

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Robert Burns, a prisoner at HMP Wymott, on 27 January 2020

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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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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Robert Burns died in hospital of peritonitis caused by a perforation of the small bowel on 27 January 2020, while a prisoner at HMP Wymott. He was 69 years old. I offer my condolences to Mr Burns' family and friends.

In May 2019, Mr Burns developed a lump in his neck, which was confirmed to be malignant. Further investigations found that he had cancer in his gullet and lungs which had spread to the lymph nodes in his neck. He underwent a course of chemo-radiotherapy and was reviewed regularly by prison healthcare staff and secondary care providers.

On 26 January 2020, Mr Burns was found to be weak and struggling to breathe. He was taken to hospital by emergency ambulance. His condition continued to deteriorate and Mr Burns died the next day.

The clinical reviewer found that prison healthcare staff made prompt referrals to secondary care providers to diagnose, treat and manage Mr Burns' condition. She was satisfied that Mr Burns received a good standard of clinical care, equivalent to that which he could have expected to receive in the community.

I make no recommendations.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Sue McAllister CB
Prisons and Probation Ombudsman

September 2020

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Summary

Events

1. On 10 December 2010, Mr Robert Burns was sentenced to 15 years in prison for sexual offences. He was initially sent to HMP Manchester, and in February 2013, he was transferred to HMP Wymott.
2. On 2 May 2019, Mr Burns was reviewed by a prison GP after developing a lump in his neck. The GP made a two week wait referral to ear nose and throat specialists for patients with suspected cancer. Hospital staff confirmed that the lump was malignant. They found evidence of cancer in his gullet and lungs which had spread to the lymph nodes in his neck. Mr Burns underwent a course of curative chemoradiotherapy and completed his treatment on 29 September. He continued to be reviewed regularly.
3. At 10.00pm on 26 January 2020, a nurse reviewed Mr Burns. She noted that he had pains in his stomach, was generally unwell and suffering from shortness of breath. At 10.08pm, she radioed a code blue medical emergency. Control room staff immediately telephoned for an ambulance.
4. Paramedics arrived at the cell at 10.30pm and Mr Burns was taken to hospital by emergency ambulance for further review.
5. Mr Burns' condition continued to deteriorate and at 12.01am on 27 January, Mr Burns died. A hospital doctor confirmed his death at 1.27am.
6. A hospital doctor gave Mr Burns' cause of death as peritonitis following a perforation of the small bowel caused by an obstruction.

Findings

7. Having reviewed the clinical care given to Mr Burns during his time at Wymott, the clinical reviewer considers that the care he received was of a good standard and equivalent to that which he could have expected to receive in the community.
8. We make no recommendations.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Wymott informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
10. The investigator obtained copies of relevant extracts from Mr Burns' prison and medical records.
11. NHS England commissioned an independent clinical reviewer to review Mr Burns' clinical care at the prison.
12. We informed HM Coroner for Lancashire and Blackburn of the investigation. The coroner provided us with the cause of death. We have sent the coroner a copy of this report.
13. We wrote to Mr Burns' next of kin to explain the investigation and to ask if she had any points she wished our investigation to consider. She did not respond to our letter.
14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Wymott

16. HMP Wymott, which is near Preston in Lancashire, is a medium secure prison holding over 1,100 adult men. Bridgewater Community Trust and Greater Manchester Mental Health Trust provide healthcare services at the prison. There are no inpatient beds but there is 24-hour nursing cover.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Wymott was in October 2016. Inspectors reported that Wymott remained a reasonably safe prison and staff-prisoner relationships were generally respectful. Healthcare provision was weak and in some areas potentially unsafe. The inspectors considered that the care of prisoners with chronic conditions was not good enough.

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to May 2017, the IMB noted that there have been significant improvements in healthcare provision at the prison. However, the Board remained concerned that some areas of health provision at the prison fell below the standard expected in the wider community.
19. A Care Quality Commission (CQC) review carried out in July 2018, found that the healthcare centre was small with insufficient treatment rooms that did not meet the needs of the prison population. The report also noted treatment rooms on the residential wings and healthcare centre did not meet infection prevention standards. However, the Board also noted that a new head of healthcare had been appointed in mid-2019 and that staffing levels had improved within the primary healthcare and pharmacy departments.

