Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Terry Barker, a prisoner at HMP Hewell, on 18 December 2019

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 020 7633 4141

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*

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 Terry Barker died in prison on 18 December of carcinomatosis (an advanced form of cancer) caused by colorectal cancer while a prisoner at HMP Hewell. Mr Barker was 51 years old. I offer my condolences to Mr Barker's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Barker received at HMP Hewell was equivalent to that he could have expected to receive in the community. She made one recommendation.

5. However, we are concerned that the prison used restraints on Mr Barker, despite his restricted mobility and deteriorating physical health and that an application for compassionate release was unnecessarily delayed.

Recommendations

- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for escorting prisoners 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 and Head of Healthcare at HMP Hewell should ensure that clear guidance is provide to staff on how to complete applications for compassionate release in a timely manner.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer, to review Mr Barker's clinical care at HMP Hewell.

7. The PPO investigator has investigated non-clinical issues, including Mr Barker's location, the security arrangements for his hospital escort/s, liaison with his family and whether compassionate release was considered.

8. The PPO family liaison officer wrote to Mr Barker's next of kin, his partner and also to his brother, to explain the investigation. They did not respond to our letter.

   The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP Hewell

9. Mr Barker was the 14th prisoner to die at HMP Hewell since December 2017. Of these deaths, six were from natural causes. We have previously made recommendations to the Governor about the inappropriate use of restraints. It is disappointing that we are having to make the same recommendation again.

Key Events

10. Mr Terry Barker was in prison for sexual offences. In June 2019, he was diagnosed with cancer that had spread across his abdomen and liver.

11. Mr Barker transferred to HMP Leyhill on 2 July. A care plan was put in place, including daily carer visits, weekly GP palliative care reviews and symptom control.

12. On 8 July Mr Barker discussed his end of life care wishes. He signed a DNACPR (Do Not Attempt Cardio-pulmonary Resuscitation) order.

13. Mr Barker went to a cancer care review at hospital on 17 July. He was told that he could not have chemotherapy because of the nature of the cancer and his life expectancy was months. On 24 July, Mr Barker met nurse specialists from a local hospice to discuss his diagnosis, prognosis and provide emotional and psychological support.

14. On 2 August, Mr Barker was released from prison on licence to an approved premises. A nurse from Leyhill travelled with Mr Barker to the approved premises, helped him to register with a local GP practice and arranged a social care referral to the local council.

15. On 17 October, Mr Barker was recalled to custody after breaching the terms of his licence. Mr Barker was taken to HMP Hewell, and was admitted directly to the prison's inpatient health unit. Mr Barker could no longer walk unaided, and healthcare staff arranged an adult social care assessment, which was sent to Worcestershire County Council.

16. At a multidisciplinary team meeting on 21 November, it was agreed that Mr Barker needed a transfer to a prison with a 24-hour healthcare facility. HMP Hewell did not have palliative care facilities and would not be able to facilitate a syringe driver for pain relief when his condition deteriorated. Mr Barker could not be transferred to a hospice as he was not deemed to be 'end of life' so the Deputy Head of Healthcare agreed to look for an alternative placement for him.

17. Also on 21 November, Mr Barker told his offender supervisor that he wanted to apply for early release on compassionate grounds. The application was started by the prison, but not completed before his death.

18. Mr Barker's health deteriorated and, on 3 December, he was taken to hospital, where, on 5 December, a hospital doctor confirmed that Mr Barker's cancer had now spread to his lungs.

19. On 9 December, Mr Barker was transferred to a hospice in a hospital. However, Mr Barker's health stabilised and on 12 December, a hospice doctor explained that he had a life expectancy of weeks rather than days, so he did not need a hospice bed. Mr Barker was taken back to prison the following day, 13 December.

20. Mr Barker continued to receive care in the prison's inpatient unit. Healthcare staff checked him hourly and his pain was managed by buprenorphine patches, a strong opioid based painkiller.

21. A nurse checked Mr Barker at 5.00am on 18 December. He was not breathing and she called a code blue on her radio (used to indicate a life-threatening emergency). Mr Barker still had a DNACPR order in place so staff did not attempt resuscitation. The out of hours doctor confirmed that Mr Barker had died at 6.35am.

Post-mortem report

22. The coroner concluded that Mr Barker died of carcinomatosis (advanced cancer) caused by colorectal adenocarcinoma.

Non-Clinical Findings

Restraints, security and escorts

23. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. 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.

24. When Mr Barker went to hospital on 3 December 2019, he could not walk unaided and used a wheelchair. A prison risk assessment found Mr Barker to be high risk to the public and officers used a single handcuff during the escort. There were no recorded medical objections to the use of restraints. Later that evening, when Mr Barker was admitted to a hospital assessment unit, officers replaced the handcuffs with an escort chain. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer).

25. Mr Barker went to a hospice on 9 December, arriving at 1.00pm. It is not clear what level of restraint was used, but prison escort paperwork was updated at 6.30pm that day to reflect, "change of risk assessment noted" and then at 8.00pm, "new RA [risk assessment] to come tomorrow stipulating removal of cuffs".

26. At 9.45am on 11 December, while still in the hospice, officers were told to re-apply a single handcuff. Escort paperwork showed that Mr Barker's health "had plateaued" and he should therefore be restrained. Again, there were no recorded medical objections to the use of restraints. Mr Barker remained in the hospice for a further two days before returning to the prison on 13 December.

27. Mr Barker had terminal cancer, was wheelchair bound and accompanied by two prison officers. We consider it unacceptable that he was restrained by a single handcuff while in the hospice. The prison risk assessment dated 11 December

shows that Mr Barker was at low risk of escape and low risk to the public. The level of restraints used did not reflect the actual risk he posed. We make the following recommendation,

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for escorting prisoners 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.

Compassionate release

28. 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).

29. On 21 November, Mr Barker told his offender supervisor that he wanted to apply for early release on compassionate grounds. The application was started, but was not completed before his death. Mr Barker's offender supervisor told the investigator that he had never completed an application for early release before, which caused an initial delay in the application process. On 2 December, he emailed the Offender Management Unit at HMP Leyhill (aware that they had an end of life unit) asking for guidance. They replied the next day, 3 December, providing a copy of the current Prison Service Instruction (PSI) and the form he should use.

30. Mr Barker's offender manager completed the appropriate section on 5 December, before he forwarded the application to the Primary Care Team Manager on 10 December. She emailed Mr Barker's offender supervisor the same day confirming that she had sent the application to a nurse, Mr Barker's care co-ordinator. Mr Barker died eight days later, before the application was completed.

31. The investigator spoke to the Deputy Head of Healthcare about delays in the application process. She said that the prison GP should complete the healthcare section of the form, rather than the nurse care co-ordinator. A nurse has since reviewed her emails and has no record of receiving Mr Barker's application.

32. Mr Barker asked for compassionate release 27 days before he died. It should not have taken 12 days for Mr Barker's offender supervisor to seek guidance on how to complete an application. Once the application had been sent to the healthcare team on 10 December, (when Mr Barker was in a hospice), he should have kept in regular contact to ensure that the application was completed without further delay. We make the following recommendation:

The Governor and Head of Healthcare at HMP Hewell should ensure that clear guidance is provide to staff on how to complete applications for compassionate release in a timely manner.

Sue McAllister CB
Prisons and Probation Ombudsman **July 2020**

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100
F I 020 7633 4141