Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr William Burnett a prisoner at HMP Durham on 21 December 2017

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 William Burnett died on 21 December 2017 of age-related frailty, while a prisoner at HMP Durham. He was 88 years old. I offer my condolences to Mr Burnett's family and friends.

The investigation found that Mr Burnett's care was equivalent, overall, to that which he could have expected to receive in the community. However, I am concerned that prison healthcare staff failed to implement the advice of secondary care specialists on action to reduce the risk of heart disease and stroke. Mr Burnett subsequently suffered serious burns when he fell after suffering a stroke.

Some of the security risk assessments for hospital visits took insufficient account of Mr Burnett's frailty and reduced mobility and he was restrained at times without appropriate justification. I am also concerned that he did not have the opportunity to be considered for early release on compassionate grounds as his personal records were not up to date.

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 **July 2018**

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Summary

Events

1. Mr William Burnett was remanded to HMP Durham on 22 September 2015. At a health screen, a nurse noted that he was frail, with limited mobility and did not want to be resuscitated if his heart or breathing stopped.

2. In 2016, secondary care specialists diagnosed that Mr Burnett had raised blood pressure and had possibly suffered a mini-stroke. They advised regular monitoring of his blood pressure and prescription of a specific medication to reduce the risk of heart disease and stroke.

3. On 18 November 2017, Mr Burnett had a stroke and fell against the heating pipes in his cell, sustaining serious burns. He was admitted to hospital as an inpatient, until 6 December. After he returned to the prison, Mr Burnett's condition deteriorated and it was agreed that he was too frail to undergo planned skin graft surgery. Healthcare staff created care plans and treated him palliatively in the healthcare unit until his death on 21 December.

Findings

4. We found that healthcare staff did not monitor Mr Burnett's blood pressure or prescribe the medication specified by his specialist. However, after his discharge from hospital, a multidisciplinary team provided a good standard of care, equivalent to that he could have expected to receive in the community.

5. We are concerned that some of the risk assessments for Mr Burnett's hospital visits took insufficient account of how his ailing condition and limited mobility had affected his risk of escape and that the use of restraints was not properly justified.

6. Prison staff did not begin an application for early release on compassionate grounds as Mr Burnett's electronic records had not been updated to reflect that there were no outstanding criminal charges against him. By the time they had clarified his status, there was insufficient time to apply for early release.

7. The prison is conducting a review of the residential risk assessment policy, which will include the risks of injury to elderly and ill prisoners.

Recommendations

- The Head of Healthcare should ensure that there are robust, effective and auditable processes to ensure that healthcare staff implement and monitor medical treatment recommended by specialists.
- The Governor and Head of Healthcare should ensure that all staff completing and authorising risk assessments justifying the use of restraints on prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.
- The Governor should ensure that prisoners' records are accurate and that significant changes in status are updated promptly.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Durham informing them of the investigation and asking anyone with relevant information to contact her. One prisoner wrote to the investigator.

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

10. NHS England commissioned a clinical reviewer to review Mr Burnett's clinical care at the prison. The clinical reviewer made a minor amendment to her report after it was circulated, so a further copy has been annexed to this report.

11. We informed HM Coroner for Durham and South Darlington of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.

12. The investigator wrote to Mr Burnett's cousin, his next of kin, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Owing to an IT problem, our family liaison officer did not receive her emailed response so she was unable to contribute to the investigation before we issued the initial report. Our family liaison officer subsequently discussed the investigation with her and sent a copy of the report, which has been amended to take account of her comments.

13. After the initial report was issued, it came to light that another of Mr Burnett's cousins was also considered a next of kin and we are sorry that she did not have an earlier opportunity to contribute to the investigation.

14. The investigation has assessed the main issues involved in Mr Burnett'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. We shared the initial report with HM Prison and Probation Service (HMPPS) and they found no factual inaccuracies. The HMPPS action plan has been annexed to this report.

Background Information

HMP Durham

16. HMP Durham, which holds up to 996 men, is a local prison primarily serving the courts of Durham, Tyneside and Cumbria. G4S provides primary healthcare services. The prison's inpatient unit has six beds with 24-hour healthcare.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Durham was in October 2016. Inspectors reported that the provision of healthcare was reasonable. Primary care was assessed as reasonably good and secondary care as very good. Inspectors found that the inpatient healthcare unit provided compassionate care in a good environment. Interactions between healthcare staff and prisoners were very good. There were deficiencies in care planning and monitoring of those with complex needs. Nurse-led clinics for lifelong conditions, such as asthma, diabetes and heart disease, did not take place due to staff shortages, although a senior nurse ensured that physical checks and referrals were made where necessary. External health appointments were well managed.

