Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mark Campbell, a prisoner at HMP The Mount, on 14 March 2021

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 Mark Campbell died in a hospice on 14 March 2021 of prostate cancer while a prisoner at HMP The Mount. Mr Campbell was 64 years old. We offer our condolences to Mr Campbell's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Campbell received at The Mount was equivalent to that which he could have expected to receive in the community. She did, however, make some recommendations about secondary health screens and recording clinical information, which we do not repeat here but which the Head of Healthcare will need to address.

5. We are concerned that the prison failed to provide relevant escort risk assessment documentation despite being asked to do so.

Recommendations

- The Governor should ensure that prison documentation relating to a prisoner is stored securely and provided promptly when requested during the course of any investigation, in line with PSI 58/2010.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer, to review Mr Campbell's clinical care at HMP The Mount.

7. The PPO investigator has investigated the non-clinical issues, including Mr Campbell's 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 Campbell's next of kin, his brother, to explain the investigation. He did not respond to our letter.

Previous deaths at HMP The Mount

9. Mr Campbell was the fourth prisoner to die at The Mount since March 2019. Of the previous deaths, one was from natural causes, one was drug related and one was self-inflicted.

10. There are no similarities between our findings in the investigation into Mr Campbell's death and our investigation findings for the previous deaths.

Key Events

11. On 26 January 2010, Mr Mark Campbell was remanded to prison custody for murder. He was later sentenced to life imprisonment with a minimum term of 14 years. Mr Campbell transferred to HMP The Mount in May 2014.

12. In 2011, Mr Campbell had a 'Well Man Test', which included blood tests for prostate problems. The tests raised no issues, but in a follow up GP review, Mr Campbell complained of a two year history of difficulty urinating. The GP examined his prostate and found that it was enlarged. Mr Campbell was reluctant to undergo further investigations and agreed that he would seek treatment if the symptoms worsened.

13. In 2012, Mr Campbell had another examination of his prostate, there were no abnormalities.

2020

14. On 7 April 2020, Mr Campbell had been experiencing COVID-19 related symptoms for a week, including a continuous cough and a high temperature. He was admitted to hospital and stayed there for one night. He was discharged from hospital the next day and returned to The Mount. Mr Campbell remained in isolation, in his cell, until 15 April when he recovered.

15. In November, Mr Campbell complained of continued urinary problems. He had several urine sample tests and the results were all abnormal. He continued to complain of pain and struggled to pass urine over the weeks that followed. On 16 November, a prison GP referred him to a hospital specialist under the two week wait referral process.

16. On 25 November, Mr Campbell complained of severe pain, inability to pass urine and had a distended abdomen. He was sent to hospital for further examination and treatment. Mr Campbell had a catheter fitted and was discharged from hospital the next day. A catheter care plan was put in place and healthcare staff saw him regularly. It was arranged for Mr Campbell to have a follow up appointment at the hospital for an MRI scan and a biopsy of his prostate.

17. On 16 December, Mr Campbell was diagnosed with prostate cancer. Over the next few months, his cancer diagnosis was subject to further investigation and treatment at Watford General Hospital, Watford.

2021

18. On 22 February 2021, Mr Campbell attended an appointment at Mount Vernon Cancer Centre. He was told that the cancer had spread to his lungs and brain, it was very aggressive and that his condition was terminal. Mr Campbell returned to The Mount after his appointment.

19. At 6.30pm, the same day, the hospital called the prison to tell them that Mr Campbell's calcium levels were very low, which meant that he needed urgent

medical attention. Mr Campbell was taken to Watford General Hospital as an emergency.

20. On 24 February, while Mr Campbell was in hospital, the prison made an application for early release on compassionate grounds on his behalf.

21. On 26 February, the hospital consultant for Mr Campbell decided that it was appropriate for a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) to be put in place.

22. On 5 March, the hospital told prison healthcare staff that Mr Campbell's treatment was now palliative only and that he had less than three months to live. The prison submitted the compassionate release application to the Public Protection Casework Section (PPCS) of Her Majesty's Prisons and Probation Service (HMPPS). However, Mr Campbell died before a decision was reached.

23. On 6 March, Mr Campbell was transferred from Watford General Hospital to Peace Hospice. He died there on 14 March.

Cause of death

24. The Coroner accepted the cause of death provided by a hospice doctor and no post-mortem examination was carried out. The doctor gave Mr Campbell's cause of death as metastatic high-grade neuroendocrine cancer of the prostate.

Non-Clinical Findings

Failure to retain and provide prison documents

25. Prison Service Instruction (PSI) 58/2010, The Prisons and Probation Ombudsman (PPO), says that Governors must ensure that when the PPO is carrying out investigations or enquiries, staff comply with requests for information and assistance. Mr Campbell's last visit to hospital was on 22 February 2021 and he did not return to The Mount. The prison did not provide us with completed escort risk assessments for 22 February to 3 March, despite being asked to do so. As a result, we were unable to determine how Mr Campbell was restrained and how his risk was assessed by the prison.

26. The guidance for prisons on the handling, retention and disposal of records is set out in PSI 35/2014. It says that the handling of records should be overseen by a Local Information Manager who should ensure that "records are clearly labelled and organised and can be retrieved quickly when required". We asked the prison why the full risk assessment could not be provided. The prison said, 'it must have just been misplaced as we have so much paperwork we deal with on a daily basis so it would have just been human error'. These documents can provide crucial evidence for investigations and we would expect the prison to ensure that evidence is preserved following a death in custody to ensure appropriate scrutiny and accountability. We are therefore unable to comment on the use of restraints and the events that took place when Mr Campbell left the prison for hospital on 22 February.

27. We recommend:

The Governor should ensure that prison documentation relating to a prisoner is stored securely and provided promptly when requested during the course of any investigation, in line with PSI 58/2010.

Lisa Burrell **December 2021**
Assistant Ombudsman

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