

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of David Brown a prisoner at HMP Doncaster on 16 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.

On 16 December 2017, Mr David Brown died in hospital of pneumonia and a heart attack, caused by congested arteries, while a prisoner at HMP Doncaster. He was 76 years old. I offer my condolences to his family and friends.

The clinical care that Mr Brown received at HMP Doncaster was well managed, compassionate and equivalent to that which he could have expected to receive in the community. We are, however, disappointed that the prison did not appoint a family liaison officer when Mr Brown became seriously ill in November 2017.

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
Deputy Ombudsman

February 2019

Contents

Summary	1
The Investigation Process	3
Background Information	4
Findings	9

Summary

Events

1. On 2 September 2014, Mr David Brown was convicted of historic sex offences and sent to HMP Doncaster.
2. Mr Brown was an elderly man, with numerous health conditions, including angina and tuberculosis of the spine. This resulted in back and walking problems. He was a heavy smoker and was offered smoking cessation advice, which he declined. Healthcare staff ensured that he was supported and gave him medication for his existing conditions.
3. In the first few weeks of Mr Brown's sentence, he had a stroke and bleeding in the space around his brain. As a result, he became more frail, and needed a wheelchair and frame to move around.
4. Throughout the following year, Mr Brown was supported by the healthcare team, and an Older Person care plan was put in place to assist him with his daily living.
5. In December 2015, Mr Brown started to experience chest pain, and in February 2016, a prison GP believed that Mr Brown had chronic obstructive pulmonary disease (COPD). He refused to have tests to confirm this, and was deemed to have the mental capacity to make this decision.
6. In April 2016, Mr Brown had a chest x-ray after he had blood in his sputum. He was not diagnosed with any further conditions but a respiratory consultant advised him to use an inhaler which he also refused.
7. A CT scan, which was taken later that month, confirmed that Mr Brown had COPD, but again he refused to use an inhaler.
8. In late 2016 and March 2017, Mr Brown was diagnosed with pneumonia which exacerbated his COPD. His health declined further, and Mr Brown made it known that he did not want to be resuscitated if his heart stopped beating.
9. Over the following months, the healthcare team supported Mr Brown and monitored him daily.
10. In November, Mr Brown was admitted to hospital three times for respiratory failure. He was discharged on 14 December, with a ventilator to assist with his breathing.
11. Healthcare staff checked Mr Brown throughout the day and night on 14 and 15 December. A nurse recorded that when she checked on him, at 8.10am on 16 December, his breathing apparatus was still in place, but when he was checked at 9.00am, Mr Brown was not wearing his breathing mask.
12. Mr Brown was breathing but did not respond to staff. An emergency ambulance was called, but resuscitation was not attempted as Mr Brown had an order in place not to resuscitate him.

13. Mr Brown was transferred to hospital that morning, and died in hospital later that day.

Findings

14. The clinical reviewer concluded that the clinical care that Mr Brown received at HMP Doncaster was equivalent to that which he could have expected to receive in the community. Care plans were put in place to monitor his conditions, and there is evidence that the support provided was timely and compassionate.
15. When his health declined, the prison acted promptly in referring him to a prison GP or transferring him to hospital as appropriate. We note that Mr Brown was not restrained when he was admitted to hospital in the months before his death.
16. We found that the prison did not appoint a family liaison officer in line with Prison Service Instruction (PSI) 64/2011 when Mr Brown was first recognised as being seriously ill.

Recommendation

- The Governor should ensure that staff notify the next of kin and appoint a family liaison officer as soon as possible when a prisoner becomes seriously ill.

The Investigation Process

17. The investigator issued notices to staff and prisoners at HMP Doncaster informing them of the investigation and asking anyone with relevant information to contact her. No one responded
18. The investigator obtained copies of relevant extracts from Mr Brown's prison and medical records.
19. NHS England commissioned a clinical reviewer to review Mr Brown's clinical care at the prison.
20. We informed HM Coroner for South Yorkshire East District of the investigation who provided us with a cause of death. We have sent the Coroner a copy of this report.
21. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found one inaccuracy regarding who provides the healthcare services at Doncaster, and their action plan is annexed to this report.