Independent Monitoring Board

18. 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 October 2017, the IMB reported difficulties in recruiting healthcare staff and a high proportion of nursing vacancies, covered by agency staff and overtime. Although they regarded this as a risk, they considered that staff delivered a good service.

Previous deaths at HMP Durham

19. Mr Burnett was the eighth prisoner to die of natural causes at Durham since January 2016. We have previously made a recommendation about restraints.

Findings

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

20. Mr William Burnett was remanded to HMP Durham on 22 September 2015, charged with historic sexual offences. It was his first time in prison. (He was subsequently convicted and sentenced to 15 years imprisonment, which was reduced to eight years on appeal.)

21. At his initial health screen, a nurse recorded that Mr Burnett was frail, with poor mobility and that he used a Zimmer frame to move around. A prison GP reviewed him and noted that he had urinary problems, but there were no acute clinical concerns or outstanding hospital appointments. Mr Burnett had spent the previous ten days in hospital, detained under Section 2 of the Mental Health Act 1983, following a significant suicide attempt by overdose. A mental health nurse assessed him and staff immediately began support under the Assessment, Care in Custody and Teamwork (ACCT) suicide and self-harm prevention procedures.

22. Before he went into prison, a community GP had signed a 'Do not attempt cardiopulmonary resuscitation' form. On 23 September, the prison notified a Macmillan Prison Project Lead Palliative and End of Life Care Specialist that Mr Burnett was under Durham's care. The same day, an entry in his medical record noted that he did not want anyone to resuscitate him if his heart or breathing stopped due to natural causes, but staff should attempt resuscitation if he made a suicide attempt. Healthcare staff reviewed this annually to check whether Mr Burnett's wishes had changed and they ensured the document accompanied him during hospital admissions.

23. Over the next two years, hospital specialists and prison healthcare staff monitored and treated Mr Burnett for several ailments, including prostate cancer and skin cancer. Relevant care plans were in place.

24. On 1 September 2016, a hospital letter indicated that Mr Burnett's blood pressure was raised and a nurse noted the need for this to be monitored. His blood pressure was taken every two or three days until 19 September and on four occasions in October and November. There is no evidence this was routinely monitored thereafter.

25. Mr Burnett became increasingly unsteady on his feet and he had several falls. On 13 September, a prison GP referred Mr Burnett to a consultant in elderly care at University Hospital of North Durham.

26. On 21 October, after surgery for skin cancer, a surgeon advised that Mr Burnett had high blood pressure and prison healthcare staff should monitor and treat this. On 27 October, a prison GP instructed healthcare staff to monitor it daily. A healthcare support worker took a blood pressure reading later that day, but there is no record of any further routine monitoring.

27. The consultant assessed Mr Burnett on 20 December and noted that he might have had a transient ischaemic attack (TIA – a temporary loss of blood flow to the brain, with symptoms similar to a stroke, also known as a mini-stroke). He requested a CT scan and recommended the prescription of clopidogrel (a

medication to reduce the risk of heart disease and stroke). The same day, an administrator recorded on behalf of a prison GP that he would start prescribing the medication when he saw Mr Burnett.

28. The consultant had planned to review Mr Burnett in March 2017, but the prison did not receive the appointment letter. When this came to light in April, he agreed to rearrange the review and CT scan.

29. On 12 July 2017, a prison pharmacist noted Mr Burnett had not had his three monthly leuprorelin injection (a hormone medication to treat prostate cancer) since January. On 21 July, a prison GP re-prescribed it.

30. On 13 November, the consultant wrote to the prison to ask whether Mr Burnett still required a review. A prison GP replied that he had not started the clopidogrel, as he had not seen Mr Burnett and he did not want to prescribe the medication at that time, as there was no evidence of any further TIAs. He examined Mr Burnett that day and found that he had become more frail.

