded that the care provided to Mr Cullen in relation to his mental health needs was not equivalent to the care he could have expected to receive in the community. Delays in his initial referral to a consultant psychiatrist meant that Mr Cullen waited much longer than he need have done to receive an appointment.

10. The subsequent cancellations of appointments due to an outbreak of illness in the prison and to bad weather were unforeseen and unavoidable. However, these delays contributed further to a longer than acceptable waiting time of 15 months between the initial request and the first consultation.

11. By the time Mr Cullen had been assessed and diagnosed with Alzheimer's on 6 June 2018, he was too physically frail to receive any treatment.

Recommendations

- The Head of Healthcare must ensure that there is an effective process for referral to external agencies. This must include systems for monitoring and following up referrals to ensure that locally agreed and nationally mandated timescales are adhered to.

The Investigation Process

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

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

14. NHS England commissioned to a clinical review Mr Cullen's clinical care at the prison.

15. We informed HM Coroner for Staffordshire of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.

16. The investigator wrote to Mr Cullen's family to explain the investigation and to ask whether they had any matters they wanted the investigation to consider. They responded that they did not have any matters they wanted to raise.

17. The investigation has assessed the main issues involved in Mr Cullen'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.

Background Information

HM Oakwood

18. HMP Oakwood is managed by G4S and is one of the largest prisons in England and Wales, providing places for around 2,100 male prisoners. Care UK provides the healthcare services, which include a daily GP clinic, some specialist services and out-of-hours GPs.

HM Inspectorate of Prisons

19. The last inspection of HMP Oakwood was conducted in February and March 2018. Inspectors reported that health services had improved considerably since their last inspection and, overall, were reasonably good. The range of services was appropriate and the management of prisoners with lifelong or complex health needs was very good, although staff shortages had led to a backlog of nurse reviews. Inspectors found that the healthcare rooms were well equipped and staff created appropriate care plans. However, there were often delays in arranging external hospital appointments because of the high demand and insufficient escort staff.

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board made up 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 March 2018, the IMB reported that Care UK provided a good service overall. There were no general concerns with regard to mental health provision, but some specific issues about funding for the Drug Recovery Unit (DRU) and difficulty finding appropriate accommodation for prisoners sectioned under the Mental Health Act. The previous IMB report had noted that there were a high number of professional vacancies, covered by agency staff, and this continued to be an issue.

Previous deaths at HMP Oakwood

21. Mr Cullen is the twenty-second prisoner to die at HMP Oakwood since June 2015, and the nineteenth to die from natural causes. There are no similarities between his and these earlier deaths.

Key Events

22. On 24 March 2014, Mr Francis Cullen was sentenced to 15 years imprisonment for sexual offences. Mr Cullen was initially remanded to HMP Nottingham and was then transferred to HMP Rye Hill in 2014. While at Rye Hill, Mr Cullen was diagnosed with atrial fibrillation (an irregular heart rate) in 2014, prostatic hypertrophy (an enlarged prostate) in 2015 and had a pacemaker inserted in August 2016.

23. Mr Cullen was transferred to HMP Oakwood on 14 March 2017. The reception screening was carried out by a nurse. Mr Cullen was referred for assessment by the mental health team as he was being monitored for dementia.

24. On 30 March, Mr Cullen was discussed at a mental health multi-disciplinary team meeting. The meeting concluded that Mr Cullen needed to be referred by a GP to external healthcare services to assess his memory.

25. On 2 May, Mr Cullen was discussed at a second mental health multi-disciplinary team meeting. His potential dementia was noted and discussed. However, it was not noticed that Mr Cullen had not yet been referred by a GP for his memory assessment.

26. Following a referral to Social Services, Mr Cullen received a care package. This began in June and comprised one visit per week to assist with a shower. Mr Cullen did not always accept this care, initially because he wanted a female instead of a male support worker to help him wash, and because he felt he did not get dirty enough to need a shower once a week. Healthcare regularly assessed Mr Cullen's capacity to consent to, or to decline, care and worked with Social Services staff to encourage Mr Cullen to wash regularly. Mr Cullen regularly accepted support from his peer carer on the wing.

27. On 22 June, an administrative officer noticed that the referral to a GP for the memory assessment discussed at the meeting on 30 March had not been completed. She placed Mr Cullen on the GP waiting list to prevent any further delay.

28. On 17 August, Mr Cullen was seen by a prison GP who referred him to a psychiatrist who specialised in the elderly mentally ill. Mr Cullen was booked into the first available appointment on 1 December, but this was subsequently cancelled due to an outbreak of norovirus on Mr Cullen's house block. The appointment was rebooked for 2 March 2018.

