Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Richard Brown a prisoner at HMP Bullingdon on 30 September 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*

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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 Richard Brown died on 30 September 2018 of severe pyelonephritis (kidney infection) and bronchopneumonia, a secondary condition of prostate cancer, while a prisoner at HMP Bullingdon. Mr Brown was 73 years old. I offer my condolences to Mr Brown's family and friends.

Mr Brown received a good standard of clinical care at Bullingdon, equivalent to that which he could have expected in the community. Prison healthcare staff responded appropriately to his changing care needs, and continued to try to communicate with hospital doctors. Although this communication was not always easy, we agree with the clinical reviewer that this was not for want of trying on the part of prison healthcare.

However, I am concerned that Bullingdon restrained Mr Brown for several hospital visits, including while he was having an ultrasound scan, and that these decisions were not justified by a fully-considered risk assessment. I am pleased to note, however, that Mr Brown was released on temporary licence by the prison for his final admission to hospital and restraints were not used.

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 **March 2019**

Contents

Summary 1

The Investigation Process 3

Background Information 4

Findings 5

Summary

Events

1. Mr Richard Brown was charged with historic sex offences and received a 15-year sentence in April 2012. He was spent time at several prisons before moving to Bullingdon on 3 April 2017.

2. Mr Brown had a history of a transient ischaemic attack (a temporary shortage of blood supply to the brain) and was reviewed regularly by healthcare staff and prescribed appropriate medications.

3. In January 2018, Mr Brown reported having blood in his urine and a prison GP referred him to hospital for tests under the 'two-week wait' rule (used when cancer is suspected). In February, the hospital reported that nodules had been found in his bladder, which could indicate bladder or prostate cancer, and further investigations were arranged.

4. In March, a radiological examination confirmed multiple bladder tumours and in April, Mr Brown attended hospital for a biopsy (a procedure to remove part of the tumour). In June, the hospital confirmed that Mr Brown had prostate cancer. He was given drug treatment used to halt the growth of the cancer, and given a prognosis of four years.

5. Mr Brown's health began to deteriorate quickly and he needed assistance to mobilise. On 21 September, he reported that he had fallen in his cell three times within 24 hours. Mr Brown declined the offer to move to the prison's healthcare unit, so adjustments were made in his cell to reduce the risk of injury from further falls.

6. On 24 September, Mr Brown's health began to deteriorate further and he was transferred to the healthcare unit. On 26 September, blood test results showed severe kidney failure and Mr Brown was admitted to hospital, where he died on 30 September.

Findings

7. Prison healthcare staff provided timely, responsive care and ensured Mr Brown's care needs were met. Mr Brown received a good level of clinical care while at Bullingdon, equivalent to that he could have expected to receive in the community.

8. We are concerned that restraints were used on several occasions and that PER (prison escort risk assessment) paperwork and medical assessments were not always completed. We do not consider that restraints were necessary and proportionate to the risks Mr Brown posed, over and above the control already available through the escorting officers. However, we are pleased to note that restraints were not used for Mr Brown's final admission to hospital.

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,

  and should send the Ombudsman a copy of the revised form.

The Investigation Process

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

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

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

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

13. The investigator wrote to Mr Brown's son to explain the investigation and to ask whether he had any matters he wanted the investigation to consider. He did not respond to our letter.

14. Mr Brown's family did not wish to receive a copy of the report or make any comment.

15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out A factual inaccuracy and this report has been amended accordingly. The action plan has been annexed to this report.

Background Information

HMP Bullingdon

16. HMP Bullingdon is a training and local prison, serving the courts of Oxfordshire and Berkshire. It holds approximately 1,100 men. Care UK provides healthcare services and Cotswold Medicare Ltd provides general practitioner services. There is an inpatient healthcare unit with 24-hour nursing care.

HM Inspectorate of Prisons

17. The most recent inspection of Bullingdon was conducted in May 2017. Inspectors found the management of prisoners with long-term conditions had deteriorated since the previous inspection. Nurse-led clinics were limited to a diabetic clinic, triage and discharge clinics. Not all nurses were adequately trained in nurse triage. The assistant practitioner held a phlebotomy clinic and undertook regular observations for prisoners with long-term conditions. The dietician held two clinics a week and provided excellent support for a wide range of conditions.

