

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Brandon Cliffe a prisoner at HMP Peterborough on 20 May 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 Brandon Cliffe, who was 21 years old, died of kidney cancer on 20 May 2019 while a prisoner at HMP Peterborough. We offer our condolences to Mr Cliffe's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Cliffe received was of a good standard for both his physical and his emotional needs and was equivalent to that which he could have expected to receive in the community. She made three recommendations about clinical issues.
5. We did not find any non-clinical issues of concern.

Recommendations

- The Head of Healthcare should ensure that all primary care staff adhere to the Royal College of Physicians National Early Warning Score guidance for frequency of monitoring of observations for unwell patients and recommended clinical escalation procedures.
- The Head of Healthcare should ensure that all primary care staff are able to identify, report and assess identified vulnerabilities including learning disabilities and mental capacity.
- The Head of Healthcare should ensure that all primary care staff seek clarification about information received from prisoners in relation to their health needs.

Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Cliffe's clinical care at HMP Peterborough. The clinical review is attached to this report as Annex 1.
7. The PPO has investigated the non-clinical issues in Mr Cliffe's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. We wrote to Mr Cliffe's next of kin, his mother, to explain the investigation. She responded with some matters she wanted the investigator to consider. These have been addressed in separate correspondence.
9. We shared our initial report with HM Prison and Probation Service (HMPPS). They identified no factual inaccuracies.

10. We sent a copy of our initial report to Mr Cliffe's mother. She identified no factual inaccuracies.

Previous deaths at Peterborough

11. There have been two deaths at HMP Peterborough in the last two years, one from natural causes and one self-inflicted death. There are no similarities between our findings in the investigation of Mr Cliffe's death and the other deaths.

Key Events

12. In August 2018, Mr Cliffe was remanded to HMP Peterborough charged with attempted robbery and actual bodily harm. He was sentenced in February 2019.
13. In December 2018, Mr Cliffe was diagnosed with kidney cancer. Further tests in January and February 2019, showed that the cancer had spread to other parts of his body. Mr Cliffe was identified as being suitable for palliative care only.
14. On 26 February, staff submitted a compassionate release application on Mr Cliffe's behalf. The application was refused by Secretary of State officials. Mr Cliffe's condition deteriorated further and on the 17 May prison staff decided to re-apply for compassionate release. Mr Cliffe died on 20 May, at Thorpe Hall Hospice, before the application could be completed.
15. There was no post-mortem examination, but the Coroner recorded Mr Cliffe's cause of death as medullary cell renal carcinoma with peritoneal, lung, lymph node and renal bed metastases (kidney cancer which had spread to his lungs, lymph nodes and renal bed).

Lisa Burrell
Assistant Ombudsman

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