Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Edward Bailey a prisoner at HMP Belmarsh on 30 November 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 we oversee can improve their work in the future.

Mr Edward Bailey died in hospital on 30 November 2018 of pneumonia and pulmonary oedema (excess fluid in the lungs) while a prisoner at HMP Belmarsh. He was 90 years old. I offer my condolences to Mr Bailey's family and friends.

Mr Bailey had several long-term medical conditions when he arrived at Belmarsh and I am satisfied that the care he received was broadly equivalent to that which he could have expected to receive in the community.

I am concerned, however, that a prison GP did not identify that Mr Bailey had acute kidney failure when he reviewed his blood test results on 13 November. This was not identified until six days later, resulting in a further deterioration in Mr Bailey's condition before he was admitted to hospital.

I am also concerned that Mr Bailey was restrained when he was taken to hospital, a decision that was clearly unjustified given Mr Bailey's age and poor health.

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 **June 2019**

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Summary

Events

1. On 8 April 2016, Mr Edward Bailey was sentenced to eight years in prison for sexual offences and sent to HMP Belmarsh. He had been diagnosed with prostate cancer in 2010 and required prostate specific antigen (PSA) blood tests every six months to check for any recurrence. He also had type 2 diabetes, kidney disease, high blood pressure and dementia.

2. Mr Bailey's PSA level was normal in February 2017, but then he refused to have further blood tests until 10 November 2018. A prison GP reviewed the blood test results on 13 November, which showed that Mr Bailey's PSA level and kidney function were abnormal. The GP made urgent hospital referrals.

3. On 19 November, a different prison GP concluded that the blood test results showed that Mr Bailey was suffering from acute kidney failure. He arranged an emergency admission to hospital. Mr Bailey was escorted by two prison officers who restrained him with an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer).

4. Mr Bailey's condition deteriorated in hospital and he died at 6.20am on 30 November. The post-mortem examination found that he died from bronchopneumonia (lung infection) and pulmonary oedema (excess fluid in the lungs). Prostate cancer was a contributory factor.

Findings

5. The clinical reviewer found that the care Mr Bailey received for his long-term conditions was broadly equivalent to the care he could have expected to receive in the community. He noted, however, that healthcare staff did not set up a care plan for prostate cancer and there was a delay in setting up care plans for dementia and diabetes.

6. The prison GP who reviewed Mr Bailey's blood test results on 13 November failed to recognise that they showed Mr Bailey had acute kidney failure. It was not until six days later, on 19 November, that another prison GP realised the severity of his condition and arranged an emergency hospital admission.

7. We are concerned that Mr Bailey, aged 90, was restrained when he was taken to hospital on 19 November. The authorising manager failed to take account of Mr Bailey's advanced age and poor health when deciding to use restraints, a decision that was clearly unjustified.

Recommendations

- The Head of Healthcare should ensure that staff set up care plans for the management of long-term conditions.

- The Head of Healthcare should ensure that abnormal blood test results are actioned appropriately and promptly.

- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints 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 revise the prison's escort risk assessment form to ensure that it requires:
    - healthcare staff to say whether the prisoner's current state of health has an impact on his mobility; and
    - prison staff to show that they have taken this information into account in assessing the prisoner's current level of risk.

The Investigation Process

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

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

11. We informed HM Coroner for Inner South London District of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

12. The investigator sent a letter to Mr Bailey's daughter to explain the investigation and to ask if she had any matters she wanted the investigation to consider. We did not receive a reply.

13. We shared our initial report with HM Prison and Probation Service (HMPPS). They did not find any factual inaccuracies. They provided an action plan in response to our recommendations, which is annexed to this report.

Background Information

HMP Belmarsh

14. HMP Belmarsh is a high security and local prison serving the courts of South East London and South West Essex. It holds approximately 900 men. Oxleas NHS Foundation Trust provides healthcare services. There is 24-hour healthcare cover and a 32-bed inpatient unit.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Belmarsh was in February 2018. Inspectors reported that health services had improved and were now good. Primary care services were comprehensive, and prisoners could see a GP the same day for urgent matters, although too many prisoners did not attend appointments.

16. The inpatient unit was adequate and part of the unit was used for palliative care when required. While an officer managed the unit well, the competing needs of differing groups (such as those with mental health needs) meant some experienced a fragmented regime. Clinical leadership and multidisciplinary working was strong and working relationships with the prison were excellent.

