Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Clark, a prisoner at HMP Bullingdon, on 24 February 2020

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 Paul Clark died in hospital from bronchopneumonia on 24 February 2020, while a prisoner at HMP Bullingdon. He was 47 years old. I offer my condolences to Mr Clark's family and friends.

Mr Clark arrived at Bullingdon with several long-term health conditions, including lung disease. The clinical reviewer found that the care Mr Clark received was equivalent to that he could have expected to receive in the community.

Mr Clark was taken to hospital on multiple occasions and was restrained each time, despite being a wheelchair user and relying on oxygen to help him breathe. This was inappropriate.

This is the fourth time in less than 18 months that I have made a recommendation to Bullingdon about the inappropriate use of restraints. In August last year, I made a recommendation to the Prison Group Director for South Central, to satisfy himself that appropriate measures had been taken to address Bullingdon's failure to comply with caselaw on the use of restraints. I am very disappointed that Bullingdon continues to make the same mistakes. I urge the Prison Group Director to address this again, urgently.

I am also concerned that Mr Clark's next of kin was notified of his death by telephone and not in person, which is contrary to Prison Service instructions.

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 **September 2020**

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Summary

Events

1. On 27 June 2014, Mr Paul Clark was sentenced to life imprisonment for sexual offences. On 7 December 2017, he was sent to HMP Bullingdon.

2. Mr Clark had several long-term health conditions, including interstitial lung disease (a term for several lung disorders characterised by inflammation or scarring to the lungs which affects their ability to absorb oxygen) and chronic obstructive pulmonary disease (COPD – a term for a group of serious lung conditions that cause breathing difficulties).

3. Mr Clark's lung function progressively worsened while at Bullingdon, and at the beginning of 2019, he was supplied with in-cell oxygen to assist his breathing.

4. In 2019 and early 2020, Mr Clark was admitted to hospital multiple times with breathing difficulties. He was restrained on each occasion. Mr Clark's last admission was on 20 February, and he died in hospital on 24 February.

5. The post-mortem examination found that he died from bronchopneumonia, caused by rheumatoid arthritis-associated interstitial lung disease.

Findings

6. The clinical reviewer was satisfied that overall, the healthcare Mr Clark received at Bullingdon was of a good standard and was equivalent to that he could have expected to receive in the community.

7. Mr Clark was a wheelchair user and needed oxygen to help him breathe. The use of restraints when he was taken to hospital was inappropriate. This is an issue we have repeatedly raised with Bullingdon. In August 2019, we made a recommendation to the Prison Group Director for South Central, to satisfy himself that effective measures had been taken to address Bullingdon's continuing failure to comply with caselaw on the use of restraints. We are disappointed to have to raise this issue yet again.

8. We also made a recommendation to the Head of Healthcare to ensure healthcare staff were trained on completing risk assessments for patients going to hospital. We were told this training had been delivered. However, the medical input to Mr Clark's risk assessments was sometimes incorrect and there still appeared to be a lack of understanding about the legal position on the use of restraints on prisoners who are seriously unwell and/or have poor mobility.

9. Mr Clark died shortly before 11.00pm on 24 February. The prison's family liaison office (FLO) was notified at 9.45am the next day, and he then telephoned Mr Clark's next of kin to tell her. Prison instructions say that the next of kin should be notified in person wherever possible. We are concerned that the prison made no attempt to do so, and there was no record of why a telephone call was considered acceptable.

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 share this report with report with risk assessment authorising manager A, B, and C, and discuss the Ombudsman's findings with them.
- The Head of Healthcare should ensure that healthcare staff complete the medical section of the escort risk assessment fully and accurately.
- The Head of Healthcare should share this report with Trainee Advanced Clinical Practitioner A, and Nurse B, and discuss the Ombudsman's findings with them.
- The Prison Group Director for South Central should write personally to the Ombudsman setting out what he has done to satisfy himself that effective measures have been taken to address Bullingdon's continuing failure to comply with caselaw on the use of restraints.
- The Governor should ensure that:
    - staff inform the prisoner's next of kin of their death without delay, and in person wherever possible; and
    - where a decision is taken that the news of a prisoner's death should not be delivered in person, the reasons for this are recorded in the Family Liaison Officer's log.

