Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Christopher Denning, a prisoner at HMP Bedford, on 24 June 2022

A report by the Prisons and Probation Ombudsman

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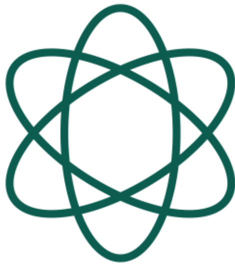
Our vision

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

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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. 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 Denning died of osteomyelitis (an infection in the bone caused by bacteria) caused by diabetes in Bedford Hospital on 24 June 2022, while a prisoner at HMP Bedford. He was 81 years old. We offer our condolences to those who knew him.

4. The clinical reviewer concluded that the quality of Mr Denning's clinical care was mixed. She found that day to day nursing care and the management of his long-term conditions was equivalent to that which he could have expected to receive in the community. She found that the communication between healthcare staff and the hospital tissue viability and podiatry teams was excellent.

5. However, the clinical review found issues of concern in Mr Denning's end of life care. Healthcare staff recorded end-of-life care discussions with each other on three occasions, but there is no evidence that advanced care planning was discussed with Mr Denning or implemented before he died. When clinical readings first showed that Mr Denning needed emergency care, he was not transferred to hospital for treatment. This area of care was not equivalent to that which Mr Denning could have expected to receive in the community.

6. We found no non-clinical issues of concern.

Recommendations

- The Head of Healthcare should ensure that all healthcare staff are aware of the difference between DNACPR, treating patients with a reversible condition and end of life care, to ensure the appropriate escalation of care.

- The Head of Healthcare should ensure that all healthcare staff are fully trained in, and practice is compliant with, the 'Dying Well in Custody Charter'.

- The Head of Healthcare should ensure that all prisoners with a terminal diagnosis are involved in advanced care planning, and at the earliest opportunity.

The Investigation Process

7. NHS England and NHS Improvement (NHSE&I) commissioned an independent clinical reviewer to review Mr Denning's clinical care at HMP Bedford.

8. The PPO investigator investigated the non-clinical issues relating to Mr Denning'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 was advised by the prison that Mr Denning had no identified next of kin.

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

Previous deaths at HMP Bedford

11. In the two years before Mr Denning's death, there had been four deaths at Bedford. Two of these were due to natural causes and two were self-inflicted.

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

Key Events

13. Mr Denning was serving two consecutive 13 year sentences for historic sex offences. He was transferred to HMP Littlehey on 3 October 2018.

14. On 12 July 2021, Mr Denning was admitted to Bedford hospital for treatment relating to his Parkinson's Disease (a progressive neurological condition which causes problems in the brain and gets worse over time). On 3 August, he was discharged from hospital and transferred to nearby HMP Bedford, where he could receive necessary 24-hour health and social care.

15. Mr Denning had complex physical health needs. In addition to Parkinson's Disease, he had atrial fibrillation (abnormal heart rhythm), hypertension (high blood pressure), glaucoma (a common eye condition where the optic nerve, which connects the eye to the brain, becomes damaged), type 2 Diabetes (a condition that results from insufficient production of insulin, causing high blood sugar) and pressure ulcers.

16. Bedford located Mr Denning in the inpatient unit and his care plans were regularly discussed and reviewed within multi-disciplinary meetings.

17. On 10 January 2022, Mr Denning made the decision that he did not want to be resuscitated if his heart or breathing stopped. He signed a do not attempt resuscitation order (DNACPR) to that effect.

18. In May, the healthcare team put additional support in place for Mr Denning, in response to the deterioration of his physical health symptoms. This was recorded and delivered using a specific care plan for Parkinson's Disease management.

19. In March, Mr Denning's pressure ulcer wound became infected and he was prescribed a course of antibiotics by prison GP. On 20 March, the GP called Bedford Hospital and arranged for transfer to hospital for treatment of his infected ulcer, which had shown no improvement. The hospital found that Mr Denning had acute osteomyelitis (an infection in the bone, caused by bacteria) and required intravenous anti-biotics to treat his symptoms.

