Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Derek Bellingham a prisoner at HMP Stafford on 11 March 2018

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 I oversee can improve their work in the future.

Mr Derek Bellingham, a prisoner HMP Stafford, died in hospital on 11 March 2018 of respiratory failure caused by pneumonia. He was 75 years old. I offer my condolences to Mr Bellingham's family and friends.

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

I am, though, concerned that a medical assessment was not carried out when Mr Bellingham arrived at Stafford.

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 **October 2018**

Contents

Summary

Events

1. Mr Derek Bellingham was serving a 14-year prison sentence for sexual offences. He was originally received into custody in 2011.

2. On 13 June 2017 while he was at HMP Parc, Mr Bellingham collapsed and was admitted to hospital for treatment of a urinary infection. A scan showed an abnormally inflamed bladder. Mr Bellingham was due to have a further examination of his bladder but was transferred before this could take place.

3. On 29 July, Mr Bellingham was transferred to HMP Stafford. He was not given a comprehensive first night assessment and his comprehensive health assessment did not take place until 13 August.

4. On 23 August, Mr Bellingham had a consultation with a prison GP, who prescribed Mr Bellingham's medication the following day.

5. Between 27 October 2017 and 24 February 2018, Mr Bellingham was admitted to hospital on four occasions with a urinary tract infection.

6. On 24 February, Mr Bellingham was admitted to hospital. Plans were being made to transfer him to a prison with inpatient facilities on his discharge. His condition deteriorated and he died in hospital on 11 March.

Findings

7. The clinical reviewer considered that the clinical care Mr Bellingham received at HMP Stafford was at least as good as that which he could have expected to receive in the community. Although his initial reception into Stafford was unsatisfactory, the care Mr Bellingham received thereafter was efficient and caring.

Recommendation

- The Head of Healthcare should ensure that all prisoners received at HMP Stafford have a timely and comprehensive medical assessment and are prescribed medication appropriately.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Stafford 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 Bellingham's prison and medical records.

10. NHS England commissioned a clinical reviewer to review Mr Bellingham's clinical care at the prison.

11. We informed HM Coroner for South 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.

12. Mr Bellingham's brother was informed the initial report was available, but did not wish to receive a copy or make any comment.

13. The investigation has assessed the main issues involved in Mr Bellingham'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.

14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Stafford

15. HMP Stafford is a medium security prison in Staffordshire for adult sex offenders, which can hold around 750 prisoners across seven wings. Care UK provides healthcare services. Nurses are on duty daily between 7.30am and 5.30pm and there is a weekday GP service, with on-call GPs outside these hours.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Stafford was conducted in February 2016. Inspectors found that health provision was not consistently meeting the needs of the ageing population. Governance was reasonable overall, with effective working between providers and the prison. The range of primary care services was appropriate and access to nurses and GPs was good. There was a very high need for hospital appointments and at times over a quarter of appointments were cancelled or rescheduled because there were not enough escort staff available. Prisoners over 65 and those with mobility problems were not routinely handcuffed for external hospital appointments except when a specific risk had been identified.

Independent Monitoring Board

17. 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 their latest annual report, for the year to 30 April 2017, the IMB reported that healthcare had improved substantially since its last report, with a reduction in waiting lists for internal services, and fewer cancelled escorts for external appointments. The waiting time for GP appointments was comparable to that in the community.

Previous deaths at HMP Stafford

18. Mr Bellingham was the twelfth person to die of natural causes at HMP Stafford since January 2016. There are no similarities between his death and the earlier cases.

Findings

Clinical Care

19. Mr Derek Bellingham had been in custody since 2011, serving a 14-year prison sentence for sexual offences.

20. Mr Bellingham had suffered poor health since 2015. He had been diagnosed with kidney cancer in 2015 and this was treated and cured in November 2015. He had had an indwelling catheter (draining urine from his bladder into a bag held outside his body) fitted following his hospital admission in September 2015. Mr Bellingham also required support and medication for other illnesses including high blood pressure and diabetes.

