

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Gary Ross, a prisoner at HMP Bullingdon, on 11 March 2021

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 Gary Ross died of lung cancer on 11 March 2021 while a prisoner at HMP Bullingdon. He was 57 years old. I offer my condolences to Mr Ross's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Ross received was equivalent to that which he could have expected to receive in the community. However, she made several recommendations, two of which are included below.
5. We found no non-clinical issues of concern.
6. This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Recommendations

- The Head of Healthcare should ensure that all prisoners with cancer have care plans in place, which should include end of life care and social care needs.
- The Head of Healthcare should introduce a robust pain management framework and pathway that includes follow up and monitoring.

The Investigation Process

7. NHS England commissioned an independent clinical reviewer to review Mr Ross's clinical care at HMP Bullingdon.
8. The PPO investigator has investigated non-clinical issues, including Mr Ross's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
9. The PPO family liaison officer wrote to Mr Ross's next of kin, a friend, to explain the investigation. He responded to our letter but did not have any specific questions for us to consider.
10. Mr Ross's family received a copy of the draft report. They did not make any comments.
11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Previous deaths at HMP Bullingdon

12. Mr Ross was the 12th prisoner at Bullingdon to die since March 2019. Of the previous deaths, six were from natural causes, three were self-inflicted, one was drug-related and in one, the cause of death was unascertained.

Key Events

13. On 29 January 2021, Mr Gary Ross was sentenced to 20 weeks in prison for fraud and was sent to HMP Bullingdon. When he arrived, he told the reception nurse that he had suspected cancer and was awaiting results of further tests.
14. On 30 January, a prison GP saw Mr Ross. The GP noted that Mr Ross had been diagnosed with lung cancer and had a secondary tumour in the brain. Mr Ross was prescribed paracetamol and ibuprofen for his pain and was given energy drinks after reporting weight loss. Staff created a nutrition care plan but did not create one for pain management or future care.
15. On 17 February, Mr Ross continued to complain that he was in a lot of pain and said he was struggling to sleep because of it. Staff noted that his personal hygiene was poor, as was the state of his cell. A prison GP prescribed nefopam (a painkiller used to treat moderate to severe pain).
16. On 20 February, prison officers called for healthcare staff as Mr Ross was weak and unable to move. A nurse attended and found that Mr Ross's blood pressure and blood oxygen levels were low. She requested an emergency ambulance and Mr Ross was taken to hospital. He was accompanied by prison officers but was not restrained.
17. On 22 February, the Governor of Bullingdon approved Mr Ross's release on temporary licence (ROTL) which meant that Mr Ross no longer had prison officers with him at the hospital.
18. On 24 February, hospital staff advised prison healthcare staff that Mr Ross had only days or weeks to live. The Governor approved a move to a hospice, where end of life care was provided. Mr Ross was moved on 25 February.
19. Mr Ross died at the hospice on 11 March at 8.45pm.

Cause of death

20. A post-mortem examination was not conducted as the Coroner accepted the cause of death provided by a doctor at the hospice. The doctor gave Mr Ross's cause of death as metastatic lung adenocarcinoma (lung cancer that has spread).

Louise Richards
Assistant Ombudsman

November 2021

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