

**Prisons &
Probation**

Ombudsman
Independent Investigations

**Independent investigation into
the death of Terrence
Eastwood,
a prisoner at HMP Wymott,
on 2 October 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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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 Eastwood, who was 67 years old, died of lung cancer on 2 October 2021, while a prisoner at HMP Wymott. We offer our condolences to Mr Eastwood's family and friends.
4. The clinical reviewer concluded that the care Mr Eastwood received at HMP Wymott was partially equivalent to that which he could have expected to receive in the community. She made several recommendations about referring prisoners with suspected cancer to specialist services, shielding and record keeping. We repeat some of the recommendations about these issues below.
5. We did not find any non-clinical issues of concern.

Recommendations

- The Head of Healthcare should ensure healthcare staff document that prisoners are isolating or shielding due to COVID-19 to ensure that staff delivering care and interventions are aware of any restrictions and considerations required.
- The Head of Healthcare should ensure all healthcare staff are aware of NICE guidance for suspected cancer and how to refer to appropriate services, to allow for early identification of disease.
- The Head of Healthcare should ensure that SystemOne records include details of discussions, actions and outcomes when prisoners are discussed at complex case meetings.

Investigation Process

6. NHS England commissioned an independent clinical reviewer, to review Mr Eastwood's clinical care at HMP Wymott.
7. The PPO investigator has investigated non-clinical issues, including Mr Eastwood's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. 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. The action plan has been annexed to this report.
9. One of the PPO's family liaison officers wrote to Mr Eastwood's next of kin, his partner, to explain the investigation. She did not respond to our letter.

Previous deaths at Wymott

10. Mr Eastwood was the 13th prisoner to die at Wymott since 2 October 2019. Of the previous deaths, 11 were from natural causes and one was from non-natural causes.
11. There are no similarities between our findings in the investigation of Mr Eastwood's death and the previous deaths.

Key Events

12. On 15 September 2017, Mr Terrence Eastwood was sentenced to 19 years in prison for historic sexual offences. He was sent to HMP Preston.
13. Mr Eastwood had a number of pre-existing medical conditions, including, type 2 diabetes, congestive cardiac failure (a condition in which the heart is unable to effectively pump blood around the body), severe osteoarthritis and cirrhosis of the liver. He was also HIV positive. Mr Eastwood had previously had four strokes and a brain aneurysm (a bulge in a blood vessel caused by a weakness in the wall of the blood vessel). He used a Zimmer frame and a wheelchair to mobilise.
14. On 4 November 2019, Mr Eastwood transferred to HMP Wymott.
15. A nurse carried out Mr Eastwood's initial health screen. She noted his pre-existing medical conditions and that he had been diagnosed with chronic obstructive pulmonary disease at his previous prison (COPD - the name for a group of lung conditions that cause breathing difficulties). His care plans were reviewed and updated, and his prescribed medications were reviewed. He was referred to secondary care providers to ensure continuity of care, and to specialist clinics at the prison to manage his various conditions. Healthcare staff reviewed Mr Eastwood daily and social carers provided ongoing support.
16. In March, restrictions began to be imposed in response to the COVID-19 pandemic. Prisoners who were exceptionally vulnerable (and potentially) vulnerable to contracting COVID-19 were advised to shield. Mr Eastwood had a number of medical conditions that made him vulnerable to contracting the virus. There is no evidence in his medical records that Mr Eastwood was shielding or that healthcare staff discussed this with him.

2021

17. On 27 May 2021, a prison GP saw Mr Eastwood. The prison GP noted that Mr Eastwood was suffering from an occasional shortness of breath and that he was using his inhalers more frequently than prescribed. Although Mr Eastwood's chest appeared clear, there was evidence of a wheezing and he had a chronic cough. Mr Eastwood was not referred to specialist services for further review.
18. On 19 June, a nurse was carrying out a routine electrocardiogram (ECG, used to monitor the electrical output of the heart). Mr Eastwood told her that he had been experiencing intermittent chest pain, which he had not reported to healthcare staff. She took his observations and noted that his oxygen saturation level was normal, but his heart rate was abnormally high. She sent him to hospital by emergency ambulance for review.
19. Mr Eastwood was admitted to hospital as an inpatient and underwent a series of tests. The test results showed that Mr Eastwood had developed community acquired pneumonia. He was treated with intravenous antibiotics. He was discharged from hospital and went back to Wymott on 23 June.

20. The prison GP saw Mr Eastwood on 1 July. He noted that while in hospital, Mr Eastwood had a chest X-ray. The results showed a partial collapse of his left lung and possible evidence of a malignant growth in his lung. The prison GP made a two week wait referral to the oncology team at Royal Preston Hospital.
21. On 20 July, Mr Eastwood attended Royal Preston Hospital for his two-week wait referral. He was admitted to hospital as an inpatient and underwent a series of tests. The results showed that Mr Eastwood had developed lung cancer. Hospital staff considered that the cancer may have spread to other areas in his body and that palliative care was the only treatment option open to him. Mr Eastwood was discharged from hospital and went back to the prison on 29 July.
22. Mr Eastwood was added to the prison's palliative care register and referred to St Catherine's Hospice for support with his prescribed medications and care. His care plans were updated, and healthcare staff continued to review him regularly. The prison started a compassionate release application on his behalf. Mr Eastwood died before the application was completed.
23. On 6 September, prison GP saw Mr Eastwood. They discussed his wishes in respect of resuscitation. Mr Eastwood said that he did not want to be resuscitated in the event his heart or breathing stopped. He signed a do not attempt cardiopulmonary resuscitation (DNACPR) order on his behalf.
24. On 1 October, Healthcare Assistant (HCA), saw Mr Eastwood. Mr Eastwood told him that he had been suffering from shortness of breath and that he had blood in his phlegm when he coughed. He also said that he was struggling to keep fluids down when he drank. The HCA referred Mr Eastwood for an urgent GP review.
25. A prison GP saw Mr Eastwood later the same day. He took his observations and noted that his oxygen saturation level and temperature were low. Mr Eastwood was taken to Royal Preston Hospital by emergency ambulance and was admitted as an inpatient.
26. Mr Eastwood's condition continued to deteriorate in hospital and at 10.00am on 2 October 2021, it was confirmed that Mr Eastwood had died.

Cause of death

27. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Eastwood's cause of death as lung cancer. He also had coronary artery disease and cirrhosis of the liver, which did not cause but contributed to his death.

Lisa Burrell

Assistant Prisons and Probation Ombudsman

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

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

T | 020 7633 4100