Background Information

HMP Doncaster

22. HMP Doncaster is a local prison, operated by Serco, which holds up to 1,145 remanded and sentenced men. Care UK provides physical and mental health services, and substance misuse services. HMP Doncaster directly employs qualified paramedics as part of their healthcare team, who respond to emergency calls within the prison.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Doncaster was in July 2017. Health services had improved considerably since the previous inspection in October 2015 and overall, were reasonably good. A wide range of primary care services was available and waiting lists were generally short, although too many patients failed to attend appointments. The management of prisoners with long-term conditions had improved, with several trained staff available to patients. The 24-hour in-house paramedic service was an example of good practice.

Independent Monitoring Board

24. 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. The IMB published its annual report for the year to July 2017
25. The IMB noted that because of the increase in the number of sex offenders in prison locally, Houseblock 1 was becoming a unit specifically for sex offenders and vulnerable prisoners. They noted that in recent years, there had been an increase in the aging population of prisoners across England and Wales and a high number of aging sex offenders were at HMP Doncaster. They had some concerns that the healthcare team did not have any specialist older or palliative care available onsite. They noted that care was only available in office hours.

Previous deaths at HMP Doncaster

26. Mr Brown was the seventh prisoner to die of natural causes at Doncaster since January 2016. There were no similarities between the circumstances of Mr Brown's death and the previous deaths at the prison.

Key Events

27. On 2 September 2014, Mr David Brown was convicted of historic sex offences and sent to HMP Doncaster.
28. During his initial healthcare induction, Mr Brown told a nurse that he had angina (chest pain usually due to not enough blood flow to the heart muscle), back and walking problems due to tuberculosis of his spine.
29. On 3 September, a nurse saw Mr Brown for the second part of his health screen. She recorded that Mr Brown had smoked cigarettes for 60 years. She offered him smoking cessation advice, which he declined. Mr Brown was prescribed medication for his condition and assessed as fit to live on a standard wing.
30. In the first few weeks of Mr Brown's prison sentence, he had a stroke and there was bleeding in the fluid space around his brain. While in hospital, Mr Brown developed pneumonia and remained as an inpatient for one month. When he was discharged, he was returned to the social care unit at HMP Doncaster.
31. Because of the stroke, regular case conferences took place to monitor Mr Brown's health, as he had some memory loss, was now frail and required a wheelchair and walking frame to mobilise. Both prison and healthcare staff continued to support Mr Brown, and there is evidence in his medical records that an Older Person care plan was put into place, as he needed further support in his daily living.
32. On 19 December 2015, Mr Brown started to experience pain in his chest and back. He told a nurse that he had been coughing for several days. She referred him to a prison GP, who noted in his medical records that he had a faint wheezing sound in his chest. He prescribed him antibiotics and an inhaler.
33. There were no further entries in Mr Brown's medical records about his chest, until 3 February 2016, when Mr Brown was seen by a prison GP who noted that, based on Mr Brown's observations and smoking habits, it was likely he had COPD. The prison GP offered him inhalers and a spirometry test (used to confirm COPD). Mr Brown declined both as he said that his chest did not cause him any concern. He agreed to a routine chest x-ray.
34. On 10 February, a prison GP discussed the results of the x-ray, which showed no recent changes in his condition, with Mr Brown.
35. On 1 April, Mr Brown had a further chest x-ray, as he had blood in his sputum. On 8 April, a prison GP reviewed the results but there were no new abnormalities. On 12 April, he saw Mr Brown who was still coughing up blood. The prison GP explained that the presence of blood in his sputum might be cancer or a reoccurrence of TB. Mr Brown said that he did not want treatment if he had cancer but agreed to have treatment if spinal TB had returned. The prison GP made an urgent referral under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks.
36. Mr Brown had a CT scan of his chest in hospital, and on 25 April, met the respiratory consultant to discuss the outcome. He advised him that the CT scan had showed Chronic Obstructive Pulmonary disease (COPD) and that he should

use an inhaler to manage this. Mr Brown said that he did not think that they worked, and did not want to stop smoking. Mr Brown was discharged from the clinic.