The Investigation Process

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

11. The investigator obtained copies of the relevant extracts from Mr Clark's medical and prison records.

12. NHS England commissioned an independent clinical reviewer to review Mr Clark's clinical care at the prison.

13. We informed HM Coroner for Oxfordshire of the investigation. The coroner provided us with the results of the post-mortem examination. We have sent the coroner a copy of this report.

14. One of the Ombudsman's family liaison officers contacted Mr Clark's next of kin, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond.

15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found one factual inaccuracy, the title prefix to a surname, which has been corrected in the final report.

Background Information

HM Prison Bullingdon

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

HM Inspectorate of Prisons

17. The most recent inspection of Bullingdon was in July 2019. Inspectors found that the healthcare had improved since their previous inspection in May 2017, and that it was now generally a very good service.

18. Inspectors said that the chronic healthcare staff shortages, noted in their previous report, had been eased by recruitment to key positions and the use of regular agency staff. They said there were good clinical governance structures and that joint working with the prison had been enhanced by strong clinical leadership. The management of patients with long-term conditions had improved and was effective. They found that the management of the inpatient unit had also improved and there was a good standard of care.

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 2019, the IMB said that the new healthcare leadership had built on progress from their predecessors. They noted a decline in the number of healthcare complaints, which appeared to reflect an improvement in the service. However, they said that there were still difficulties in recruiting permanent staff and there was a dependence on long-serving agency staff.

Previous deaths at HMP Bullingdon

20. Mr Clark was the eighth prisoner to die at Bullingdon since February 2018. Four of the previous deaths were from natural causes and three were self-inflicted. In three previous cases, the PPO has expressed concern about the inappropriate use of restraints.

Key Events

21. On 27 June 2014, Mr Paul Clark was sentenced to life imprisonment for sexual offences. On 7 December 2017, he was moved to HMP Bullingdon.

22. Mr Clark had been in poor health before he arrived at Bullingdon and had several long-term health conditions. He had an operation on his lungs in 2012 and it was noted when he arrived at Bullingdon that he had interstitial lung disease (a term for several lung disorders characterised by inflammation or scarring to the lungs which affects their ability to absorb oxygen) and chronic obstructive pulmonary disease (COPD – a term for a group of serious lung conditions that cause breathing difficulties). He also had asthma and rheumatoid arthritis. He was morbidly obese and although he regularly attended a dietary clinic at Bullingdon, his attempts to lose weight were largely unsuccessful.

23. Throughout his time at Bullingdon, Mr Clark had episodes of breathlessness, often exacerbated by severe coughing fits. Twice in June 2018, he collapsed, and on the second of these occasions he passed out after a coughing fit. The following month he stopped working because of his COPD and a wheelchair was provided to enable him to attend education sessions.

24. In January 2019, approval was granted for Mr Clark to have in-cell oxygen to alleviate his breathing problems. He was admitted to hospital four times in 2019 (May, June, September and October) due to respiratory problems. He was restrained using an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to a prison officer) on each occasion.

25. In 2020, Mr Clark's condition declined more rapidly. He had regular coughing fits that left him breathless, and on many occasions had very low oxygen levels in his blood despite the supplementary oxygen he received from his in-cell machine.

26. On 21 January, Mr Clark's key worker noted that the oxygen machine in his cell had been changed to enable him to receive a higher rate of oxygen, and that supplementary oxygen bottles were kept in the wing office if needed.

27. On 27 January, Mr Clark was taken to hospital after becoming very unwell. He was restrained with an escort chain. He returned to prison the same day. The next day, his key worker noted Mr Clark was getting progressively less mobile and had been issued with a personal alarm in case he was unable to activate his cell bell in an emergency.

28. On 12 February, Mr Clark was admitted to hospital as an emergency. He was restrained using an escort chain. He returned to the prison the next day. On 16 and 18 February, a code blue (a medical emergency code used to indicate that a prisoner is unconscious or having breathing difficulties) was called, but it was not necessary to admit him to hospital on either occasion.

29. On 20 February, another code blue was called and Mr Clark was taken to hospital and admitted. He was restrained using an escort chain. Over the next few days his condition deteriorated. At 10.00am on 23 February, a prison

manager authorised the removal of restraints. Mr Clark died on 24 February at approximately 10.56pm.

