Prisons & Probation Ombudsman
Independent Investigations

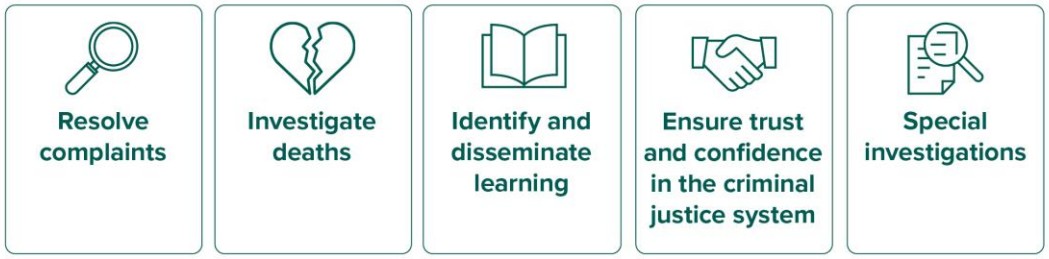
Independent investigation into the death of Mr Eric Austin, a prisoner at HMP Bullingdon, on 15 February 2023

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

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, detained individuals in immigration centres, and people recently released from prison.

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 then our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Eric Austin died from COVID-19 at HMP Bullingdon on 15 February 2023. He was 53 years old. I offer my condolences to Mr Austin's family and friends.

The clinical reviewer found that the clinical care that Mr Austin received at Bullingdon was of a good standard and equivalent to that which he could have expected to receive in the wider community.

When Mr Austin was not in prison, he was street homeless, but also spent time in mental health hospitals. His behaviour was often unusual and there was not a significant change to this or an obvious decline in his health prior to his death from COVID-19. His death was unexpected, and the cause only determined as a result of a post-mortem examination. We make no recommendations.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Adrian Usher
Prisons and Probation Ombudsman **January 2024**

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Summary

Events

1. On 7 February 2023, Mr Eric Austin was sent to HMP Bullingdon on a fixed two week recall after breaching the conditions of his licence from a previous sentence.

2. Mr Austin's lifestyle for many years revolved around alcohol dependence, acquisitive crime, homelessness and periods in prison. He also had mental health problems and had sometimes been detained under the Mental Health Act, most recently in January.

3. Mr Austin said that he had been smoking cannabis and heroin and drinking alcohol prior to his recall to prison. He was monitored for withdrawal problems during his first few days in prison but did not require any treatment.

4. Mr Austin's behaviour was at times bizarre, and also sometimes inappropriate towards female staff. This was similar to his behaviour during previous sentences. Because of difficult interactions with other prisoners, staff put Mr Austin on a separate regime for his own safety. This meant, for example, that he collected his medications at different times to other prisoners.

5. On 14 February, a member of the Patient Liaison Team carried out a wellbeing assessment of Mr Austin following reports that he had not been engaging with staff. She noted that he and his cell were untidy and unhygienic, but Mr Austin denied that he was unwell.

6. On 15 February, at around 11.40am, a prison officer went to Mr Austin's cell with his lunch and found him collapsed on his bed. Healthcare staff were quickly in attendance, and they were joined by paramedics approximately 20 minutes later. Concerted and well-coordinated efforts to revive Mr Austin were unsuccessful and a doctor declared him dead at 12.23pm. The post-mortem concluded that he died from COVID-19.

Findings

7. The clinical reviewer found that the clinical care that Mr Austin received at Bullingdon was of a good standard and equivalent to that which he could have expected to receive in the wider community.

