

**Prisons &
Probation**

Ombudsman
Independent Investigations

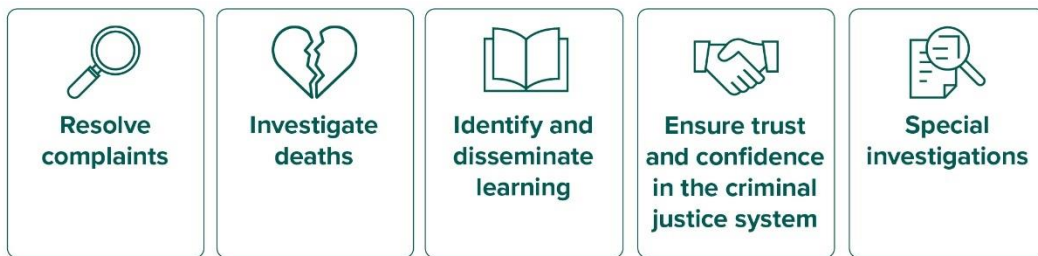
Independent investigation into the death of Mr Keith Cavendish-Coulson, a prisoner at HMP Bullingdon, on 5 February 2023

A report by the Prisons and Probation Ombudsman

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE



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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 Keith Cavendish-Coulson died of bronchopneumonia on 5 February 2023 at HMP Bullingdon. He was 79 years old. We offer our condolences to his family and friends.
4. The clinical reviewer concluded that the healthcare Mr Cavendish-Coulson received at Bullingdon was equivalent to what he could have expected to receive in the community. She has made a number of recommendations about access to palliative care support from external agencies, monitoring weight, referrals to secondary care providers, escalation of elevated NEWS2 scores and Do Not Attempt Cardiopulmonary Resuscitation orders. We repeat some of the recommendations below.
5. We did not find any non-clinical issues of concern.

Recommendations

- The Head of Healthcare should ensure timely referrals are made to secondary services (such as SALT and Local Authority) when supplementary assessment is needed to form a clear picture of the prisoner's needs.
- The Head of Healthcare and Governor should ensure that:
 - healthcare staff are the decision makers when deciding if an ambulance is needed for a prisoner; and
 - there is a clear agreed communication and decision-making process in place to ensure there are no delays in calling an ambulance.
- The Head of Healthcare should ensure that there is a clear escalation process in place for healthcare staff to escalate elevated NEWS2 scores and clinical concerns.

The Investigation Process

6. HMPPS informed us of Mr Cavendish-Coulson's death on 5 February 2023. The investigator issued notices to staff and prisoners at HMP Bullingdon informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
7. The investigator obtained copies of relevant extracts from Mr Cavendish-Coulson's prison and medical records.
8. NHS England commissioned an independent clinical reviewer to review Mr Cavendish-Coulson's clinical care at the prison.
9. We informed the Coroner for Oxfordshire District of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
10. The Ombudsman's family liaison officer wrote to Mr Cavendish-Coulson's friend to explain the investigation and to ask if she had any issues she wished the investigation to consider. She did not respond.
11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS identified some minor factual inaccuracies and we have amended our report accordingly.

Previous deaths at HMP Bullingdon

12. Mr Cavendish-Coulson was the fifteenth prisoner to die at Bullingdon since February 2020. Of the previous deaths, nine were from natural causes, two were self-inflicted, two were drug related and one was unascertained. There have been three further deaths since Mr Cavendish-Coulson's death, two from natural causes and one self-inflicted.
13. There are no similarities between the findings of our investigation into Mr Cavendish-Coulson's death and the findings of our investigations into the other deaths at Bullingdon.