21. In early 2017, Mr Bellingham underwent two cognitive assessments which were largely normal, albeit with some gaps in his function. He had the mental capacity to make decisions.

22. In June 2017, while at HMP Parc, Mr Bellingham had an episode of urosepsis. (Sepsis is a life-threatening bacterial infection of the blood, urosepsis is a form of sepsis that complicates a urinary tract infection.) He was admitted to hospital for two weeks to be treated with intravenous antibiotics. A care plan was created and regularly revised to assist Mr Bellingham with his catheter during his time at HMP Parc, but he continued to struggle. A computerised tomography (CT) scan done during his admission to hospital showed abnormalities to his bladder. (This scan produces detailed images of structures inside the body, including the internal organs and blood vessels.) Mr Bellingham was due to undergo further investigations but was transferred to HMP Stafford before these could take place.

23. On 29 June, when Mr Bellingham was transferred to Stafford, he did not receive a comprehensive first night assessment. On 31 July, he was seen by a nurse after wing staff raised concerns about his personal hygiene. Mr Bellingham did not have a comprehensive health assessment until 13 August, when he discussed his previous medical history with another nurse.

24. On 23 August, Mr Bellingham had a consultation with a prison GP, who reviewed his medication. Mr Bellingham complained that he had not had his usual medication since arriving at Stafford. His medication was prescribed the following day and Mr Bellingham was referred to a hospital urologist.

25. It became clear to healthcare staff that Mr Bellingham was having difficulties coping with his catheter and he also had episodes of incontinence of faeces. He declined any help. On 14 September, at a medical review with the prison GP, his blood pressure was found to have settled and he continued to maintain that he was able to care for himself.

26. On 22 September, the prison GP carried out a mini-mental state examination. The results of this were normal so did not explain the problems that Mr Bellingham was having with his self-care while on the wing.

27. On 27 October, Mr Bellingham was admitted to hospital with urosepsis and a stroke. He was regularly visited by healthcare staff while in hospital and

discussions were had about his discharge care package with hospital staff. Mr Bellingham required social care four times a day.

28. On 14 December, Mr Bellingham returned to Stafford from hospital. It became clear that he was unable to look after himself, follow instructions or clearly communicate his needs to staff. This suggested that he had lost the capacity to make decisions but there is no record of a formal mental capacity assessment being made. Peer carers were appointed to support Mr Bellingham.

29. On 16 December, Mr Bellingham returned to hospital with another episode of urosepsis. While in hospital it was confirmed he developed shingles and had had another stroke. There was regular contact between prison healthcare, safer custody and the hospital staff about concerns over Mr Bellingham's vulnerability and safety in the prison setting.

30. On 9 January, Mr Bellingham returned to Stafford. Staff were concerned about how he would cope in prison. The Deputy Healthcare Manager, a custodial manager and a social worker met to discuss Mr Bellingham and concluded that Mr Bellingham was unable to care for himself. Long term care plans were devised and a nurse began the process of applying for NHS Continuing Healthcare (CHC) funding (a package of care for adults aged 18 or over which is arranged and funded solely by the NHS).

31. On 15 January, the CHC forms were completed and sent off. The following day, Mr Bellingham had a mental health assessment and safeguarding concerns were raised by a nurse. An independent advocate was requested who would be able to support Mr Bellingham to understand his rights and participate in decisions about his care and treatment.

32. On 3 February, Mr Bellingham was admitted to the hospital with another case of urosepsis. Hospital staff wished to discuss the Do Not Attempted Resuscitation (DNAR) process. (DNAR means that in the event of cardiac or respiratory arrest, no attempt at the resuscitation will be made. All other appropriate treatment and care will continue to be provided.) However, Mr Bellingham lacked the mental capacity to engage in this process. During his stay in hospital, a multidisciplinary meeting was held and a move to an establishment with an inpatient facility was discussed, but there is no record of any action being taken.