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 its latest annual report, for the year to 30 June 2018, the Board expressed concern about the high volume of mental health inpatients, multi-unlock and constant watch patients. The additional care these patients required affected the regime of those in the healthcare unit and other areas of the prison when staff were used to provide support.

18. The Board also noted that healthcare staff had to deal with some very challenging individuals and commended the sensitive manner in which prison staff managed them.

Previous deaths at HMP Belmarsh

19. Mr Bailey was the eighth prisoner to die at Belmarsh since November 2016. Of the previous deaths, five were from natural causes and two were self-inflicted. There have been no deaths since. We have previously made a recommendation to Belmarsh about the inappropriate use of restraints.

Key Events

20. On 8 April 2016, Mr Edward Bailey was sentenced to eight years in prison for sexual offences and sent to HMP Belmarsh.

21. Mr Bailey had been diagnosed with prostate cancer in 2010 and was successfully treated with hormone therapy. He was supposed to have a prostate specific antigen (PSA) test every six months to check for any recurrence. (A PSA test is a blood test that measures levels of a protein in the blood used to help diagnose prostate cancer.) He had type 2 (diet controlled) diabetes, kidney disease, high blood pressure and a diagnosis of unspecified dementia. Staff placed him in the prison's inpatient unit.

22. On 3 May 2016, 19 January and 13 February 2017, Mr Bailey's PSA level was normal. Mr Bailey refused to give a blood sample on 28 June to check his PSA level.

23. On 4 December, Mr Bailey again refused to have a PSA test. A prison GP noted on 15 December that Mr Bailey's PSA had now not been checked for ten months. He made an entry in his medical notes that this should be checked as a high priority. On 29 December, Mr Bailey agreed to let the GP take a sample, "next week". However, there is no evidence to show that an appointment was made to take the blood sample.

24. Mr Bailey refused to give a blood sample on 2 July to check his PSA levels.

25. On 8 July, Mr Bailey told a nurse that he thought he may have lost weight and did not feel well in himself. When asked to describe how he was feeling, he became agitated and said that he was old and sick. He refused to be examined by the nurse.

26. A prison GP saw Mr Bailey the following day, 9 July. Mr Bailey said he felt unwell but could not describe any specific symptoms. He said that he felt low in mood and did not enjoy the prison food. He weighed 11st 2 lbs, a loss of nine pounds in six months. The GP prescribed a low dose of mirtazapine for mild depression and gave vitamin supplements.

27. On 11 July, Mr Bailey refused to give a blood sample to check his PSA level. His weight was checked on 23 July, and was found to be stable at 11st 1 lbs.

28. On 27 August, Mr Bailey's temperature was high at 38.9°C and slight 'crackles' could be heard on the left side of his chest. A prison GP prescribed antibiotics for a possible infection. The next day Mr Bailey's temperature was normal at 36.7°C.

29. Mr Bailey reported feeling unwell on 17 September. He told a prison GP that he had abdominal pain and had opened his bowels ten times that day. He had no other symptoms and his medical observations were normal. The GP agreed to keep him under review.

30. A prison GP examined Mr Bailey on 6 October. He still had diarrhoea and now weighed 10st 5 lbs, a further loss of 10lbs since 23 July. Mr Bailey refused to provide a blood sample for testing. A stool sample showed clostridium difficile, a

bacterial infection affecting the bowel causing diarrhoea. Mr Bailey was given metronidazole antibiotics for 14 days.

31. Mr Bailey agreed to provide a blood sample on 10 November. A prison GP reviewed the blood test results on 13 November. The GP noted that Mr Bailey's PSA level was above the recommended level, and made an urgent referral to the hospital's urology department. The GP also noted a severe deterioration in kidney function and made an urgent referral to the nephrology department.

32. The GP saw Mr Bailey again on the morning of 16 November when he had complained of feeling unwell the previous evening. His temperature was normal at 37.1°C and his oxygen saturation level (blood oxygen level) was good at 99%.

33. On 19 November, a prison GP reviewed Mr Bailey and decided that the recent blood test results showed that he was in acute kidney failure. He arranged Mr Bailey's emergency admission to Queen Elizabeth Hospital. Two prison officers escorted him and used an escort chain to restrain him. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.) A prison manager reviewed the risk assessment the following morning and restraints were removed at 8.25am.

34. An ultrasound showed Mr Bailey had chronic kidney disease and an enlarged prostate. A hospital doctor said that the kidney failure had been caused by dehydration, resulting from the clostridium difficile diarrhoea.