29. Over February 2018, Mr Cullen's health began to deteriorate, with increased calls to the healthcare team. Due to this decline in health, on 12 February, a nurse decided it was appropriate to discuss end of life care and resuscitation options with Mr Cullen. Mr Cullen said he did not want anyone to resuscitate him if his heart or breathing stopped and signed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order to that effect. On 14 February a palliative care plan was created.

30. On 2 March, the consultant psychiatrist who was due to attend Oakwood to assess Mr Cullen's memory problems was unable to reach the prison due to bad weather. The appointment was rebooked again, for 6 June.

31. On 6 June, Mr Cullen was assessed and diagnosed with cognitive moderate-severe Alzheimer's. The consultant suggested some medication that the GP could prescribe if Mr Cullen's physical condition improved but concluded that Mr Cullen was too frail to undergo further investigations or more intrusive treatment.

32. Later that day, Mr Cullen had a fall in his cell and hit his head. He was taken to New Cross Hospital to be examined. He was discharged back to the prison the same day.

33. On 7 June, Mr Cullen's care needs were reassessed. He was no longer able to manage his personal hygiene needs. His social care visits were increased to three per day with immediate effect.

34. On 11 June, fortisips (a nutritional drink) and was prescribed because of the risk of Mr Cullen inhaling his food. All non-essential medication was stopped.

35. On 14 June, the prison GP assessed Mr Cullen and concluded that he had now reached the end of life. Diamorphine and fentanyl patches were prescribed to help manage his pain. A multi-professional complex care (MPCC) meeting was held. The meeting discussed Mr Cullen's wish to remain at Oakwood and a care plan was created to meet his needs. It was also decided that Mr Cullen's needs would be reviewed daily or more frequently if problems occurred. Mr Cullen was referred to the palliative care nurse at Compton Hospice in case specialist advice was needed. A nurse from the hospice who visited and assessed Mr Cullen on 15 June, was happy with the plan that was in place.

36. On 22 June, at 3pm, prison staff called healthcare staff to Mr Cullen's cell as he had fallen over when trying to use the toilet. A nurse went to see Mr Cullen who had no injuries and reported no pain. A 'falls' risk assessment was completed and a urinal bottle was placed by Mr Cullen's bed.

37. On 23 June, at approximately 12.30pm, a nurse went to Mr Cullen's cell and found him unresponsive and lying on his back. His breathing was laboured. Mr Cullen's cell door was now left unlocked to allow healthcare staff to sit with him throughout the night.

38. On 24 June, a nurse was sitting with Mr Cullen and noted at 04:53am that he took his last breath. At 4.55am she recorded that there was no cardiac output. Mr Cullen had a DNACPR in place so there was no emergency response. She notified the control room that Mr Cullen had died and advised that a paramedic crew needed to be called to certify death. The paramedics arrived in Mr Cullen's cell at 5.30am and pronounced him dead at 05.35am.

39. We make the following recommendation:

The Head of Healthcare must ensure that there is an effective process for referral to external agencies. This must include systems for monitoring and following up referrals to ensure that locally agreed and nationally mandated timescales are adhered to.

Restraints, security and escorts

40. When prisoners have to 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 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. The last time Mr Cullen attended hospital prior to his death was 6 June 2018, due to a head injury caused by a fall. A risk assessment was carried out which concluded that Mr Cullen need not be restrained due to his frailty and reduced mobility. Mr Cullen was not restrained at any time during this hospital visit and was escorted by one prison officer. Mr Cullen's last visit to hospital prior to this had been 14 February 2017.

Liaison with Mr Cullen's family

42. On 14 June 2018, the Head of Safer Custody contacted Mr Cullen's nephew to inform him that Mr Cullen's health had deteriorated. They discussed Mr Cullen's plans for his funeral and she provided her contact details.

43. On 24 June, at 8.40am, the Head of Safer Custody called Mr Cullen to inform him of his uncle's death. Mr Cullen's nephew lives in Ireland, so a visit by prison staff was not possible. She offered her condolences and support.

44. The Head of Safer Custody remained in contact with Mr Cullen's nephew until the funeral on 17 July, which she attended. The prison contributed towards the costs in line with national policy.

Compassionate release

45. 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.

46. On 13 June 2018, the Head of Safer Custody visited Mr Cullen to discuss compassionate release as his health was continuing to deteriorate. Mr Cullen said that he had no home to go to and no family to stay with. He said that the prison was his home and he did not want to be considered for compassionate release.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100
F I 020 7633 4141