8. Mr Austin's cell at Bullingdon was very messy and this was in keeping with previous stays in prison. Mr Austin had a history of self-neglect in prison. Information was passed by a prisoner to the investigator that Mr Austin may have been neglected by staff and that they ignored his requests for help in the lead up to his death. However, the investigation did not substantiate these claims. The day before he died, a member of the Patient Liaison Team who knew Mr Austin well from previous stays at Bullingdon, visited him as he had not been engaging with other staff. He interacted well with her and said he had no problems and agreed to tidy up his cell. On the day he died, although one member of staff thought Mr Austin was a bit lethargic, they said that otherwise he was his normal self. CCTV for the day he died, showed Mr Austin moving around in a way that was normal for him, and several

staff saw Mr Austin on the morning he died. None of them had any concerns aroused by his presentation. We did not find evidence of neglect.

9. We make no recommendations.

The Investigation Process

1. HMPPS notified us of Mr Austin's death on 15 February 2023.

2. 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. A prisoner responded and details of their concerns are included in this report.

3. The investigator obtained copies of the relevant extracts from Mr Austin's medical and prison records.

4. NHS England commissioned an independent clinical reviewer to review Mr Austin's clinical care at Bullingdon.

5. We informed HM Coroner for Oxfordshire of the investigation. He provided us with the cause of death. We have sent the Coroner a copy of this report.

6. The Ombudsman's family liaison officer contacted Mr Austin's sister to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond, but subsequently Mr Austin's brother contacted the PPO. He raised a health concern, which is covered in the clinical reviewer's report, and he asked for a copy of this report.

7. The initial report was shared with Mr Austin's brother. He did not make any comments.

8. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found a factual inaccuracy relating to the catchment area for Bullingdon, which has been corrected in this final report.

Background Information

HMP Bullingdon

9. HMP Bullingdon is a local and resettlement prison, serving the courts of Oxfordshire, Berkshire, Buckinghamshire and Wiltshire. It currently holds approximately 1,000 prisoners. The majority of the prisoners are on short sentences. Practice Plus Group provides healthcare services and Oxford Health NHS Foundation Trust provides mental health services. There is an inpatient healthcare unit, with 24-hour nursing care.

HM Inspectorate of Prisons

10. The most recent inspection of HMP Bullingdon was in November 2022. Inspectors were concerned about staff shortages and the impact this had on prisoners. However, despite this, they said that the initial arrival into prison and assessment of prisoners was good. They said clinical activity was governed effectively and that there was active learning from incidents as well as from recommendations from the PPO. They said there was an innovative, well-led and effectively governed health service, and that primary care was well led and had good systems to support care.

11. Inspectors said that the Patient Liaison Team offered an impressive patient-facing service, which was improving communication and access to a range of health promotion initiatives. They also said that arrangements for safeguarding adults remained well-embedded. The prison was represented at the local safeguarding adults board, and staff from the local authority joined safeguarding meetings when appropriate.

Independent Monitoring Board

12. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to 30 June 2022, the IMB reported that they were concerned about staff shortages and the high number of inexperienced staff.

Previous deaths at HMP Bullingdon

13. Mr Austin was the 16th prisoner to die at Bullingdon since February 2020. Of the previous deaths, ten were from natural causes, two were self-inflicted, and one was drug related. The cause of death of a further two could not be ascertained by the pathologist. Mr Austin was the fourth prisoner to die from COVID-19 in this period, but the first in over a year, and he was the first post-pandemic COVID-19 death. There are no similarities between our findings following the investigation into Mr Austin’s death and our findings following investigations into the previous deaths. There have been two further deaths since that of Mr Austin, one of which was due to natural causes and the other was self-inflicted.

Key Events

14. Mr Eric Austin had a long history of mental health problems. He was diagnosed with bipolar disorder (a condition which can cause extreme mood swings), schizophrenia (a disorder causing disruptions to thought processes, emotional responsiveness and social interactions) and a non-specific personality disorder (a condition where a person's thoughts, perceptions and feelings significantly differ from an average person). Mr Austin also had a history of alcohol and drug abuse, acquisitive offences, homelessness and frequent short stays in prisons and psychiatric inpatient centres. Mr Austin was not a healthy person and was clinically obese but did not have any long-term physical health conditions that he was receiving treatment for. On admission to HMP Wandsworth in June 2022, Mr Austin said he thought he might have diabetes. Tests showed he did not. He was tested for diabetes again at HMP Bullingdon and found not to have it.