31. On 18 November, Mr Burnett's cellmate found him collapsed on floor in the toilet area of his cell. His cellmate estimated he had been there for around half an hour. Mr Burnett had fallen against a radiator and sustained severe burns to his back. Staff noted symptoms of a stroke and called an emergency ambulance. Paramedics took him to University Hospital of North Durham, where he remained until 6 December. The discharge letter from the hospital confirmed that Mr Burnett had suffered a stroke and doctors planned to perform a skin graft on 11 December. A hospital consultant had completed further documents confirming Mr Burnett's wishes about resuscitation in the event of cardiac failure.

32. Healthcare staff monitored Mr Burnett closely in the inpatient unit and implemented various care plans, including chronic wound management, infection control, prevention of pressure ulcers and falls prevention. However, within days of his return, his condition began to deteriorate. On 10 December, a nurse informed the hospital that he was too unwell to undergo the planned surgery the next day.

33. On 11 December, Mr Burnett told a prison GP that he wanted no further intervention and wanted to be "left in peace". The doctor considered it inadvisable to go ahead with the skin graft surgery, as Mr Burnett was too frail and he agreed to discuss this with his surgeon.

34. We are satisfied that the decision to cancel further surgery was reasonable, given Mr Burnett's fragile and deteriorating state of health and that it was in keeping with his own wishes. However, we share the clinical reviewer's concern that the failure to monitor Mr Burnett's high blood pressure, prescribe clopidogrel and monitor receipt of an important hospital appointment were missed opportunities to reduce his risk of a stroke. We do not know whether this affected the outcome for Mr Burnett, but it is essential to have robust systems in place to communicate and implement treatment recommended by secondary care specialists. We make the following recommendation:

The Head of Healthcare should ensure that there are robust, effective and auditable processes to ensure that healthcare staff implement and monitor medical treatment recommended by specialists.

Mr Burnett's clinical care

35. From 11 December, Mr Burnett was nursed in bed and the Head of Healthcare informed the palliative and end of life care specialist that Mr Burnett had deteriorated. On 12 December, she assessed Mr Burnett and made suggestions about aspects of his care. Later that day, the Head of Healthcare chaired a multidisciplinary team (MDT) meeting with a prison GP, a social worker, a prison chaplain and a nurse. They noted the palliative and end of life specialist's report and concluded that after Mr Burnett's stroke, his health had further deteriorated with reduced mobility, intermittent confusion, incontinence and difficulty swallowing, which had caused hydration and nutrition concerns.

36. The palliative and end of life specialist actively reviewed Mr Burnett and the prison GP sought her advice on end of life medication. Over the following days, healthcare staff consulted her about pain relief to ensure he was comfortable and informed her of any deterioration in his condition. Anticipatory drugs for end of life and a syringe driver were available.

37. On the morning of 21 December, Mr Burnett was close to death and four healthcare staff remained with him. The Deputy Head of Healthcare verified he had died at 11.34am. A prison GP confirmed his death, noting CVA-R Parieto-Occipital Infarct (stroke), co-morbidities prostate cancer, severe burns and age-related deterioration (frailty). Another prison GP subsequently certified the cause of Mr Burnett's death as 1a: frailty of old age, 2: cerebrovascular accident leading to burns to the skin of the back.

38. We agree with the clinical reviewer that, overall, healthcare staff at Durham provided a good standard of care, equivalent to that which Mr Burnett could have expected to receive in the community. They implemented appropriate care plans which addressed his needs and they liaised effectively with the palliative care specialist to keep him comfortable in the period leading to his death.

39. The clinical reviewer made recommendations on matters that were not directly related to Mr Burnett's cause of death but which the Head of Healthcare will wish to address.

Mr Burnett's location

40. When Mr Burnett arrived at Durham, reception staff admitted him to the healthcare centre as an inpatient. He later moved to a shared cell in a residential wing. Healthcare staff provided specialist furniture and they gave him an air flow mattress. Prisoners on the wing helped to collect his meals and run other errands. They also reported to staff when they had concerns about his falls or poor appetite. During periods when he was particularly unwell, Mr Burnett was readmitted to the inpatient unit. Nurses explained to him why it was better for him to move to the unit. Although he preferred to live on a residential wing, he understood and accepted that he needed the extra help available in healthcare.

41. The Head of Healthcare visited Mr Burnett in the healthcare centre, on his residential wing and while he was in hospital to check how he was coping and he advised him how to contact healthcare staff if he needed help.