18. However, there was good attendance at primary care clinics, and waiting lists were in line with those in the community. GP provision was appropriate and waiting times for routine appointments were acceptable. Allocated daily slots ensured that emergency appointments were available. While a 24-hour nursing service was provided, the NHS 111 telephone line was accessed appropriately for medical support.

Independent Monitoring Board

19. 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 most recent annual report for the year to 30 June 2018, the Board noted that improved facilities in the prison had reduced the need for prisoners to receive treatment outside the prison. This meant that prisoners were treated more quickly, and that officers did not have to leave the prison on escort duty. Staff levels had also been increased but the board noted that it would take time to build up the experience and knowledge lost in previous staff cuts.

Previous deaths at HMP Bullingdon

20. Mr Brown’s death was the fourth death from natural causes at Bullingdon since 2017. This is the third time we have made a recommendation about the inappropriate use of restraints since February 2017.

Findings

Diagnosis of Mr Brown's terminal illness and informing him of his condition

21. Mr Richard Brown was remanded to HMP High Down in June 2011 for historic sex offences and sentenced in April 2012. He was at several prisons before transferring to Bullingdon on 3 April 2017.

22. Mr Brown had a history of transient ischaemic attack, which required long term medication and blood-thinning medicines. Medical staff managed this condition appropriately.

23. On 29 January 2017, Mr Brown reported having blood in his urine. A prison GP referred Mr Brown to a urology specialist under the two-week wait rule on the same day. Prison nurses saw Mr Brown daily and, on 12 February, Mr Brown attended hospital, Oxford for a cystoscopy. (This is a visual inspection of the bladder using a camera inserted into the penis.) On 23 February, the urology department reported that nodules had been found in the lower bladder, which could indicate bladder or prostate cancer. Further investigations were arranged.

24. A nurse saw Mr Brown on 22 March, with a suspected urinary tract infection. No action was taken. On 28 March, the urinary tract infection was confirmed by a prison GP who prescribed antibiotics.

25. On 4 April, Mr Brown attended hospital for a biopsy of the tumour. On 19 April, Mr Brown was seen by a prison GP and treated for a second urinary tract infection. She reviewed Mr Brown on 31 May, and noticed that he had lost a considerable amount of weight. He was referred to a dietician and given food supplements.

26. On 12 June, Mr Brown attended hospital to see the consultant for the results of his biopsy. The consultant confirmed that Mr Brown had prostate cancer, which had spread to the bladder. He was treated with bicalutamide, a drug to help contain the progression of the disease, and given a prognosis of four years. Prison medical staff did not agree with this prognosis given Mr Brown's poor health and frailty. Mr Brown was weak and he needed assistance from both a Zimmer frame and a wheelchair to mobilise.

27. We agree with the clinical reviewer that healthcare staff appropriately referred Mr Brown for urgent investigative tests when he presented with blood in his urine. It took several weeks to get a definitive diagnosis and prognosis but this was due to delays at the hospital, not prison healthcare.

Mr Brown's clinical care

28. On 13 June, the hospital informed prison medical staff that blood test results showed that Mr Brown's kidneys were under strain. Arrangements were made to readmit him to hospital the next day and a nephrostomy tube was inserted. (This is a tube that drains the urine directly from the kidney into a bag. It is used when urine cannot be passed normally through the bladder outwards down the penis.) On 15 June, Mr Brown returned to prison, where he was monitored.

29. On 17 June, a prison GP noted that Mr Brown was cheerful but frail. He was reviewed by the prison dietician, later that day and prescribed metoclopramide for nausea, and changes to his food supplements were made.

30. On 22 June, the nurse manager received confirmation from the hospital that Mr Brown's cancer was advanced and had spread to the lymph nodes in his pelvis and to his bones in multiple places. Mr Brown was referred to a hospice for advice on symptom management.

31. On 23 June, a nurse saw Mr Brown and discussed his diagnosis and options. He was offered a move to the healthcare unit but again declined as he felt supported on his wing. Healthcare staff began daily checks on him on the wing.

32. On 26 June, a prison GP saw Mr Brown and injected a long acting anti-prostate cancer drug (zoladex) under the skin. On 28 June, a multidisciplinary team meeting was held to discuss Mr Brown and it was agreed to look at his compassionate release.