15. Mr Austin spent most of 2022 in prison over three separate sentences. He also had two periods in hospital following detentions under the Mental Health Act. When not in prison or in hospital, Mr Austin was homeless and living on the streets. On 9 November, after leaving a restaurant without paying and then shoplifting, Mr Austin telephoned the police and asked to be arrested as he wanted to go back to prison. He was sentenced to 16 weeks imprisonment on 11 November and taken to HMP Bullingdon.

16. On 5 January 2023, Mr Austin was released from Bullingdon on licence. He failed to report to his probation office although he was contacted several times by his community offender manager (COM).

17. On 11 January, Mr Austin was picked up by British Transport Police after he attempted to make a forced entry into a property. Due to his bizarre behaviour, he was assessed as not having mental capacity. He was held under section 136 of the Mental Health Act and then sent to Ashurst psychiatric intensive care unit (PICU). He was released from there on 3 February.

18. While he was in the PICU, on 19 January, Mr Austin's licence was revoked. On 7 February, he was picked up by the police and taken to hospital where they determined Mr Austin's issues were due to drug misuse. The hospital discharged Mr Austin the same day and he was recalled to prison and sent to Bullingdon.

19. On entry to Bullingdon, Mr Austin said that prior to prison he had been smoking cannabis and heroin as well as drinking alcohol. Mr Austin was not very clear on the details of his substance misuse and there were no clinical indications that he needed any medication associated with detoxification. However, he was kept under observation for any withdrawal symptoms for four days.

20. Mr Austin exhibited unusual behaviour. This included protracted periods of shouting, singing and using his emergency cell bell (ECB) for no apparent reason. On 9 February, an officer noted that Mr Austin went through the night without sleeping. He also caused a lot of friction with other prisoners as a result of his behaviour at night including inappropriate comments, although staff did not think that he was being deliberately provocative. For his own protection, staff placed him on a separate regime to the other prisoners, which meant that he was let out of his

cell at a different time to them, for example, to collect his medication. Also, because of a history of assaults and inappropriate behaviour towards female staff, this limited some contacts by them with Mr Austin.

21. On 10 February, Mr Austin moved to a different wing, and the following day monitoring for his alcohol withdrawal ended. Staff doing the monitoring said that his responses seemed out of context. They also said that officers informed them that Mr Austin had been seen collecting food from rubbish bins.

Events of 14 – 15 February

22. After the end of his detoxification monitoring on 11 February, Mr Austin had no further interactions with healthcare staff besides collecting his medication every day. However, on 14 February, a member of the Patient Liaison Team visited Mr Austin to carry out a welfare assessment, after seeing notes that he was not engaging with staff. Mr Austin interacted with her appropriately. She asked him if he had any medical concerns and he said no. She commented on the unhygienic state of his messy cell and Mr Austin agreed that it needed cleaning. She spoke to a member of the wing staff about this, but they said that cleaning could only be done with the cooperation of Mr Austin. The video evidence from 15 February shows that there was no cleaning carried out by anyone.

23. Early in the morning of 15 February, Mr Austin pressed his ECB multiple times. On answering one of these calls before 6.00am, an officer asked Mr Austin what he wanted but he was preoccupied with changing the channels on his television and did not give any answer.

24. At around 9.40am, Mr Austin pressed his ECB again. A different officer responded, and Mr Austin asked for his lunch. The officer explained that this would not be for another couple of hours. That officer returned to Mr Austin's cell about half an hour later. This time Mr Austin said that he wanted to speak to a supervising officer (SO), but refused to say what about, although the officer told him it would help him if the supervising officer knew what he wanted to speak about. The information was passed on to the supervising officer who said they would attend later when they finished their tasks. However, because Mr Austin collapsed before that could happen, it is unknown what he wanted to speak about.

