Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Bailey a prisoner at HMP Garth on 8 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 Michael Bailey died on 8 November 2018 of chronic obstructive pulmonary disease in the regional healthcare inpatient unit at HMP Preston. Mr Bailey was 61 years old. I offer my condolences to his family and friends.

I am satisfied that Mr Bailey received a good standard of care at Garth and Preston, equivalent to that he could have expected in the community.

However, I am concerned that Mr Bailey's wish to die in prison, rather than hospital, was not effectively communicated among healthcare staff at Preston.

Although Mr Bailey had been at Preston for two years and eight months before his death, he remained, technically, a prisoner at HMP Garth, where he had been before transferring to Preston. I am concerned that this made it difficult for staff at Garth to exercise their responsibilities effectively, particularly in relation to compassionate release.

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 **October 2019**

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Summary

Events

1. On 25 April 2013, Mr Bailey was sentenced to 17 years imprisonment. He was transferred to HMP Garth in April 2014. He was diagnosed with chronic obstructive pulmonary disease (COPD) in May 2015, besides having a number of other health conditions.

2. On 7 March 2016, Mr Bailey transferred to the regional healthcare unit at HMP Preston for inpatient treatment and end of life care, but remained technically the responsibility of Garth. Mr Bailey's condition gradually deteriorated and he had two stays in hospital as a result. Mr Bailey recovered and returned to prison. His mobility deteriorated and he became dependent on a wheelchair and then became bedbound in August 2018.

3. Mr Bailey had appropriate care plans in place to support him and was reviewed regularly by palliative care staff from a local hospice.

4. Mr Bailey discussed his wish to die in prison, rather than hospital, with healthcare staff at Preston. This was documented in his records but he was taken to hospital on 6 November 2018. He was too unwell to return to prison and died in hospital on 8 November.

Findings

5. We are satisfied that Mr Bailey was seen regularly by doctors, the palliative care team and relevant professionals and that his healthcare was equivalent to that he could have expected to receive in the community.

6. Mr Bailey's wish to die in prison, rather than hospital, was not communicated effectively within the healthcare team at Preston.

7. Discussions about compassionate release were not documented at Preston and the subject was not discussed with Garth, the prison responsible for making a compassionate release application.

8. We are concerned that, although Mr Bailey, lived in the healthcare unit at Preston for two years and eight months before his death, he was not formally transferred and remained the responsibility of Garth. We consider that this made it difficult for staff at Garth to exercise their responsibilities effectively.

Recommendations

- The Head of Healthcare at Preston should ensure that care plans are clearly communicated to all staff involved in the care of a patient so that end of life preferences can be respected.

- The Governors of Garth and Preston should ensure that their staff are aware of their responsibilities for initiating compassionate release applications for terminally ill prisoners and the Head of Healthcare at Preston should ensure that healthcare staff share relevant information about the prisoner's condition so that the compassionate release application can be made at the appropriate time.

- The Prisons Group Director for Cumbria and Lancashire should:
    - ensure that prisoners who have been transferred to the regional healthcare unit at HMP Preston are formally transferred there once it becomes clear that they will not be returning to their original prison; and
    - provide the Ombudsman with the outcome of his review of the regional beds policy.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMPs Garth and Preston 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 Bailey's prison and medical records.

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

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

13. The investigator wrote to Mr Bailey'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. The investigation has assessed the main issues involved in Mr Bailey'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 our initial report with HM Prison and Probation Service (HMPPS). They did not identify any factual inaccuracies. They provided an action plan which is annexed to this report.

Background Information

HM Prison Garth

16. HMP Garth holds up to 846 men, many serving indeterminate sentences for public protection (IPP), life sentences, or other long sentences. Lancashire Care Foundation Trust provides health services. Nurses are on duty between 7.00am and 9.00pm every day. Chorley Medics provide a service outside these times. GP clinics are held every day, normally from 9.00am to 1.00pm but occasionally from 1.00pm to 5.00pm. There is no inpatient unit.

HM Prison Preston

17. HMP Preston is a local prison holding up to 811 adult men. Spectrum CIC has been responsible for healthcare services at the prison since 1 April 2017. There is an inpatient unit for up to 30 prisoners, which is used as a regional facility, including for end of life care.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Garth was conducted in January 2017. Inspectors reported that the range of primary healthcare clinics was appropriate but waiting times, at around 5 weeks, were unacceptably long for GP appointments. Prisoners with urgent health needs were seen promptly and access to the community out-of-hours GP service was appropriate. Prisoners with acute health needs or injuries could access daily nurse assessment clinics.