Previous deaths at HMP Wymott

20. Mr Burns was the eleventh prisoner to die at Wymott since January 2018. Of these deaths, nine were from natural causes and two were drug related. There are no similarities between our findings in the investigation into Mr Burns' death and our investigation findings for the previous deaths.

Key Events

21. On 10 December 2010, Mr Robert Burns was sentenced to 15 years in prison for sexual offences. He was sent to HMP Manchester.
22. During his initial health screen, a nurse noted that Mr Burns had been previously diagnosed with high blood pressure, asthma and COPD. A care plan was created to manage his conditions and he was reviewed regularly by healthcare staff.
23. In February 2011, while at Manchester, Mr Burns fractured his hip. In April, Mr Burns was diagnosed with deep vein thrombosis (DVT, a blood clot) in his lower left leg. Care plans were created and he continued to be reviewed regularly by both prison healthcare staff, and secondary care staff.

HMP Wymott

24. On 1 February 2013, Mr Burns was moved to HMP Wymott. At his initial health screen, staff noted his pre-existing medical conditions and prescribed medications, updated his care plans and made referrals to secondary care providers to ensure continuity of his care.
25. Mr Burns had little significant contact with healthcare staff until 2 May 2019, when he was reviewed by a prison GP after he complained of having trouble swallowing. He had also found an elongated lump on the right side of his neck. The prison GP prescribed a course of antibiotics and made a referral to hospital for an ultrasound scan. The scan was carried out on 15 May, and the results showed that the growth in Mr Burns' neck was fixed (an immovable lump is more likely to be an indicator of cancerous lymph nodes). The prison GP made a two week wait referral to the ear nose and throat specialists at hospital (for patients suspected of having cancer).
26. On 6 July, Mr Burns attended hospital to undergo a CT scan of the lump. Biopsies were also taken for analysis and the results indicated that the lump was malignant. Hospital staff told Mr Burns that while it was not clear from the results of the tests where his cancer originated from, there was evidence of it in his gullet and lungs, which in turn had spread to the lymph nodes in his neck, causing the lump. On his return to the prison later that day, care plans were created to manage his care and healthcare staff continued to review Mr Burns regularly.
27. On 14 August, a prison GP reviewed Mr Burns. He told the prison GP that he did not wish to be resuscitated if his heart or breathing stopped and signed a do not attempt cardiopulmonary resuscitation (DNACPR) order to that effect. On 20 August, Mr Burns began curative chemoradiotherapy (a combination treatment of chemotherapy and radiotherapy). Hospital staff advised him that although he was undergoing active treatment, the chances of him being cured were very small.
28. On 3 September, a nurse made a referral to a hospice, for advice on pain management and to consider admitting Mr Burns for palliative care. The hospice rejected the application because Mr Burns was still receiving active treatment.

However, they said that if Mr Burns' prognosis changed in the future, then a further referral could be made to the palliative care team. Mr Burns completed his course of treatment on 29 September.

