

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Bernard Short, a prisoner at HMP Swaleside, on 19 October 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. Our office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Bernard Short, who was 74 years old, died of metastatic prostate cancer on 19 October 2019 at HMP Swaleside. We offer our condolences to Mr Short's family and friends.
4. The clinical reviewer concluded that the clinical care that Mr Short received after his cancer diagnosis was not equivalent to that which he could have expected to receive in the community. She has made eleven recommendations about clinical issues, some of which are outlined below.
5. We did not find any non-clinical issues of concern.

Recommendations

- The Head of Healthcare should ensure that the reception screening of any incoming prisoner should be carried out by a Registered Nurse, in line with the requirements of the NHS England Service Specification.
- The Head of Healthcare should ensure that a second health screen is offered to all incoming prisoners.
- The Head of Healthcare should ensure that healthcare staff request the medical records from the GP practice that the prisoner had last been registered with.
- The Head of Healthcare should ensure that healthcare staff follow a recognised and structured end of life pathway for prisoners, including a personalised care plan, holistic assessment and regular multi-disciplinary and multi-agency reviews, in line with guidance, the IC24 policy and NICE guidance.
- The Head of Healthcare should ensure that prisoners are fully involved in reviews of their medication, care planning and decision making in line with the Nursing and Midwifery Code of Conduct and the General Medical Committee.
- The Head of Healthcare should ensure that all prisoners receive secondary care treatment within the timeframe set by the national referral to treatment time waiting time targets.
- The Governor and the Head of Healthcare should ensure that HMP Swaleside have measures in place to aid communication with those who have hearing and speech difficulties.
- The Head of Healthcare should ensure that healthcare staff document fully all consultations, providing a care plan with clear goals and outcomes, in order to

meet the record keeping standards in line with the Nursing and Midwifery Code of Conduct and the General Medical Committee.

- The Head of Healthcare should ensure that they introduce a system by which to measure and report on the quality of end of life care.

Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Short's clinical care at HMP Swaleside.
7. The PPO investigator investigated the non-clinical issues in Mr Short's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. The PPO family liaison officer wrote to Mr Short's next of kin to explain the investigation. She did not respond.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out no factual inaccuracies.

Previous deaths at Swaleside

10. Mr Short was the eleventh prisoner to die at Swaleside since October 2017. Of the previous deaths, 8 were from natural causes, 2 were self-inflicted deaths and one was a drug-related death. There are no similarities between our findings in the investigation of Mr Short's death and the other deaths.

Key Events

11. Mr Bernard Short was serving time in prison for sexual offences and was transferred to HMP Swaleside on 31 August 2019.
12. In November 2018, Mr Short was diagnosed with prostate, lung, liver cancer and bony metastases (spread of cancer to the bone tissue). He also had type 2 diabetes and was profoundly deaf. Mr Short's preferred method of communication was British Sign Language (BSL).
13. On 19 April 2019, prison staff applied for early release on compassionate grounds on Mr Short's behalf. The application was refused on 29 August, because a consultant's prognosis of life expectancy was given as between three and six years if Mr Short continued to take his medication, and he was still assessed as being a high risk to the public.
14. In September, Mr Short saw a prison GP and complained of shortness of breath and chest pain. He was offered a bed in the prison's inpatient unit but he declined. Mr Short was sent to hospital for further review. Test results showed that he had acute coronary syndrome (a condition that causes sudden, low blood flow to the heart) and heart failure. He was discharged from hospital and was returned to the prison the same day after receiving treatment.
15. On 9 October, Mr Short was seen by a nurse, who was concerned about his health. She asked an officer, who is BSL trained, to explain to Mr Short that he needed to go to hospital. She also discussed a DNACPR (do not attempt cardiopulmonary resuscitation) with Mr Short, which was agreed and put in place. Mr Short was taken to hospital and admitted as an inpatient. He was not restrained.
16. The nurse made a referral to a hospice after discussions with Mr Short and his wife, but his health deteriorated quickly and, on 19 October, it was confirmed that Mr Short had died.
17. There was no post-mortem examination, but the Coroner gave Mr Short's cause of death as metastatic prostate cancer.

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