37. The next day, Mr Brown had breathing difficulties, and was transferred to hospital, with a lower respiratory tract infection. It was noted in his discharge note that this exacerbated his COPD. He was treated with antibiotics before he was returned to prison.
38. On 22 June, Mr Brown told a prison GP and signed an order to the effect that, in the event of cardiac arrest, he did not want to be resuscitated.
39. Over the following months, Mr Brown was offered daily assistance with his personal care but he often refused help from staff involved in his care. His observations were taken at least once a day, and when he reported feeling unwell, healthcare staff completed a National Early Warning (NEW) score assessment (used to determine the degree of illness and to prompt critical care intervention) as part of his Older Person care plan.
40. On 8 December, a nurse assessed Mr Brown after a nurse from the social care team was concerned that Mr Brown's oxygen saturation level was borderline low. The first nurse diagnosed a possible respiratory tract infection, and Mr Brown was transferred, without restraints, to hospital, where he was admitted and diagnosed with pneumonia. He was prescribed antibiotics and returned to HMP Doncaster the next day.
41. He was diagnosed again with pneumonia in March 2017. There are no further relevant entries in his medical record until 7 June when Mr Brown saw a prison GP to review his decision not to be resuscitated in the event that he stopped breathing. Mr Brown confirmed that he did not want to be resuscitated, and signed an order to that effect. He named his wife as his next of kin.
42. At 8.25am on 8 September, a nurse took Mr Brown his medication. She noticed that he was short of breath and was wheezing so took his observations. His NEW score was recorded as 2, which was a low score, and she planned to review him again in 4 hours.
43. At 12.10pm, a nurse took Mr Brown's observations, and his NEW score was now 7. She referred him to see a prison GP, who diagnosed a chest infection and prescribed him antibiotics and steroids.
44. On 5 November, Mr Brown asked to see a nurse. A nurse saw Mr Brown at 4.20pm in the treatment room. She took his clinical observations but was unable to take his oxygen saturation levels, as his fingers, legs and toes were cold and blue in colour. His other observations were within the normal range.
45. A nurse checked on Mr Brown at 8.00pm that evening, and noted no concerns. Mr Brown reported feeling okay.
46. She checked on him again at 1.00am on 6 November. Mr Brown's breathing was now laboured, and she could hear a clear wheezing sound. She took Mr Brown's oxygen saturation level, which was at 82%. (Normal saturation levels range from 95 to 100 percent. Values under 90% are considered low.) A nurse

administered oxygen therapy, which brought his levels up to 99%, but on each occasion, after oxygen therapy had been given, his oxygen levels dropped again.

47. The nurse asked the control room to call an ambulance, and Mr Brown was taken to hospital, unrestrained, with a record that he did not want to be resuscitated if he stopped breathing. A nurse in charge of the hospital's respiratory ward spoke to a nurse at the prison, and told her that Mr Brown's COPD had got worse, he was in respiratory failure and needed the use of a BiPAP machine (a ventilator that helps with breathing).
48. On 12 November, Mr Brown was discharged from hospital. A nurse saw him when he returned to prison. She discussed his recent admission, and took his observations, all of which were in the normal range.
49. He continued to be monitored, and on 17 November, members of the healthcare team saw Mr Brown twice because he had breathing difficulties. However, his observations remained within a normal range.
50. On 18 November, Mr Brown continued to have pains in his chest and he was monitored throughout the morning. A nurse took his observations at 11.39am, and calculated his NEW score as 12. She asked the control room to call an ambulance, and Mr Brown was transferred to hospital, unrestrained.
51. While an inpatient, Mr Brown was treated for respiratory failure with intravenous antibiotics, and was placed on a ventilator to help him breathe. As Mr Brown's oxygen levels were low, he was returned to prison on 24 November, with oxygen therapy.
52. On 29 November, a prison GP and a nurse reviewed Mr Brown. They discussed his long-term prognosis and Mr Brown acknowledged that his breathing was getting worse, and that his COPD was now severe. They talked about the option of early release on compassionate grounds. (Early release can be considered when a prisoner has a terminal illness and death is likely to occur with three months.) The prison GP agreed to contact his consultant about Mr Brown's prognosis.
53. At 8.05am the next day, a nurse reviewed Mr Brown, and noted that he was struggling to breathe. She helped him with his oxygen mask, and agreed to check on him within the hour. At 9.00am, the nurse noted in his medical record that he was more alert. However, his health declined throughout the day, and he was taken, unrestrained, to hospital that afternoon, with respiratory failure.
54. On 14 December, he was discharged to prison, and needed a BiPAP machine throughout the night, and oxygen during the day. Mr Brown's care plan continued three or four times that day, and nursing staff checked on him throughout the night and following day.
55. At 7.30pm on 15 December, a nurse checked on Mr Brown and found him asleep. She woke him to put his BiPAP mask on, and checked that the machine was on. On 16 December, a nurse confirmed that the mask remained in place at 12.32am and at 6.03am. The first nurse noted in his medical records that his mask was still in place at 8.10am.

