Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Bourne, a prisoner at HMP Littlehey, on 14 May 2021

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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 Peter Bourne died of aggressive non-Hodgkin lymphoma (cancer in the lymphatic system) in May 2021 while a prisoner at HMP Littlehey. He also had chronic obstructive pulmonary disease (COPD), kidney failure, diabetes and hypertension, which did not cause but contributed to his death. He was 82 years old. We offer our condolences to Mr Bourne's family and friends.

4. The clinical reviewer concluded that the clinical care that Mr Bourne received at Littlehey was of a reasonable standard and equivalent to that which he could have expected to receive in the community.

5. The clinical reviewer found that Mr Bourne's physical health care was appropriately monitored and treated. However, when Mr Bourne's health started to deteriorate in May, healthcare staff missed an opportunity to use NEWS2 scores (NEWS2 – a tool used to detect and monitor acute illness). This is a matter we have raised in several other fatal incident investigations at Littlehey.

6. The clinical reviewer made one recommendation related to Mr Bourne's death, which we have reflected below. We did not identify any non-clinical issues of concern.

Recommendations

- The Head of Healthcare should ensure that staff use the National Early Warning Score (NEWS) assessment tool and follow the recommended clinical escalation procedures.

The Investigation Process

7. NHS England commissioned an independent clinical reviewer to review Mr Bourne's clinical care at Littlehey.

8. The PPO investigator has investigated the non-clinical issues in Mr Bourne's care, including his 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 Bourne's family to explain our investigation. Mr Bourne's family had no specific questions but requested a copy of the report.

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

11. Mr Bourne's family received a copy of the draft report. They did not make any comments.

Previous deaths at HMP Littlehey

12. There were 27 deaths at Littlehey in the two years before Mr Bourne's death. Twenty-six of the previous deaths were from natural causes (eight of which were related to COVID-19). One of these deaths was self-inflicted and one remains unclassified. Since Mr Bourne died, there have been four deaths from natural causes.

13. We have made a recommendation about the use of the NEWS2 tool following our investigations into five other deaths at the prison. In June 2019, February 2020 and June 2021 the Head of Healthcare agreed to ensure that all clinical staff consistently use and are aware of the triggers for escalation of care. We continue to be concerned that, although our previous recommendations have been accepted, they have not been implemented and that practice has not changed.

Key Events

14. On 27 September 2018, Mr Bourne was sentenced to 11 years and 6 months in prison for sexual offences. He was sent to HMP Lewes and transferred to HMP Littlehey on 15 November 2019.

15. Mr Bourne had a significant medical history, including type 2 diabetes, chronic kidney disease, hypertension and chronic obstructive pulmonary disease (COPD). Mr Bourne also had a hip replacement. On 21 March 2020, Mr Bourne agreed to shield, in line with prison COVID-19 measures.

16. On 3 May 2021, Mr Bourne was seen by a nurse when he reported he was unwell after his recent COVID-19 vaccine. His observations were recorded as normal but his NEWS2 score was not recorded. (NEWS2 is a tool used to detect and monitor acute illness and support clinical decisions.)

17. On 4 May 2021 Mr Bourne was reviewed by a prison GP. Mr Bourne's observations were normal, but the GP did not record his NEWS2 score.

18. Mr Bourne said that he still felt unwell on 6 May 2021 and officers asked healthcare staff to review him. A nurse recorded that Mr Bourne's blood oxygen saturations were 98% and his heart rate was 87bpm (within normal range). The nurse did not record either his respiratory rate or his NEWS2 score.

19. On 7 May, an officer called the healthcare department as Mr Bourne appeared drowsy and confused. A nurse went to the wing, took his observations, including his NEWS2 score, which was 6. This score indicated that Mr Bourne needed urgent medical attention, so she appropriately requested an emergency ambulance.

20. Mr Bourne was admitted to Hinchingbrooke Hospital, where they found that his kidneys were not functioning properly. His health deteriorated and an end-of-life plan was put in place on 12 May.

21. On 14 May at 5.45pm Mr Bourne died whilst in hospital from aggressive non-Hodgkin lymphoma. He had not been diagnosed or treated for this condition before his death.

Post-mortem report

22. A post-mortem examination was not conducted. A hospital doctor confirmed Mr Bourne's death, and the Coroner accepted his cause of death was aggressive non-Hodgkin lymphoma. Mr Bourne also had type 2 diabetes, COPD, kidney disease and hypertension, which did not cause but contributed to his death.

Clinical Findings

23. The independent clinical reviewer concluded that the care that Mr Bourne received was equivalent to that he could have expected to receive in the community. Mr Bourne's complex health problems were monitored, and appropriate risk assessments were completed. He considered that it was reasonable that Mr Bourne's lymphoma had not been diagnosed as he had reported no symptoms. The clinical reviewer was concerned that healthcare staff did not use NEWS2 consistently and made a recommendation about this.

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