Contact with Mr Clark's next of kin

30. Mr Clark's had nominated a relative as next of kin. The prison's Family Liaison Officer (FLO), an offender supervisor, contacted her by telephone on 24 February, at around 1.10pm. He told her that Mr Clark's condition was deteriorating. She said that the prison had told her on 21 February that he was in hospital, and that she intended to visit him that day. However, it appears that she was unable to go ahead with her planned visit.

31. When the FLO came into work on 25 February, he discovered that Mr Clark had died the previous night. He decided to inform Mr Clark's next of kin as soon as possible, and after checking the details with the hospital, he telephoned her at about 10.30am. He followed this up with another call later that afternoon with further information and to check that she was alright following the news of the death.

32. On 2 March, the FLO visited Mr Clark's next of kin at her home, and passed on Mr Clark's possessions and the balance of his account.

33. The prison contributed towards Mr Clark's funeral in line with national guidance.

Support for prisoners and staff

34. After Mr Clark's death, the duty governor debriefed the staff who had been with Mr Clark at the hospital, to ensure they had the opportunity to discuss any issues arising.

35. On 25 February, the prison posted notices to staff and prisoners informing them of Mr Clark's death, and offering support.

Post-mortem report

36. A post-mortem examination showed that Mr Clark died from bronchopneumonia, caused by rheumatoid arthritis-associated interstitial lung disease.

Findings

Clinical care

37. Mr Clark arrived at Bullingdon with serious health conditions. The clinical reviewer found that the care he received was of a good standard and equivalent to that which he could have expected to receive in the community. She highlighted several areas of good practice from the healthcare team at Bullingdon.

Use of restraints

38. When prisoners leave prison (for example, to go to hospital), staff complete a risk assessment to determine the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public which must 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.

39. A judgment in 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.

40. Prison Service Instruction 33/2015, *External Prisoner Movements*, says normal practice is for male Category B and Escape-List prisoners to be double cuffed while on escort. All other prisoners will be single cuffed unless the individual risk assessment indicates that double cuffing is required and is proportionate. It goes on to say that restraints should not normally be used where the prisoner's mobility is severely limited (for example, due to advanced age or disability) unless there are grounds for believing that an escape attempt may be made with external assistance.

41. On 14 January 2020, Mr Clark had a hospital appointment. The medical section of the risk assessment form was completed by Trainee Advanced Clinical Practitioner A (ACP), on 7 January. He wrote that Mr Clark was a wheelchair user, but that his medical condition did not restrict his ability to escape unaided and that there was no medical objection to the use of restraints. He asked for the use of an escort chain and noted "unable to double cuff (COPD)". Authorising manager A noted that Mr Clark was a wheelchair user and authorised the use of an escort chain.

42. On 27 January, Mr Clark was taken to hospital when he fell ill. The medical section of the risk assessment was completed by Nurse A. She wrote that there was a medical objection to the use of restraints and that Mr Clark's medical condition would restrict his ability to escape unaided. She said he had impaired mobility and "very poor breathing and mobility. Takes own oxygen". The authorising manager was the same as on the previous occasion and they wrote, "Escort chain due to mobility issues. Wheelchair user."

43. Mr Clark was admitted to hospital as an emergency on 12 February. The medical section of the risk assessment form was completed by Nurse B. She wrote that there was a medical objection to the use of restraints but she annotated that part of the form with "chain to officer". She said Mr Clark's medical condition would restrict his ability to escape unaided. She did not add any further comments to the form, but she wrote in Mr Clark's medical notes:

> "Risk assessment and PER [person escort record] completed and medical notes printed and both handed over to the security. Highlighted that Paul has got limited mobility and is on continuous oxygen cylinder."

Authorising manager A signed off the escorting arrangements again and approved the use of an escort chain due to mobility issues.

44. On 18 February, Mr Clark had another hospital appointment. The medical section of the risk assessment was completed by ACP A, on 11 February. As with his previous form on 7 January, he said there was no objection to the use of restraints, and that Mr Clark's medical condition did not restrict his ability to escape unaided, but that an escort chain should be used because of Mr Clark's COPD. Authorising manager B, noted Mr Clark was a wheelchair user and an escort chain should be used.

45. Mr Clark's final trip to hospital was on 20 February. Nurse B completed the medical section of the risk assessment and as previously, wrote that there was no risk of unaided escape and there was an objection to the use of restraints. However, she wrote, "Chain to escort." As previously, she also made a note in the medical record:

> "Plan: Both handed over to the security Risk assessment (Ua1P1) and PER completed for hospital escort. Noted that the patient requires chain to the staff. Limited mobility on continuous oxygen."