33. On 4 July, Mr Brown appeared to be in pain around the site of his nephrostomy, which was red and inflamed and potentially infected. On 6 July, a prison GP increased the dose of a slow release, long acting painkiller (tramadol MR). The clinical reviewer commented that this indicated that she thought that the pain was from Mr Brown's cancer and not infection at the nephrostomy site, as pain from secondary cancers in the bone is common in advanced prostate cancer. Blood test results showed a strain on Mr Brown's kidneys but these were an improvement on tests completed before the nephrostomy operation.

34. Mr Brown continued to receive daily checks and was again treated for nausea with metoclopramide. On 3 August, a prison GP reviewed Mr Brown. His pain was under control, he no longer had nausea and he was putting on weight.

35. On 7 August, the prison received a letter from a hospital consultant who confirmed widespread prostate cancer and widespread bony metastases (a spread of cancer to the bones). The consultant's opinion was that injections could control the cancer for many months, or even years. Again, the prison medical team disagreed with this view, given Mr Brown's overall presentation.

36. On 16 August, the prison GP made an application for Mr Brown's compassionate release. He noted that the hospital oncology team had given a prognosis of several years so compassionate leave might be rejected on this basis.

37. On 13 September, a prison GP reported that Mr Brown's health was deteriorating. He appeared confused and had redness and pus at the site of his nephrostomy and had tenderness. Mr Brown had also become increasingly fidgety with his catheter and confused. He was given antibiotics, and blood tests showed kidney strain, mild anaemia and slightly raised levels of white cells in the blood, suggesting an infection.

38. On 17 September, a prison GP saw Mr Brown, who appeared in a good mood. He told her that he thought his nephrostomy tube had not been working for two weeks. She compared the earlier test results with the most recent kidney blood tests. As there was no change there was evidently no acute renal function problem. Mr Brown had a urology appointment the following week and the prison

GP wrote a letter to the consultant to seek further advice on the management of Mr Brown's healthcare.

39. On 20 September, a nurse suspected that the urostomy tube was not draining properly and she rang the hospital urology team for advice. The surgical registrar told her that that Mr Brown did not need to be seen before his scheduled appointment the following week.

40. A multidisciplinary meeting took place at the prison later that day and a decision was made to place Mr Brown on a clinical palliative care pathway plan. It was also agreed to contact the specialist palliative team at the hospice again for further advice and to ask the prison GP to restart the process for compassionate leave. This had been placed on hold due to Mr Brown's prognosis.

41. On 21 September, Mr Brown reported to a nurse that he had fallen in his cell three times within 24 hours. She offered Mr Brown a move to the prison's healthcare unit. He declined this so adjustments were made to his cell to reduce the risk of injury from further falls.

42. The same day, healthcare staff noted that Mr Brown was in discomfort and had pulled out his urostomy catheter. He was offered hospital admission but declined. The prison GP decided to wait for his next urology appointment on 25 September. Mr Brown appeared low in mood, telling a nurse he felt "fed up". Blood results received later that day showed a further, marked decline in kidney function. Another prison GP spoke to hospital medical staff, who told him an urgent urology review was needed. However, the hospital's palliative care consultant, telephoned the prison GP to express a different opinion. The prison GP called the on-call urology registrar to push for a review due to his concerns but they still did not agree to see Mr Brown.

43. On the same day, Mr Brown told a nurse that he had suffered three falls in the past 24 hours but he insisted that he did not want to move to the healthcare unit. A mattress was placed on the floor next to Mr Brown's bed to prevent injury from any further falls. That evening, a nurse noticed that Mr Brown appeared confused.

44. On 24 September, a decision was made to move Mr Brown to the prison's healthcare unit until a hospice bed became available. The prison GP recorded a deterioration in Mr Brown's health in the past few days and worsening kidney function. He discussed admission to hospital for a repeat urostomy tube with the hospital urology team. The urology team felt that assessment and admission could wait until Mr Brown's scheduled appointment the next day. Mr Brown was very frail and was unable to stand and he told her that his main concern was to be comfortable. A prescription for oral morphine liquid was written on an as-needed basis.

45. On 25 September, a prison GP decided that Mr Brown was too ill to transfer to hospital. A special pressure-relieving mattress was provided and arrangements were made for a member of the hospice team to come to see Mr Brown within the next few days.