Key Events

14. On 13 December 2022, Mr Keith Cavendish-Coulson was sentenced to sixteen months in prison for historic sex offences and was sent to HMP Bullingdon. He was 79 years old.
15. Mr Cavendish-Coulson had pre-existing medical conditions, including hyperthyroidism (underactive thyroid gland causing the metabolism to slow), peripheral neuropathy (damage to the nerves around the spinal cord and brain) and atrial fibrillation (abnormally fast, irregular heartbeat) for which he had had a pacemaker fitted in 2019. He also had a surgical procedure to remove a malignant tumour from his left kidney in 2008. Mr Cavendish-Coulson had mobility issues and he used a wheelchair and walking frame to help him to move around.
16. Prior to his arrival at Bullingdon, Mr Cavendish-Coulson had lived in a care home. Due to his poor physical condition, care home staff had put a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order in place, which meant that, in the event his heart or breathing stopped, he would not be resuscitated. Although Mr Cavendish-Coulson's medical records reflected that there was a DNACPR in place, care home staff did not send a copy of the DNACPR order to the prison.
17. A nurse carried out an initial health screen. She noted Mr Cavendish-Coulson medical conditions, created care plans to manage his conditions, and made referrals to secondary care providers to ensure continuity of his care. She noted that Mr Cavendish-Coulson was overweight and that the care plan devised to manage his care stipulated that his weight should be monitored weekly. There is no evidence to indicate that this was done.
18. In the early hours of the following morning, prison staff found Mr Cavendish-Coulson on the floor of his cell. He had slipped while trying to move from his chair to his bed. Although he was uninjured, staff moved him to the prison's healthcare inpatient unit for closer observation.
19. On 17 December, a nurse carried out a routine review. She took a note of Mr Cavendish-Coulson's observations and recorded that his oxygen saturation and temperature was low. She considered that he would benefit from a review by hospital staff and telephoned for an emergency ambulance. A Custodial Manager (CM), who was acting as Oscar 1 (who is responsible for overseeing operational matters at the prison), asked if an ambulance was necessary as she was aware that Mr Cavendish-Coulson had a DNACPR order in place. The nurse explained that although he did not wish to be resuscitated, he did not have an end-of-life care plan in place, his condition was deteriorating, and that he needed to go to hospital for further review.
20. Paramedics arrived and noted that his oxygen saturation level had improved, so he did not need to be admitted to hospital. The paramedics advised healthcare staff to prescribe Mr Cavendish-Coulson with a course of antibiotics and to closely monitor his condition.
21. Later that evening, Mr Cavendish-Coulson's condition worsened. He was taken to hospital by emergency ambulance. Hospital staff carried out a number of tests and

the results showed that he had developed right sided pneumonia. He was prescribed a course of antibiotics and was admitted to hospital as an inpatient.

22. While in hospital, hospital staff discussed with Mr Cavendish-Coulson the issue of resuscitation and the DNACPR order he had signed while in the community. He said that he still did not want to be resuscitated in the event his heart or breathing stopped, and hospital staff created a formal DNACPR notification. Mr Cavendish-Coulson was discharged back to the prison on 29 December. On his return, staff implemented an open-door policy to ensure that healthcare staff had access to his cell 24 hours a day to provide continuous care.
23. During a review on 5 January 2023, a nurse took a note of Mr Cavendish-Coulson's observations. His pulse and oxygen saturation level were low. There is no evidence that she escalated her findings to more senior nursing colleagues as she should have done.
24. On 6 January, a dietician saw Mr Cavendish-Coulson. She noted that while he was in hospital, and following his return to Bullingdon, staff had to encourage him and assist him with eating. He also told her that he was having trouble swallowing liquids and food. She asked him which foods he preferred to eat in an attempt to encourage him to eat more. Following her review, she asked the prison kitchen for a diet better suited to his needs.
25. The dietician was concerned that healthcare staff were recording differing levels of concern about the difficulty he was experiencing when swallowing in Mr Cavendish-Coulson's medical record. She planned to discuss the issue with healthcare staff to decide if he would benefit from a referral to a speech and language therapist (SALT). She put in place a nutrition and fluid chart to monitor his food and fluid intake, and she planned to review him again in two weeks. It is not clear if the referral to SALT was discussed with healthcare staff.
26. Mr Cavendish-Coulson was bed-bound, and as a result, it was difficult for healthcare staff to routinely monitor his weight. There is no evidence that healthcare staff used alternative methods, such as a mid-upper arm circumference check. Later that day, a Healthcare Assistant (HCA) saw Mr Cavendish-Coulson. She took a note of his observations and recorded his pulse and oxygen saturation level as low. She recorded his NEWS2 score (National Early Warning Score) as eight (a potential clinical emergency) and asked a nurse to see him.
27. The nurse reviewed Mr Cavendish-Coulson immediately and noted that his breathing appeared shallow and laboured. Mr Cavendish-Coulson did not respond when he called his name. He administered oxygen therapy and Mr Cavendish-Coulson's condition improved. The nurse considered that he would benefit from a further review at hospital, and he was taken to hospital by emergency ambulance.
28. In hospital, Mr Cavendish-Coulson was diagnosed with pneumonia and was admitted to hospital as an inpatient. Hospital staff treated him with intravenous antibiotics. On 9 January, Mr Cavendish-Coulson was discharged back to the prison. Following his return, healthcare staff and social care staff continued to review and support Mr Cavendish-Coulson regularly.