25. Shortly before 11.00am, officers took Mr Austin to collect his medication following the completion of the medication dispensation to the other prisoners. The pharmacy technician who gave Mr Austin his medication, said that he did not appear much different from normal except that he looked tired and as if he had just got out of bed. He said that as usual, Mr Austin needed some encouragement to actually take his medication. On the way back to his cell, Mr Austin tried to persuade another prisoner to give him a vape capsule and became quite abusive when they refused.

26. Not long after Mr Austin returned to his cell, it was time for lunch. Because Mr Austin was on a separate regime, an officer brought his lunch to him at around 11.40am. He found Mr Austin collapsed on his bed with his sweatshirt half raised over his head. The officer pulled the sweatshirt further up so that he could see Mr Austin's face and quickly established that he was not breathing. Officers called for an ambulance and started cardiopulmonary resuscitation (CPR). They also very

quickly attached a defibrillator (a device that can shock a heart back into normal rhythm in some circumstances) to Mr Austin, but it advised no shock.

27. About three minutes after Mr Austin was discovered by the officer, healthcare staff arrived in his cell and after several minutes of attempting to resuscitate Mr Austin, further healthcare staff arrived and took over. They continued until paramedics arrived and took charge shortly after 12.00pm. The first paramedics to arrive at Bullingdon were in an air ambulance, followed by 3 other ambulances. However, despite their combined efforts, a doctor declared Mr Austin dead at 12.23pm.

Contact with Mr Austin's family

28. On 9 February, Mr Austin told staff that he had no contact with his brother and sister and did not give contact details to the prison. However, following his death, Bullingdon checked earlier records and found an address for his sister, and the prison's family liaison officer (FLO) visited her on the afternoon of her brother's death. She said she had little contact with him and said she wanted no further involvement. Subsequently prison staff were able to speak to Mr Austin's brother who remained in contact with Bullingdon after that. The prison contributed to Mr Austin's funeral expenses in line with national policy.

Support for prisoners and staff

29. A prisoner told the investigator that support for prisoners after Mr Austin's death was good. Staff also confirmed at interview that they received the support that they needed.

Post-mortem

30. The post-mortem report concluded that Mr Austin died from COVID-19.

Inquest

31. On 21 November 2023, an inquest concluded that Mr Austin died from natural causes.

Findings

Clinical care

32. The clinical reviewer said that the clinical care that Mr Austin received at Bullingdon was of a good standard and equivalent to that which he could have expected to receive in the wider community. She found that there were no concerning changes in Mr Austin's health in the days leading to his death, which she said was unexpected.

COVID-19

33. It is unknown where Mr Austin contracted COVID-19 but there was not an outbreak in the prison at the time. In the post-pandemic period in February 2023, there were no longer COVID-19 tests on entry to prisons. So, Mr Austin was not tested for the virus at any time at Bullingdon, and he did not display symptoms out of character with his normal presentation.

Care by prison staff

34. A prisoner wrote to the PPO and said that they had heard from other prisoners that Mr Austin was consistently asking to be seen by healthcare but was kept in his cell, and that there was an obvious mental and physical decline that was not addressed. He also said that on the day Mr Austin died, he had been seen by many people on the landing struggling to breathe and asking for medical help, and that their response was that as Mr Austin was still smoking a vape, he could not be very unwell. The prisoner also said that Mr Austin pressed his ECB but that it was not answered.

35. The investigator put this information to several of the people that he interviewed, who saw Mr Austin on 15 February. They all said that Mr Austin did not appear noticeably worse than on previous days or more breathless. One of the officers said that it was common for prisoners to alert her to someone if they were unwell or if an ECB light was on (when the bell is pressed a red light remains on outside the cell until it is reset) and had not been noticed by staff. She said neither of these things happened on 15 February. She said no one approached her with concerns about a lack of attention for Mr Austin either before or after he died. When asked about his mobility, she said that Mr Austin had a slow shuffle, would stop and start talking and usually had to be encouraged to start moving again. On reflection, she thought that maybe he was disguising his mobility problems in this way.