19. The most recent inspection of HMP Preston was conducted in March 2017. Inspectors noted that healthcare provision had deteriorated. Care for prisoners with long-term conditions was inconsistent and care plans were inadequate. Inspectors found that the standard of care in the inpatient unit was generally good.

Independent Monitoring Board

20. 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.

21. In its latest annual report for Garth, for the year to November 2017, the IMB reported that it was pleased with the improvements made in general healthcare provision over the reporting year. They found that recommendations to healthcare from a recent inspection at Garth had been partially achieved.

22. In its latest annual report for Preston, for the year to March 2018, the IMB reported that there had been improvements since Spectrum took over healthcare services and the number of nurses was increasing. It considered healthcare facilities could be improved to provide better services to prisoners.

Previous deaths at HMP Garth and Preston

23. Mr Bailey was the seventh prisoner to die from natural causes while a prisoner at Garth since January 2016. There are no similarities in Mr Bailey's case to these previous deaths.

24. Mr Bailey was the sixth prisoner to die from natural causes at Preston since October 2015. In our investigation into a previous death in March 2018, we expressed concern that, although the prisoner had been transferred to the regional healthcare unit Preston more than two years before his death, he remained the responsibility of his previous prison and that this had led to confusion.

Findings

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

25. On 25 April 2013, Mr Bailey was sentenced to 17 years imprisonment for sex offences. He was transferred to HMP Garth in April 2014. He was diagnosed with chronic obstructive pulmonary disease (COPD) in May 2015. He also had high blood pressure, irritable bowel syndrome, deep vein thrombosis and neck problems.

26. On 7 March 2016, Mr Bailey was transferred to the regional inpatient healthcare unit at HMP Preston for better management of his health conditions and end of life care.

Mr Bailey's clinical care

27. On arrival at Preston on 7 March 2016, Mr Bailey's care plans were reviewed and discussed and agreed with him. His clinical observations were normal apart from his blood oxygen level, which was low due to his COPD.

28. On 14 April, Mr Bailey went to hospital and was treated for pneumonia. He returned to Preston on 26 April. He increasingly required greater support from staff with all aspects of his care. He had regular treatment for constipation and from June 2018 required continuous oxygen therapy. Mr Bailey's mobility became poor and he required a wheelchair to get around.

29. In August 2018, Mr Bailey became bedbound and his care plans were updated accordingly. He received ongoing support from the palliative care team at St Catherine's Hospice. On 5 October, he was reviewed by a consultant and a nurse from the hospice, who found him to be very weary and frail. He complained of abdominal pain, said that he felt lightheaded when he sat up and was eating very little. They reviewed his pain relief medication.

30. On 9 October, a prison nurse noted that Mr Bailey had developed a pressure sore. This was monitored when he was moved and the appropriate dressings were applied.

31. On 14 October, Mr Bailey went to hospital after being examined by a prison nurse for severe stomach pain. He received treatment at hospital for dehydration and exacerbation of his COPD. Mr Bailey was in hospital for ten days, he was very unwell and it was thought by hospital staff that he might not live through. Mr Bailey said he did not want to be resuscitated if his heart or breathing stopped. He signed an order to that effect while in hospital.

32. On 24 October, Mr Bailey returned to Preston and continued to receive full assistance with personal care. Mr Bailey told a prison GP that he wanted to die in prison and did not want to go to hospital if he deteriorated and, on 30 October, he discussed his end of life wishes with a prison nurse.

33. Mr Bailey's condition deteriorated and he slept for long periods during the day. A prison nurse contacted the hospice for advice about his symptom control. On 6 November, a prison nurse requested an ambulance for Mr Bailey because his

condition had worsened. He was transferred to hospital where a doctor told prison healthcare staff that he thought he could die at any time.

34. On 8 November, a prison nurse visited Mr Bailey in hospital and discussed with hospital staff whether his care could be managed back at Preston. Mr Bailey died that evening in hospital at 7.02pm.

35. A post-mortem report found that Mr Bailey died of end stage COPD.

36. We agree with the clinical reviewer that the care Mr Bailey received was equivalent to that he could have expected to receive in the community.