Authorising manager C authorised the use of double handcuffs, but this was modified to an escort chain, "on medical advice".

46. Escorting staff removed the escort chain at 10.00am on 23 February (the day before Mr Clark died), on the authorisation of a prison manager. The note added to the risk assessment form says the chain was removed "due to Paul's health, weak heart and no mobility due to severe COPD".

47. We consider that the use of restraints on Mr Clark for these hospital admissions was inappropriate. He was a Category C prisoner and a wheelchair user who had severe breathing difficulties and was accompanied by two prison officers We consider that the use of restraints was disproportionate to the risks he posed.

48. We are concerned about some of the healthcare staff's input to the risk assessment. ACP A recorded that Mr Clark's medical condition did not restrict his ability to escape unaided. This was clearly inaccurate as Mr Clark was not only a wheelchair user, but he had severe lung disease and was reliant on having access to an oxygen cylinder to help him breathe.

49. We are also concerned that all the staff involved in Mr Clark's risk assessments, including healthcare staff, appeared to be under the impression that prisoners

with poor health and/or mobility should be restrained using an escort chain. We were particularly concerned that this was sometimes described as an alternative to double hand cuffs which are normally only necessary for Category A and B prisoners. We have seen no evidence of any consideration of sending Mr Clark out unrestrained, given his condition.

50. We have made recommendations to Bullingdon about the use of restraints in three previous cases within the last 18 months. In August 2019, we made a recommendation to the Prison Group Director for South Central, to satisfy himself that effective measures had been taken to address Bullingdon's continuing failure to comply with caselaw on the use of restraints. We are disappointed, therefore, that we have, yet again, identified that staff are not applying the caselaw correctly. We recommend:

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 share this report with risk assessment authorising manager A, B, and C, and discuss the Ombudsman's findings with them.

The Head of Healthcare should ensure that healthcare staff complete the medical section of the escort risk assessment fully and accurately.

The Head of Healthcare should share this report with Trainee Advanced Clinical Practitioner A, and Nurse B, and discuss the Ombudsman's findings with them.

The Prison Group Director for South Central should write personally to the Ombudsman setting out what he has done to satisfy himself that effective measures have been taken to address Bullingdon's continuing failure to comply with caselaw on the use of restraints.

Informing Mr Clark's next of kin

51. PSI 64/2011, *Safer Custody*, sets out the process for informing the next of kin of a prisoner's death and says:

> *"Wherever possible, the FLO and another member of staff must visit in person the next of kin or nominated person to break the news of the death.* Time will be of the essence in order to try to ensure that the family do not find out about the death from another source.
>
> *"Where the prisoner had been located a long distance from their next of kin, consideration must be given to requesting the assistance of a FLO from the nearest prison."* [Italics indicates a mandatory requirement.]

52. Mr Clark died shortly before 11.00pm on 24 February. The prison's FLO, was told at 9.45am the next morning, and was asked to contact Mr Clark's next of kin as she had not been told about the death. He telephoned her at 10.30am. The

FLO told the investigator that he was concerned that Mr Clark's next of kin may have intended to visit him in hospital that day, and he wanted to ensure that she was told of his death straightaway, to avoid her learning of his death when she arrived at the hospital. He said that while a telephone call had not been ideal, he and the duty governor had agreed this was the best course of action in the circumstances.

53. Prison guidance is clear that wherever possible, the FLO and another member of staff should visit the next of kin in person to break the news of a death. It also says that consideration should be given to asking for the assistance of a FLO at a prison nearer to the next of kin if they live a long way away. (Mr Clark's next of kin lived 90 miles away from the prison.)

54. There was an almost 11-hour delay before the FLO was told of Mr Clark's death. It is unclear why. Even if the FLO could not be contacted on the evening of Mr Clark's death, we consider that a prison manager should have considered either travelling to Mr Clark's next of kin early in the morning of 25 February or asking a FLO from a prison nearer to her to do so. We are also concerned that the FLO rationale for contacting Mr Clark's next of kin by telephone was not recorded.

55. We recommend:

The Governor should ensure that:

- **staff inform the prisoner's next of kin of their death without delay, and in person wherever possible; and**
- **where a decision is taken that the news of a prisoner's death should not be delivered in person, the reasons for this are recorded in the FLO log.**

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