

**Prisons &
Probation**

Ombudsman
Independent Investigations

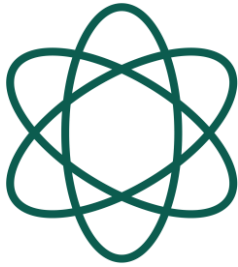
Independent investigation into the death of Mr Jerry Burdon, a prisoner at HMP Leyhill, on 21 November 2021

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. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.'
3. Mr Jerry Burdon died on 21 November 2021, of bronchopneumonia, due to non-small cell carcinoma at HMP Leyhill. He was 72 years old. We offer our condolences to Mr Burdon's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Burdon received at Leyhill was of a good standard and equivalent to that which he could have expected to receive in the community. The clinical reviewer made one recommendation about the protocol between the prison and local ambulance trust to prevent misunderstandings for end of life patients who may need to go to hospital, which we repeat below. He also escalated concerns about Mr Burdon's hospital treatment, which is not within the remit of this investigation, but which the NHS England Commissioning Team will need to address.
5. We found no non-clinical issues for concern.

Recommendation

- The Governor and the Head of Healthcare should review the protocol with the local ambulance service to ensure they understand the prison context when staff request ambulances for end of life patients.

The Investigation Process

6. HMPPS notified us of Mr Burdon's death on 22 November 2021.
7. NHS England commissioned an independent clinical reviewer, to review Mr Burdon's clinical care at HMP Leyhill. The clinical reviewer's report is as Annex 1.
8. The PPO investigator investigated the non-clinical issues relating to Mr Burdon's care.
9. The investigator and clinical reviewer interviewed two members of staff and a prisoner on 6, 8 and 10 December 2021 using Microsoft Teams. The interview transcripts are attached as Annexes 2– 4.
10. We informed HM Coroner for Avon of the investigation. The investigation was suspended from April 2022 until March 2023 while we waited for a copy of the post-mortem report. We have sent the Coroner a copy of this report.
11. The PPO family liaison officer wrote to Mr Burdon's niece, to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond to our letter.
12. 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.

Previous deaths at HMP Leyhill

13. Mr Burdon was the eighth prisoner to die at Leyhill since November 2019 from natural causes. There are no significant similarities between our findings in this investigation and those of the other deaths. There have been five deaths from natural causes since Mr Burdon's death.

Key Events

14. On 19 February 2001, Mr Jerry Burdon was sentenced to life imprisonment for kidnapping, sexual offences and robbery. He was 52 years old. Mr Burdon was sent to HMP Winchester and spent time in several prisons.
15. Mr Burdon had a heart attack in 2017 and had several long term medical conditions, including a perforated duodenal ulcer, type 2 diabetes, lung cancer (diagnosed in July 2019) chronic obstructive airways disease (COPD) and chronic kidney disease. Healthcare staff reviewed him regularly and adjusted his medications to manage his conditions.
16. On 11 October 2019, Mr Burdon was transferred to HMP Leyhill. Healthcare staff completed his reception health screen. They noted his lung cancer diagnosis and confirmed that he would need to attend hospital appointments to discuss his treatment options.
17. On 31 October, a consultant oncologist at Southmead Hospital noted that Mr Burdon's lung function was very poor, but that the cancer had not spread.
18. Prison and healthcare staff held monthly complex case meetings to discuss Mr Burdon's ongoing care and prison staff appointed a prison support orderly (another prisoner) to help Mr Burdon with his daily activities.
19. On 9 December, Mr Burdon began palliative chemotherapy at Bristol Haematology and Oncology Centre. Staff from Macmillan support team met Mr Burdon on 4 March 2020, to discuss how he could manage the side effects from his cancer diagnosis and treatment.
20. On 2 July, Mr Burdon said that he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect.
21. On 11 February 2021, Mr Burdon had his first COVID-19 vaccination and on 19 April he had the second dose.
22. On 5 May, Mr Burdon told the consultant oncologist that he felt increasingly unwell. After completing a series of CT scans, the oncologist told Mr Burdon that it appeared his treatment was no longer stabilising the cancer and that they would consider a different treatment.
23. On 8 September, the CT scans were repeated and the results showed that the cancer had spread. On 13 October, after more CT scans, the hospital oncologist told Mr Burdon that the scans showed more disease than expected, with significant changes in his right lung and that he had cancer in his left tonsil. The oncologist made an urgent two week referral to the Ear Nose and Throat (ENT) team, and copied the referral to healthcare staff at Leyhill.

Events in November 2021

24. Prison staff arranged for Mr Burdon to attend ENT appointments on 1 November, and on 11 November.

25. On 19 November, Mr Burdon attended hospital as a day patient and hospital specialists conducted a panendoscopy (an operation to fully assess the oral cavity, larynx and oesophagus) and removed his tonsils (a tonsillectomy). That day, Mr Burdon returned to Leyhill with oral morphine.
26. During the night on 20 November, Mr Burdon reported that he had been vomiting, shaking and feeling unwell. Prison staff told him they would arrange for healthcare staff to see him first thing in the morning.
27. On 21 November, wing staff asked healthcare staff to check on Mr Burdon. The Head of Healthcare, and a Healthcare Assistant visited him in his cell and noted that he was short of breath and initially unresponsive. They administered oxygen and Mr Burdon told them that he had abdominal pain. At 9.04am, she called an emergency ambulance. Paramedics arrived at 9.35am.
28. The paramedics told Mr Burdon that he was dying and that he should go to hospital, but he did not want to. Mr Burdon made the informed decision to remain at Leyhill. The paramedics and the Head of Healthcare discussed Mr Burdon's acute episode and unexpected deterioration, his signed DNACPR and his high respiratory rate and oxygen levels. They considered that he had the capacity to make decisions about his care and treatment, including that he did not want to be taken to hospital.
29. Healthcare staff thought the paramedics did not understand the limited options at Leyhill and asked them to discuss the situation with the duty GP at Leyhill. (The prison's palliative care suite had not been prepared and could not immediately be made ready for Mr Burdon.)
30. As the paramedic contacted the duty GP, to update her on the latest position, Mr Burdon became unresponsive. In line with his DNACPR order, healthcare staff did not attempt to resuscitate him.
31. At 10.15am, it was confirmed that Mr Burdon had died in his cell.

Post-mortem report

32. The post-mortem report concluded that Mr Burdon died of bronchopneumonia, caused by non-small cell lung carcinoma. Coronary artery atheroma and chronic obstructive pulmonary disease were also listed as contributory factors.

Good practice

33. The clinical reviewer found that there was excellent continuity of Mr Burdon's care with a patient centred approach. Healthcare staff made efforts to assess Mr Burdon's capacity and involved him in decisions that affected his care and treatment. He also found that there was good two-way communication between the Leyhill and the hospital oncology team.

Inquest

34. The inquest into Mr Burdon's death was held on 15 August 2023 with a verdict of natural causes.

Sue McAllister
Prisons and Probation Ombudsman

August 2023

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