20. Prison nursing staff visited Mr Denning in hospital as part of their preparations for his transfer back to prison. They created care plans for the treatment of his wounds. Mr Denning was discharged from hospital on 10 May and transferred back to Bedford, where the care plans were implemented.

21. On 18 May, a nurse sent an email to the prison Offender Management Unit to enquire about release on temporary licence for Mr Denning, considering his poor health.

22. On 25 May, a prison GP suggested that end-of-life care should start for Mr Denning. Healthcare discussed end-of-life care during clinical review meetings on 8 June and 15 June.

23. On 21 June at 11.00am, a nurse went to take Mr Denning's clinical observations and noticed that he was not responsive to her voice. His overall health had deteriorated significantly. Mr Denning's oxygen levels, pulse, blood pressure and

breathing rate were all lower than the average and his National Early Warning Score (NEWS2 is a tool used to detect acute illness and deterioration) was 7, showing that emergency clinical care was needed. She escalated the score to the prison Matron, who advised her to make Mr Denning comfortable and take his physical observations later that day.

24. At 3.30pm, Mr Denning's NEWS score was recorded as 9. The nursing team continued to follow the earlier instruction to keep him comfortable.

25. On 22 June at 10.49am, a prison GP reviewed Mr Denning and discussed end-of-life care with him. Mr Denning said that he wished to continue with treatment. The GP recorded that Mr Denning's NEWS score was at 7 again. She applied oxygen therapy and arranged for an emergency ambulance transfer to Bedford Hospital.

26. When he arrived in hospital, Mr Denning was treated for an infection of his pressure wound and given intravenous antibiotics. His condition worsened and he died at Bedford Hospital on 24 June at 5.58pm. The bedwatch officer (staff responsible for ensuring that prisoners are kept in secure and lawful custody) was with him when he died.

Post-mortem report

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 Denning's cause of death as osteomyelitis (an infection in the bone caused by bacteria) caused by type 2 Diabetes Mellitus.

Clinical Findings

28. On 21 June, healthcare staff noted a significant deterioration in Mr Denning's health. They completed the appropriate clinical observations on 3 occasions between the morning of 21 June and the morning of 22 June. On each occasion, the scores showed that Mr Denning required emergency treatment. Nursing staff escalated the scores to the Matron, who was under the impression that Mr Denning was in end-of-life care due to his DNACPR. She asked nurses to keep Mr Denning comfortable. However, Mr Denning was not in end-of-life care and should have been transferred to hospital immediately.

29. Later that day, a prison GP discussed end of life care with Mr Denning for the first time. He said that he wanted to continue with treatment. The prison provided oxygen therapy and transferred Mr Denning to hospital, where he could access the appropriate care.

30. The clinical reviewer was unable to assess whether the oversight would have affected the outcome for Mr Denning. However, an appropriate emergency response would have allowed for earlier intervention when Mr Denning was identified as needing emergency care.

31. The Head of Healthcare at Bedford recognised that this was a serious omission and put measures in place to address the learning within the healthcare team. Measures included the addition of a prompt to the staff handover document, that makes clear the distinction between a DNACPR and end-of-life care. The revised document has been shared with the relevant local secure service leads. To support this ongoing work, we make the following recommendation:

    The Head of Healthcare should ensure that all healthcare staff are aware of the difference between DNACPR, treating patients with a reversible condition and end of life care, to ensure the appropriate escalation of care.

Advanced Care Planning

32. On 25 May, a prison GP recorded that end-of-life care should be started for Mr Denning. There are two further records from healthcare staff on 8 and 15 June that mention end-of-life care in clinical discussion. However, staff never discussed with, nor put in place, advanced care planning for Mr Denning. We make the following recommendations:

    - **The Head of Healthcare should ensure that all healthcare staff are fully trained in, and practice is compliant with, the 'Dying Well in Custody Charter'.**

    - **The Head of Healthcare should ensure that all prisoners with a terminal diagnosis are involved in advanced care planning, and at the earliest opportunity.**

The inquest into Mr Denning’s death was held on 20 July with a verdict of natural causes.

Tallulah Frankland
Assistant Ombudsman **November 2022**

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