

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Terrance Galligan a prisoner at HMP Bullington on 10 June 2019

A report by the Prisons and Probation Ombudsman

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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Summary

1. 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.
2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Terrance Galligan, who was 92 years old, died of bronchopneumonia on 10 June 2019, at HMP Bullingdon. We offer our condolences to Mr Galligan's friends.
4. The clinical reviewer concluded that the clinical care that Mr Galligan received at Bullingdon was equivalent to that which he could have expected to receive in the community. She has made three recommendations about clinical issues.
5. We did not find any non-clinical issues of concern.

Recommendations

- The Head of Healthcare should consider including parameters within a patient's care plan which triggers a microbiological assessment for specimens of urine or sputum for those patients who are a known risk of infection.
- The Head of Healthcare should ensure that GPs review the new CUK end of life policy and review the process for discussing advanced directives. This should include timeliness for discussing and recording DNAR decisions.
- The Head of Healthcare should review the process for obtaining and storing mental capacity assessment documentation in line with best practice.

Investigation Process

6. NHS England commissioned an independent clinical reviewer, to review Mr Galligan's clinical care at HMP Bullingdon. The clinical review is attached to this report as Annex 1.
7. The PPO has investigated the non-clinical issues in Mr Galligan's care, including his location, the security arrangements for his hospital escorts and whether compassionate release was considered.
8. Mr Galligan did not have a named next of kin.
9. We shared our initial report with HM Prison and Probation Service (HMPPS). They did not identify any factual inaccuracies. HMPPS provided an action plan which is annexed to this report.

Previous deaths at Bullingdon

10. There have been five deaths from natural causes at HMP Bullingdon in the last two years. There are no similarities between our findings in the investigation of Mr Galligan's death and the other deaths.

Key Events

11. Mr Galligan was serving a twelve-year sentence for sexual offences and was transferred to HMP Bullingdon in March 2019.
12. Mr Galligan was diagnosed with a progressive lung disease while in the community. When he arrived at Bullingdon, he was frail and his physical appearance was described as 'wasted'. He also had a persistent cough and suffered from breathlessness. Mr Galligan was identified as being suitable for palliative care only.
13. Mr Galligan had recently received a long sentence and did not meet the criteria for early release on compassionate grounds.
14. Mr Galligan was admitted to hospital on two occasions while at Bullingdon. On both occasions he was not restrained.
15. There was no post-mortem examination but the Coroner established that the provisional cause of Mr Galligan's death was bronchopneumonia caused by pulmonary fibrosis.

Lisa Burrell
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