Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Terrence Brown, a prisoner at HMP Exeter, on 25 April 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*

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 Terrence Brown, who was 87 years old, died of lung cancer on 25 April 2020 at HMP Exeter. We offer our condolences to Mr Brown's family and friends.

4. The clinical reviewer concluded that the clinical care that Mr Brown received was of a good standard, and equivalent to that which he could have expected to receive in the community. The Head of Healthcare will want to consider the three recommendations in her review, one of which we repeat below as it relates to the circumstances of Mr Brown's death.

5. We are concerned that Mr Brown was restrained in hospital on three occasions, despite a risk assessment stating that restraints should be removed. We do not consider his restraint adequately reflected healthcare staff's concerns about the extent of Mr Brown's illness and mobility.

Recommendations

- The Head of Healthcare should ensure that staff record conversations relating to pain management in full, including details of action taken.

- The Governor should ensure that all staff undertaking risk assessments for prisoners in 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.

Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Brown's clinical care at HMP Exeter.

7. The PPO has investigated the non-clinical issues in Mr Brown's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

8. Mr Brown's family received a copy of the initial report. They raised an issue that does not impact on the factual accuracy of this report and have been addressed through separate correspondence.

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

Previous deaths at Exeter

10. Mr Brown was the 18th prisoner to die at HMP Exeter since April 2018. Of the previous deaths, five were from natural causes, four were self-inflicted and two are unclassified.

Key Events

11. On 10 June 2019, Mr Terrence Brown was sentenced to 14 years 3 months in prison for sexual offences. He was sent to HMP Bristol and transferred to HMP Exeter just over a month later.

12. Before he went to prison, Mr Brown was referred for investigation of possible cancer, after he was treated for a fall at home. On 19 June, Mr Brown was diagnosed with lung cancer. Mr Brown also had diabetes, an abdominal aortic aneurysm and chronic obstructive pulmonary disease. Mr Brown needed extra support for mobility due to his low body weight and frailty.

13. On 11 June, while awaiting results for his cancer investigation, prison healthcare staff suggested that Mr Brown sign a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) order due to his health issues, frailty and possible cancer. Mr Brown agreed and signed the order.

14. Mr Brown's condition was not treatable. He remained on the social care wing at HMP Exeter and later moved to the palliative care room, where he stayed until his death.

15. On 31 March 2020, Mr Brown was told that it was likely he had less than three months to live. On 3 April, the prison started the process for early release on compassionate grounds. The application was refused due to Mr Brown's risk level and the particular difficulty of finding accommodation that could meet his needs during the ongoing pandemic.

16. On 25 April, staff found Mr Brown in his cell with no signs of life. Due to the DNACPR being place, they did not attempt to resuscitate him.

17. The post-mortem examination confirmed that Mr Brown died of lung cancer.

Non-Clinical Findings

Restraints

18. When Mr Brown was taken to hospital on 7 January, 3 February and 16 April 2020, he was restrained by an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer) on one occasion and cuffs on the other two occasions. However, on four other hospital visits Mr Brown was not restrained.

19. Mr Brown was very unwell when he arrived at Exeter and had been diagnosed with terminal cancer. Healthcare staff had completed the escort risk assessment to reflect that Mr Brown was terminally ill and had mobility issues. Mr Brown's risk to others was recorded as 'normal'. We do not consider that sufficient weight was given to his medical condition when assessing his risk, so make the following recommendation:

    The Governor should ensure that all staff undertaking risk assessments for prisoners in 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.

Karen Johnson
Assistant Ombudsman **October 2020**