Mr Bailey's location

37. On transfer to Preston on 7 March 2016, Mr Bailey lived in the inpatient healthcare unit. He was nursed in his cell and specialist equipment, including a pressure relieving mattress, was put in place to manage the problems caused by his lack of mobility.

38. On 27 October 2018, Mr Bailey told a prison GP that he did not want to go to hospital when his condition deteriorated. He expressed the wish to die at Preston. The GP noted that Mr Bailey had the mental capacity to make this decision and agreed with it. The GP passed this information on to a nurse and asked that Mr Bailey's care plans were updated. Mr Bailey's wish to die in prison was discussed again on 30 October and 6 November and recorded in his notes.

39. On 6 November 2018, a prison nurse called an ambulance for Mr Bailey due to his deteriorating condition. The Head of Healthcare told the clinical reviewer that the nurse had felt that Mr Bailey might have received better symptomatic care at hospital. She was unclear whether the nurse was aware of the record in Mr Bailey's notes that he did not want to go to hospital.

40. We agree with the clinical reviewer that clearer communication about Mr Bailey's end of life wishes might have prevented his admission to hospital on 6 November. We make the following recommendation.

    The Head of Healthcare at Preston should ensure that care plans are clearly communicated to all staff involved in the care of a patient so that end of life preferences can be respected.

Restraints, security and escorts

41. 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.

42. Mr Bailey went to hospital twice during 2018 and on each occasion no restraints were used. We are satisfied that the prison acted appropriately in relation to the use of restraints.

Liaison with Mr Bailey's family

43. On 14 October 2018, a Supervising Officer (SO) at Garth was appointed as family liaison officer and attempted to locate Mr Bailey's son. Initially, contact was made with his sister as his son could not be found. On 7 November, the SO made contact with Mr Bailey's son and arranged for him to visit Mr Bailey in hospital.

44. Mr Bailey's funeral took place on 11 December 2018. The prison contributed to the funeral costs in line with national policy.

Compassionate release

45. 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 Prisons and Probation Service (HMPPS).

46. Mr Bailey expressed a wish to die in prison in the week before his death. The Head of Healthcare at Preston said that discussions did take place earlier with Mr Bailey about compassionate release although these were not recorded in his notes.

47. The Head of the Offender Management Unit at Garth told the investigator that compassionate release had not been considered for Mr Bailey. Mr Bailey remained a prisoner of Garth while he was in the regional healthcare unit at Preston. It remained the responsibility of Garth to initiate a compassionate release application for Mr Bailey. However, there is no evidence that staff at Preston made those at Garth aware that Mr Bailey's condition had deteriorated to the point that compassionate release could be considered. Although staff at Preston said that conversations took place with Mr Bailey about compassionate release, it is important that such conversations are documented and communicated to the establishment responsible for making the application. We make the following recommendation:

    The Governors of Garth and Preston should ensure that their staff are aware of their responsibilities in initiating compassionate release applications for terminally ill prisoners and the Head of Healthcare at Preston should ensure that healthcare staff share relevant information about the prisoner's condition so that the compassionate release application can be made at the appropriate time.

Regional healthcare policy

48. Although Mr Bailey lived in the healthcare unit at Preston for two years and eight months before his death, he was never formally transferred to Preston and

remained the responsibility of Garth. This meant that, although Garth was responsible for making an application for compassionate release, they did not do so because of poor communication between the two prisons.

49. In our investigation into the death of another prisoner at Preston in March 2018, we found that the fact that the prisoner had remained the responsibility of another prison for more than two years after his transfer to Preston, had caused problems with family liaison, escort risk assessments and record keeping.

50. We expressed concern that when a prisoner is transferred to a regional healthcare bed at Preston for a long period, responsibilities become confused. We recommended that the Prison Group Director (PGD) for Cumbria and Lancashire should ensure that there is a process to review whether and at what stage prisoners who are transferred to a regional healthcare bed at Preston should be formally transferred. We were told in response that the PGD would be reviewing the regional beds policy in October 2018. We have not seen evidence that this has happened.

49. We remain concerned that the arrangements in place at the time of Mr Bailey's death in November 2018, made it difficult for the original prison to exercise its responsibilities in a meaningful way. We recommend that:

The PGD for Cumbria and Lancashire should:

- **ensure that prisoners who have been transferred to the regional healthcare unit at HMP Preston are formally transferred there once it becomes clear that they will not be returning to their original prison; and**
- **provide the Ombudsman with the outcome of his review of the regional beds policy.**

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