46. The nurse manager, the Head of Healthcare, recorded that the prison Governor would support early release on compassionate grounds. An open-door policy was agreed allowing medical staff immediate access to Mr Brown's cell. Extra staff were arranged for the night shift so that full care could be provided for Mr Brown. Mr Brown was given slow-release morphine tablets to give longer lasting pain relief. The use of a syringe driver for pain relief was also considered.

47. Prisoners who had cared for Mr Brown on the wing were given the opportunity to visit him in the healthcare unit. Injectable medicines that are used for emergency symptom relief in terminal care were prescribed on a standby basis. Through the day, Mr Brown was in considerable pain and had to be given his oral morphine liquid hourly. Nursing observations recorded that he was more settled during the afternoon but still in pain when moved. During the night, a nurse reported Mr Brown was sleeping well but was later confused, delirious and in pain when moved.

48. On the morning of 26 September, a prison GP saw Mr Brown. His health had deteriorated quickly over the past few days and repeated blood test results showed severe kidney failure. At 11.42am, the prison GP rang the hospital and spoke with the palliative care consultant. He told her he was unhappy treating Mr Brown for end of life care, given the prognosis Mr Brown had received a few months earlier. The palliative care consultant spoke with the urology consultant who agreed that Mr Brown needed an urgent urology assessment.

49. At 2.41pm that day, the nurse manager received a call from hospital doctor. He told her that Mr Brown should be referred to the oncology team because there was no active treatment for him from a urological point of view. He was judged to be borderline for palliative care and therefore needed an oncology assessment. At 4.24pm, confirmation was received from the hospital that neither the oncology or urology departments had any available beds. It was recommended that Mr Brown be referred to the accident and emergency department.

50. At 5.32pm, a nurse manager had a discussion with another nurse manager, who decided that it would be in Mr Brown's best interests to manage him in the prison's healthcare unit with a view to sending him to hospital the following day. She told the clinical reviewer that he made a considered decision, balancing the issues of dignity and comfort, against the likelihood of lasting benefit from a hospital transfer.

51. However, at 7.49pm, a prison GP discussed the situation with the palliative care consultant and a decision was made to transfer him to the accident and emergency department as quickly as possible. Mr Brown was admitted to hospital that night.

52. On 27 September, the palliative care consultant phoned the hospital for an update. He was told that Mr Brown was under the care of the oncology team, who were planning to insert another nephrostomy tube. Prison medical staff enquired about Mr Brown daily. His condition continued to deteriorate and he died in hospital on 30 September.

53. The post-mortem report shows that Mr Brown died from severe pyelonephritis (kidney infection) and bronchopneumonia, a secondary condition of prostate cancer.

54. The clinical reviewer concluded that the clinical care Mr Brown received from healthcare staff at Bullingdon, from definitive diagnosis to his admission to hospital a few days prior to his death, was good and equivalent to what he could have expected in the community. He added that he considered that prison healthcare staff made repeated attempts to communicate effectively with hospital doctors on a treatment approach and that, although communication with hospital staff was difficult at times, in his opinion "this was not for want of trying" by prison healthcare.

55. We agree with the clinical reviewer that Mr Brown's clinical care at Bullingdon was equivalent to that he could have expected to receive in the community. Mr Brown was able to access outpatient appointments and received the treatment prescribed by his consultants. Appropriate care plans were put in place and consideration was given to his wishes.

Mr Brown's location

56. We are satisfied that Mr Brown's location was appropriate and that staff at Bullingdon clearly reviewed his location as his condition changed. Mr Brown refused to be moved to the healthcare unit and every effort was made to respect his wishes and care for him on a standard wing. Mr Brown was moved to the healthcare unit on 24 September when he became too poorly to remain on the wing and while he waited for a bed at the hospice.

57. An open-door policy was put in place to allow medical staff ease of access to Mr Brown's cell for medical treatment. Mr Brown's friends from the wing were given the opportunity to visit him.

Restraints, security and escorts

58. 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.

59. A judgment of 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.

60. Mr Brown went to hospital on a number of occasions following his diagnosis. The escort risk assessments provided by the prison indicated that he presented a medium risk of escape and high risk of harm to others.