33. On 14 February, Mr Bellingham was discharged back to Stafford and continued to be cared for by prison staff. Mr Bellingham lacked the capacity to recognise food or drink without help. He also struggled to communicate with his carers and staff and was often confused. On 19 February, after scoring zero on a mini mental health assessment, Mr Bellingham was referred to the local old age psychiatrist for support with his ongoing mental health care.

34. On 24 February, Mr Bellingham was admitted again to hospital with urosepsis. He seemed to be responding well to treatment.

35. On 9 March, Stafford made a request to transfer Mr Bellingham to another establishment with inpatient facilities on his discharge from hospital. Before plans materialised, his health suddenly declined and he developed pneumonia. Mr Bellingham died in hospital on 11 March.

36. We agree with the clinical reviewer that although Mr Bellingham received good care from Stafford, his transfer to the prison should have been managed better. A first night healthcare assessment should have been completed to ensure that Mr Bellingham received the support and medication that he needed. We make the following recommendation:

The Head of Healthcare should ensure that all prisoners received at HMP Stafford have a timely and comprehensive medical assessment and are prescribed medication appropriately.

Mr Bellingham's location

37. Mr Bellingham was originally placed on normal location at HMP Stafford. Healthcare and wing staff assisted him in managing his needs. On 9 March, as it became clear that he was unable to manage his healthcare needs, a request was made for him to be moved to another establishment with inpatient facilities. Mr Bellingham's health declined rapidly before the arrangements could be finalised.

38. The clinical reviewer notes that hospital referrals from Stafford were prompt and appropriate. Prison nurses cared for Mr Bellingham's physical and emotional needs, often carrying out tasks that should have been completed by social carers. Care plans were completed and regularly reviewed.

Restraints, security and escorts

39. 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.

40. The prison conducted risk assessments for Mr Bellingham when he visited the hospital and it was appropriately decided that it was unnecessary for him to be restrained, given his poor health and limited mobility.

Liaison with Mr Bellingham's family

41. On 27 October, the prison appointed a worker from the safer custody department as the prison's family liaison officer after Mr Bellingham had been admitted to a hospital's resuscitation unit. The family liaison officer made contact with Mr Bellingham's next of kin, his brother, who lives in France. He updated him on his brother's health. Mr Bellingham's brother gave the family liaison officer new contact details and the family liaison officer said he would keep him informed.

42. The family liaison officer made regular visits to Mr Bellingham during his multiple admissions to hospital. On 7 January, a deputy family liaison officer was appointed to assist the family liaison officer in supporting Mr Bellingham.

43. On 21 January, the family liaison officer attempted to contact Mr Bellingham's brother on the contact numbers he had provided but was unable to make any contact.

44. On 8 February, during another admission to hospital, the family liaison officer attempted to contact Mr Bellingham's brother several times to update him on Mr Bellingham's poor health. Another attempt was made on 17 February but without success. The family liaison officer asked for a letter be sent to his brother with the prison's contact details.

45. On 10 March, a further four attempts were made to contact Mr Bellingham's brother, as Mr Bellingham's health had deteriorated during his latest stay in hospital. The following day, Mr Bellingham died and continued attempts were made to get in contact with his brother.

46. The funeral took place in April and was attended by the family liaison officer and two other colleagues. Mr Bellingham's brother responded to the prison's letter after the funeral had taken place and the prison has continued to liaise with the family. We are satisfied that the prison, in particular the family liaison officer, provided a high level of support to Mr Bellingham.

Compassionate release

47. 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.

48. On 1 December 2017, an application for early release on compassionate grounds was made by the Offender Management Unit Hub Manager. This application was placed on hold as Mr Bellingham did not meet the criteria as he had not been diagnosed with a terminal illness and was expected to recover from his stroke.

49. On 6 February, discussions were had about reapplying for compassionate release, but it was agreed that Mr Bellingham would still not fit the criteria. Although he was very unwell, he had not been given a terminal diagnosis and did not have a definitive prognosis. By this stage, Mr Bellingham also lacked the capacity to apply for parole. We are satisfied that compassionate release was appropriately considered.

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