29. On 12 January, a GP at the prison saw Mr Cavendish-Coulson. He told the GP that since his return from hospital he had been experiencing pain in his left wrist and thumb. The GP could not find an obvious cause for his discomfort and planned to carry out a subsequent review to see if his condition continued. During the review, the GP and Mr Cavendish-Coulson discussed the DNACPR that had been put in place while he was in hospital. Mr Cavendish-Coulson confirmed that he wanted the DNACPR to stay in place as he did not wish to be resuscitated. The GP contacted Sobell House Hospice, Oxford, for advice on palliative care. Hospice staff informed him that they would visit Mr Cavendish-Coulson on 6 February.
30. On 23 January, a HCA noted that Mr Cavendish-Coulson still had difficulty swallowing and that he had only eaten a quarter of his meal. There is no evidence that she informed other healthcare staff of his lack of appetite.
31. On 26 January, hospital staff telephoned prison healthcare staff and informed them that the test results from Mr Cavendish-Coulson's recent hospital admission had indicated that his kidney cancer had returned and that it had spread from his brain to his lungs. They considered that he was not fit enough to undergo any active treatment. Prison healthcare staff and social care staff continued to review and support Mr Cavendish-Coulson regularly.
32. At 7.26am on 5 February, a nurse saw Mr Cavendish-Coulson. She considered that his breathing was more laboured than normal. She took a note of his observations and recorded his oxygen saturation level as low and his respiratory rate was raised. She radioed a medical emergency code blue (indicating a prisoner is unconscious or is having breathing difficulties) and staff in the prison control room telephoned for an emergency ambulance. She administered oxygen therapy while she waited for the paramedics to arrive.
33. The paramedics arrived at 7.40am. They considered that nothing could be done for Mr Cavendish-Coulson and advised to stop oxygen therapy. At 7.55am, they administered morphine to make him more comfortable. His condition continued to worsen, and at 8.06am, the paramedics were unable to find a pulse. They attached an ECG (electrocardiogram used to measure the electrical output of the heart), which measured a faint heartbeat but considered this to be his pacemaker.
34. At 8.26am, the paramedics confirmed that Mr Cavendish-Coulson had died.

Post-mortem report

35. The post-mortem report gave Mr Cavendish-Coulson's cause of death as bronchopneumonia. Renal cancer, congestive cardiac failure and pulmonary thromboembolic (a blocked blood vessel in the lungs) were listed as contributory factors.

Adrian Usher
Prisons and Probation Ombudsman

October 2023

Inquest

The inquest, held on 26 September 2023, concluded that Mr Cavendish-Coulson died from natural causes.

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