61. On 12 February, Mr Brown attended hospital for a cystostomy procedure. There is no information on the PER about the level of restraints used on Mr Brown and there is no medical assessment. However, the record does state that restraints were removed for treatment. On 21 February, when Mr Brown attended hospital for radiotherapy, he was restrained using double cuffs with two prisoner officers in attendance. No medical assessment was completed but restraints were reduced to an escort chain due to Mr Brown having poor mobility.

62. On 26 March, Mr Brown attended for an appointment with the hospital consultant. He was restrained with double cuffs and escorted by two officers. Restraints remained on Mr Brown during the appointment and there was no medical objection. On 4 April and 15 May 2018, Mr Brown attended hospital but there is no information on the escort risk assessments and no medical assessments were completed.

63. On 12 June, Mr Brown attended hospital. He was escorted by two prison officers and restrained with double cuffs. No medical objection was raised to restraints. Mr Brown returned to hospital the following morning for an ultrasound scan. The same escort and restraints were used as the previous day but on this occasion the medical assessment objected to the use of restraints due to Mr Brown's poor mobility and the use of a Zimmer frame. Nevertheless, the level of restraints was not adjusted or and they were not removed for treatment.

64. On 14 June, Mr Brown's assessed risk to the public was reduced to medium. He was escorted to hospital by two prison officers and restrained with double cuffs. These were only removed for surgery. Mr Brown went to hospital on three separate occasions between 16 July and 7 August. The prison has been unable to provide the PERs for these dates.

65. On 29 September, Mr Brown went to hospital the final time and remained there until he died. He was released on temporary licence (ROTL) and was not restrained during the escort or bedwatch.

66. We are pleased to note that a ROTL was put in place for the end of Mr Brown's life and that restraints were not used for his final admission to hospital. However, we are concerned about the level of restraints used for Mr Brown before this and the lack of medical input to the risk assessments. Mr Brown was an elderly man, who had poor mobility, which was not considered during escort or when assessing his risks. The risk assessments appear to have been based primarily on Mr Brown's offence, with little consideration of how his health affected the level of risk he posed at the time, as the 2007 judgment requires. We are also concerned that the PERs and medical assessments were not completed for all Mr Brown's escorts.

67. Whenever restraints are used, the risk assessments must accurately reflect the risk posed at that time to ensure proportionality and to maintain human dignity. We are not satisfied that the prison appropriately considered Mr Brown's level of risk or clearly justified the use of restraints as his condition deteriorated. Although it is the Governor's responsibility to ensure that the risk assessment process is properly managed, the Head of Healthcare also needs to ensure that healthcare staff fully understand the requirements of the High Court judgement and contribute to risk assessments.

68. 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,**

and should send the Ombudsman a copy of the revised form.

Liaison with Mr Brown's son

69. The OMU (offender manager unit) administrative officer, was appointed as the prison's family liaison officer (FLO) on 25 September when Mr Brown's health began to deteriorate and he was assessed as being in need of palliative care. She contacted Mr Brown's son and next of kin in accordance with Mr Brown's wishes and arrangements were made for him to visit.

70. The FLO kept Mr Brown's son up to date on his condition and provided on-going support. She explained the FLO role and the steps to be taken after Mr Brown's death, such as the coronial process and assistance with funeral arrangements. She continued to provide support to Mr Brown's son after his father died. In line with national guidance, the prison made a financial contribution to the funeral, which was held on 24 October.

Compassionate release

71. 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.

72. On 26 June 2018, it was agreed during a multidisciplinary meeting the palliative care consultant would consider compassionate release. On 16 August, the consultant submitted the compassionate release form but noted that it was unlikely to be approved as a hospital doctor had given Mr Brown a life expectancy of "a few years". The process was later placed on hold because of this.

73. On 20 September, during a multidisciplinary meeting and due to Mr Brown's deteriorating health, a decision was again taken to consider compassionate release. On 25 September, the Governor agreed to support Mr Brown's compassionate release, but due to his rapid decline in health, the application was

not completed before his death. However, ROTL was arranged for Mr Brown, which allowed him to attend hospital without the use of restraints.

74. We are satisfied that Bullingdon considered and applied for compassionate release in a timely manner and recognise that this was not possible due to the hospital's prognosis for Mr Brown.

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