36. The investigator also watched CCTV footage of Mr Austin on 15 February. As Mr Austin was on a separate regime for his own protection, the only time that he was out of his cell on the morning of 15 February, was when he was taken to collect his medication. This would have been the only opportunity for other prisoners to observe him that day but not many others were on the landings at that time. When the officer opened his cell door, Mr Austin came out and leant on the landing railings opposite his door for about 20 seconds before he followed the officer. After he went through a set of gates, Mr Austin stopped and leant against another set of railings. After a pause there, he took about twelve steps to the next set of railings

which he leaned over for about 35 seconds, using his vape and talking to someone out of camera shot.

37. After that Mr Austin disappeared from view and then reappeared to lean on the same set of railings, about 7 minutes later after receiving his medication from the pharmacy technician. The video shows an officer trying to encourage Mr Austin to get moving again and gesticulating in the direction of his cell. Mr Austin then spoke to this officer for about 25 seconds before noticing a prisoner on the other side of a gate and moving towards him much more quickly than previously. We know from interview information that Mr Austin asked that prisoner for a vape and then became quite abusive when refused. Several officers gathered around Mr Austin to encourage him to move away and back to his cell. He did so, again at a much quicker pace than previously and without stopping at the previous three railings that he had leant against on his way to collect his medications.

38. Although Mr Austin was overweight and unfit, and shuffled along (he also had some lesions to his feet that might have been relevant to the way he walked which prison staff were unaware of), his presentation on the CCTV was consistent with previous observations by staff. He did not appear to be someone at imminent likelihood of collapse.

39. Bullingdon were not able to supply ECB data, but the CCTV for 15 February showed clearly when Mr Austin's ECB light outside his cell came on. He rang it several times overnight. Between 8.06am and 9.40am, Mr Austin pressed his ECB six times. On four occasions, officers answered it and spoke to Mr Austin. Two other times, it was reset by prisoners walking past the cell (they do not have the authority to do this). At 10.05am, an officer looked in on Mr Austin briefly although he had not rung his ECB. Following Mr Austin collecting his medication, his light did not come on and it was not on at the time the officers discovered him after he collapsed.

40. Officer statements indicate that on one of the occasions that Mr Austin pressed his ECB, it was to ask for his lunch, but it was much too early for that. And, on another occasion, it was to ask to speak to a senior officer although Mr Austin refused to say what about. It is clear from CCTV that his ECB was not ignored on 15 February, and that several different officers looked in on Mr Austin and none of them were alarmed by his presentation.

41. Having examined the evidence closely, we do not find that Mr Austin was neglected while at Bullingdon. Mr Austin had longstanding mental health and behavioural problems which could make him challenging to understand. However, at interview, the investigator encountered two compassionate and engaged members of staff who communicated well with Mr Austin, one of whom saw him on the day before he died, and another one who was on the wing on the day he died.

42. We make no recommendations.

Good Practice

Emergency response

43. The attempts to resuscitate Mr Austin after he was found collapsed in his cell were well documented on video and in writing. This showed good communication between healthcare staff, prison staff and the paramedic services. Particularly notable were the very clear instructions and information from an Advanced Nurse Practitioner (ANP) and a Custodial Manager (CM), and the handover to the Ambulance Service staff.

Patient Liaison Team

44. Bullingdon piloted the creation of a new team that bridges healthcare and prison staff, and this has spread to other prisons in the Thames Valley region. Staff from a range of backgrounds make up the Patient Liaison Team who perform a healthcare pastoral role. We were impressed that one of the members of this team picked up from wing notes that Mr Austin was not engaging with staff. She went to see him as she said he had engaged well with her in the past and thought he might talk to her and tell her if there were any problems. It was clear from her interview with the PPO that she was empathic and not dismissive of Mr Austin. She asked him directly if he had any clinical problems, to which he replied that he did not. She also spoke to an officer about getting his cell cleaned.

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