42. On 28 July 2016, the Head of Healthcare asked the prison's Offender Management Unit to consider transferring Mr Burnett to another prison with 24-hour healthcare, due to his frailty. (There is no evidence of any immediate action on this request, possibly because he was on medical hold at that time.) In September 2016, prison managers stated that Mr Burnett should be taken to visits in a wheelchair.

43. After his discharge from hospital on 6 December 2017, Mr Burnett returned to the inpatient unit. After a fall in the early hours of 8 December, he was moved to a cell closer to the nurses' station and prison managers agreed to an open-door policy from 8.00am to 8.30pm, with nurses' discretion outside those hours. Mr Burnett had a bell to call nurses, as he could not reach the buzzer. The MDT meeting on 12 December, noted that he did not want to be moved elsewhere in the prison, or to hospital.

44. After Mr Burnett's death, the Head of Healthcare wrote to prison managers recommending risk assessments to reduce the potential risk of exposed heating pipes to elderly and ill prisoners. The health and safety department replied that it would not be feasible to modify the pipes. The prison has since confirmed that a review of the residential risk assessment policy has started.

45. We are concerned that Mr Burnett received such serious burns in his cell. However, in view of the steps already taken to address the risks, we make no further comment on this issue.

Restraints, security and escorts

46. 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.

47. Mr Burnett was an elderly and frail man with limited mobility and several serious health conditions. He was on the enhanced level of the prison's Incentives and Earned Privileges Scheme and successive security risk assessments had concluded he was a low risk of escape. Despite this, prison managers authorised the use of single handcuffs for some of his hospital visits without indicating why they considered this necessary. On occasion, medical objections to the use of restraints were seemingly ignored.

48. We are pleased to note that for Mr Burnett's last admission to hospital in November 2017, a prison manager decided that no restraints should be used and only one officer should escort him. However, due to the inconsistencies in both the risk assessments and use of restraints on previous occasions, we are not satisfied that all staff understand that risk assessments should take account of how a prisoner's health and mobility affects their risk of escape, as the High Court judgment requires. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff completing and authorising risk assessments justifying the use of restraints on prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

Liaison with Mr Burnett's family

49. On 11 December, the Head of Healthcare telephoned Mr Burnett's cousin, his next of kin, to inform her of Mr Burnett's deterioration. (He called again to update her on 19 December.)

50. A prison chaplain acted as the prison's family liaison officer. On 13 December, he informed Mr Burnett's cousin of the decline in his health and offered to arrange visits in the healthcare unit. They also discussed how she wished to be informed in the event of Mr Burnett's death.

51. After Mr Burnett's death, the family liaison officer contacted Mr Burnett's next of kin and another cousin to offer condolences and support and to consult them about the funeral arrangements. He arranged Mr Burnett's funeral and led the service, which was held on 19 January. In line with national policy, the prison contributed to the costs of the funeral. We are satisfied that the prison liaised appropriately with Mr Burnett's family.

Compassionate release

52. Release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months can be permanently released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. The criteria for early release for determinate sentenced prisoners are set out in Prison Service Order (PSO) 6000 Among the criteria is that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of the Her Majesty's Prison and Probation Service (HMPPS).

53. On 12 December, Mr Burnett told the palliative and end of life specialist that he wanted to move to a nursing home for his final days and this was discussed at the MDT held that day. However, there was contradictory information in his paper and electronic records as to whether he had outstanding criminal charges. The Head of Healthcare agreed to clarify this as he felt it could impact adversely on an application for compassionate release. He informed the prison's Offender

Management Unit (OMU) of Mr Burnett's deterioration and asked for release on compassionate grounds to be explored. The OMU confirmed with the court that there were no further charges and staff intended to apply for early release, but Mr Burnett died before they were able to do so.

54. The investigation found that Mr Burnett's electronic personal record (NOMIS) contained several references to outstanding charges throughout 2017 (the last such reference was in November 2017). However, a court document in his paper records, dated 6 March 2017, noted that he was not guilty on all charges and was not required to return to court. Although it might have been challenging to complete an urgent application for compassionate release within the relatively short time between Mr Burnett's deterioration and his death, the confusion caused by the conflicting information and the failure to update his personal records denied him the opportunity for this to be considered. We make the following recommendation:

The Governor should ensure that prisoners' records are accurate and that significant changes in status are updated promptly.

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