29. On 8 October, an application for Mr Burns' early release on compassionate grounds was submitted to the Public Protection Casework Section (PPCS) of HM Prison and Probation Service (HMPPS). The application was refused on the grounds of a lack of offending behaviour work undertaken by Mr Burns.
30. Hospital staff reviewed Mr Burns on 12 November. They told him that he would need a MRI scan of his neck on 30 December, to assess the effectiveness of the chemoradiotherapy. He was also referred for a CT scan of his chest to ascertain the extent of the cancer in his lungs. The scan was planned for 29 January 2020. Healthcare staff continued to review Mr Burns regularly, updating his care plans and seeking advice on his care from secondary care providers. Mr Burns never received a definitive prognosis, so the application for early release was not resubmitted.
31. On 22 January 2020, staff radioed a code blue emergency, indicating that a prisoner is having breathing difficulties, because Mr Burns was struggling to breathe. A nurse responded. When she reviewed Mr Burns, he told her that the lump in his throat was obstructing his airway and as a result he was struggling to breathe. Paramedics arrived and Mr Burns was taken to hospital by emergency ambulance for review. Hospital staff considered that his difficulty breathing was a progression of his cancer. Mr Burns was discharged back to Wymott the following day.
32. At 7.55pm on 26 January, Mr Burns was reviewed by a nurse after he complained of severe stomach pains and feeling very weak. He told her that he had not had a bowel movement for several days. She examined him and noted his stomach was swollen and hard. She told him a nurse would review him later that evening.
33. At 10.00pm, a nurse reviewed Mr Burns. She noted he was generally unwell and suffering from shortness of breath. At 10.08pm, she radioed a code blue emergency. Control room staff immediately called an ambulance.
34. While waiting for the paramedics to arrive, the nurse took Mr Burns' observations (checks of a patient's breathing, pulse, temperature, blood pressure and oxygen levels to give an indicator of their physical condition). She noted his oxygen saturation level was 78% (a normal oxygen saturation level is between 95-100%) and his blood pressure was 148/110 (a normal blood pressure reading is between 90/60 and 120/80). She administered oxygen therapy, and his oxygen level improved.
35. Paramedics arrived at the cell at 10.30pm. They carried out an ECG which indicated he was suffering from tachycardia (a condition in which the heart rate increases to over 100bpm). They considered he needed to be reviewed at hospital. Mr Burns was taken to hospital by emergency ambulance but his condition continued to deteriorate.

36. At 12.01am on 27 January, Mr Burns died. A hospital doctor confirmed his death at 1.27am.

Post-mortem report

37. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Burns' cause of death as peritonitis and a perforation of the small bowel due to an obstruction caused by an inguinal hernia.

Contact with Mr Burns' Family

38. Mr Burns had listed his next of kin.
39. On 16 September 2019, after healthcare staff had made a referral for Mr Burns to be considered for palliative care, the prison appointed an officer to act as family liaison officer (FLO). He spoke with Mr Burns about informing his family of his condition.
40. The FLO visited Mr Burns' next of kin at the address listed on prison records to inform her of her father's condition, but there was no one at home. He returned to the prison and tried to telephone Mr Burns' next of kin, but again there was no reply.
41. The FLO told Mr Burns about the difficulty he was experiencing contacting his next of kin. Mr Burns told him that he did have an alternative address for his next of kin. However, he said he did not wish her to be informed of his condition until after his death. The FLO asked him on a number of occasions if he had changed his mind and if he would like his next of kin to be informed. Mr Burns said that he did not.
42. On the day Mr Burns died (27 January), in accordance with his wishes, the FLO visited the home address of his next of kin to inform her of his death. She was not at home, so he then visited her at her place of work and told her that he had died. He remained in contact with her offering support and advice.
43. Mr Burns' funeral was held on 12 February. Members of prison staff attended. The prison contributed to the costs of the funeral in line with national guidance.

Support for prisoners and staff

44. The prison posted notices informing other prisoners of Mr Burns' death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by his death.
45. After Mr Burns' death, the staff who were accompanying him at the hospital when he died were given the opportunity to discuss any issues arising, they were also offered support by the staff care team.

Findings

Clinical care

46. The clinical reviewer considered that prison healthcare staff made prompt, appropriate referrals, both to prison GPs and to secondary care providers, to diagnose, treat and manage Mr Burns' condition.
47. She noted that treatment recommendations were followed up by healthcare staff, and that Mr Burns was involved in the management of his condition. The collaborative working between prison healthcare staff and hospital specialists was in line with Prison Service Order (PSO) 3050, *Continuity of care for prisoners*. She considered that Mr Burns' death was neither foreseeable nor preventable.
48. The clinical reviewer concluded that the standard of care Mr Burns received at Wymott was of a high standard and equivalent to that which he could have expected to receive in the community.
49. We make no recommendations.

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