56. At 9.00am, a nurse went to visit Mr Brown at unlock. His BiPAP machine was disconnected but he was still breathing. She tried to wake him but he was unresponsive. At approximately 9.05am, the nurse radioed for the emergency response nurse to attend his cell. She arrived at the cell within two minutes, and took over his care. After trying unsuccessfully to take his observations, she asked for the control room to call an emergency ambulance, and implemented oxygen therapy.
57. The ambulance records confirm that the call was received from the prison at 9.09am, and the ambulance arrived on scene at 9.13am. Paramedics were aware that Mr Brown did not want to be resuscitated, and on the advice of the hospital's on-call doctor, Mr Brown was transferred to hospital, where he died at approximately 2.00pm.

Contact with Mr Brown's family

58. The Head of Safer Custody told the investigator that on 9 December 2017, a family liaison officer was told that, should the situation arise, she would be allocated as Mr Brown's family liaison officer. This information was not recorded anywhere in Mr Brown's prison records. The Head of Safer Custody said that the family liaison officer was not appointed at this stage as Mr Brown was well enough to return to prison. As the family liaison officer was on leave during the week that Mr Brown died, another family liaison officer was appointed in her absence. However, the second family liaison officer was not appointed until the day Mr Brown died.
59. That day, the second family liaison officer visited Mr Brown's wife who did not respond when she knocked on her door. The police agreed to visit to break the news but again, she did not respond. The next day, the family liaison officer visited Mr Brown's wife's again and broke the news.
60. Two members of prison staff attended Mr Brown's funeral which was held on 29 January 2018. The prison contributed towards for Mr Brown's funeral costs in line with national instructions.

Support for prisoners and staff

61. After Mr Brown's death, the Assistant Director debriefed the staff who were on duty as bedwatch officers at the time of Mr Brown's death, to discuss any issues arising, and to offer support. The staff care team also offered support.
62. The prison posted notices informing other prisoners of Mr Brown's death, and offering support.

Cause of death

63. The post-mortem report gave the cause of death as pneumonia and a heart attack, caused by congested arteries.

Findings

Clinical care

64. The clinical reviewer considered that Mr Brown received a very good standard of care at HMP Doncaster, equivalent to that which he could have expected to receive in the community.
65. She noted that he had many chronic conditions, which needed specialist care, and that the processes in place ensured that his care was organised and well delivered.
66. When Mr Brown's health declined, he was promptly referred to a prison GP and, when appropriate, to hospital. On each occasion that he was returned to prison, the healthcare team appropriately re-assessed his needs.
67. We note that there were occasions when Mr Brown chose not to take the advice of medical professionals and often declined help with his daily care needs. It is clearly documented in his medical record that healthcare staff felt that he had the mental capacity to make these decisions.
68. We agree with the clinical reviewer that Mr Brown's care was equivalent to that which he could have expected to receive in the community. We are satisfied that prison staff ensured that his health and social care needs were met, and that the healthcare team worked hard to deliver compassionate care to Mr Brown.

Family liaison

69. PSI 64/2011, Safer Custody, requires that prisons should have arrangements to engage with the next of kin, or other nominated person, of prisoners who are either seriously or terminally ill. Prison Rule 22 also requires the governor to inform the prisoner's spouse or next of kin and "any person who the prisoner may reasonably have asked should be informed" when a prisoner is seriously ill.
70. We consider that when Mr Brown's health declined in November 2017, a family liaison should have been appointed and the prison should have informed his next of kin and supported her prior to Mr Brown's death. We make the following recommendation:

The Governor should ensure that staff notify the next of kin and appoint a family liaison officer as soon as possible when a prisoner becomes seriously ill.

Compassionate release

71. On 29 November 2017, a prison GP and a nurse discussed the issue of early release on compassionate grounds with Mr Brown. The prison GP wrote to Mr Brown's respiratory consultant to find out his prognosis. This was not provided before Mr Brown's death and it is therefore reasonable that an application for compassionate release was not pursued.

**Prisons &
Probation**

Ombudsman
Independent Investigations