35. Mr Bailey's kidney function continued to deteriorate and on 25 November, he was diagnosed with pulmonary oedema, a condition caused by excess fluid in the lungs making it difficult to breathe. He was also diagnosed with pneumonia, for which he was given strong antibiotics. Mr Bailey was reviewed by the renal consultant and dialysis was not advised due to his frailty and poor health.

36. On 28 November, Mr Bailey refused any further tests to investigate or monitor his condition and said that he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect. The doctor treating Mr Bailey told him and his family that without further tests it would be difficult to give a prognosis and he could offer no further treatment apart from making him as comfortable as possible. Mr Bailey died two days later, on 30 November at 6.20am. His daughter was with him when he died.

Contact with Mr Bailey's family

37. The prison's family liaison officer (FLO) was a prison chaplain and knew Mr Bailey well. He attended the prison's church service every Sunday, and the prison chaplain visited the inpatient unit on a daily basis as part of his chaplaincy duties.

38. The FLO visited the hospital on 29 November to visit Mr Bailey and meet his daughter. He introduced himself and explained his role. He offered support and agreed to visit her again the next day.

39. The FLO attended the hospital the next morning when Mr Bailey died. He spent some time with Mr Bailey's daughter and at her request said a prayer for her father. He visited Mr Bailey's daughter at her home on 4 December, to return his

property and to answer any questions she had. He kept in contact with Mr Bailey's daughter and assisted with funeral arrangements.

40. Mr Bailey's funeral was on 10 January 2019. The prison contributed towards the cost of the funeral in line with prison guidance.

Support for prisoners and staff

41. A custodial manager debriefed the escort officers on their return from hospital and offered them support.

42. The prison posted notices informing other prisoners of Mr Bailey's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Bailey's death.

Post-mortem report

43. The post-mortem examination found that Mr Bailey died from bronchopneumonia (lung infection) and pulmonary oedema (excess fluid in the lungs). Prostate cancer was a contributory factor.

Findings

Clinical Care

44. Mr Bailey had multiple long-term conditions that required monitoring, namely type 2 diabetes, high blood pressure, kidney disease, prostate cancer and dementia. The clinical reviewer found that the monitoring of Mr Bailey's long-term conditions was satisfactory and that for the most part, Mr Bailey received a standard of care that was equivalent to that which he could have expected to receive in the community.

45. The clinical reviewer noted that Mr Bailey's PSA levels were not checked every six months as directed, but this was largely due to Mr Bailey's refusal to have blood tests. He also noted that healthcare staff did not set up care plans for dementia and diabetes until October 2016, and there was no care plan in place for prostate cancer. The clinical reviewer noted that Mr Bailey was regularly reviewed by staff in the inpatient unit, but it would have been good practice to have had care plans for all his conditions, and for them to have been set up earlier. We make the following recommendation:

    The Head of Healthcare should ensure that staff set up care plans for the management of long-term conditions.

46. The clinical reviewer found that there was a delay in arranging Mr Bailey's hospital admission once blood test results showed a deterioration in his kidney function, and this aspect of his care was not equivalent to that which he could have expected to receive in the community.

47. On 13 November 2018, Mr Bailey's blood test results showed a severe deterioration in his kidney function and a raised PSA level. A prison GP made urgent referrals to the nephrology and urology departments. On 19 November, when another GP noted the blood test results, he concluded that Mr Bailey had acute kidney failure and he arranged an emergency transfer to hospital.

48. There was a delay of six days in Mr Bailey being sent to hospital, during which time Mr Bailey's kidney function deteriorated further. It is not possible to say if this delay affected the eventual outcome. We make the following recommendation:

    The Head of Healthcare should ensure that abnormal blood test results are actioned appropriately and promptly.

Restraints

49. When prisoners have to travel outside 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.

50. When Mr Bailey was taken to hospital on 19 November, he was restrained with an escort chain. A prison risk assessment showed him to be a medium risk to

the public and low risk of escape. The healthcare section of the risk assessment was not completed. The escort chain was removed the next morning.

51. Mr Bailey was 90 years old and was seriously unwell when he was taken to hospital. The decision to apply restraints was made without any healthcare input, and there was no evidence that the authorising manager considered Mr Bailey's age and poor health before authorising the use of restraints. The decision was clearly unjustified. We make the following recommendations:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints 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 revise the prison's escort risk assessment form to ensure that it requires:

- **healthcare staff to say whether the prisoner's current state of health has an impact on his mobility; and**
- **prison staff to show that they have taken this information into account in assessing the prisoner's current level of risk.**

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