Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Brian Goldburn, a prisoner at HMP Littlehey, on 2 August 2023

A report by the Prisons and Probation Ombudsman

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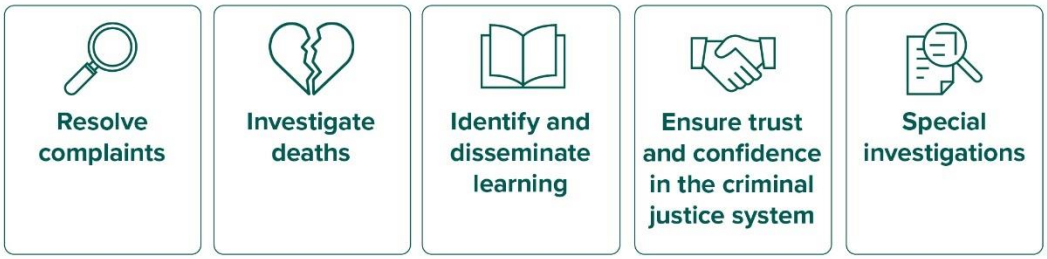
OUR VISION

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

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 Brian Goldburn died in hospital of COVID pneumonitis (a lung infection caused by COVID-19) on 2 August 2023, while a prisoner at HMP Littlehey. He also had ischaemic heart disease (caused by a lack of sufficient oxygen to the heart), hypertension (high blood pressure) and aortic valve disease (heart valve disease) which contributed to but did not cause his death. He was 79 years old. We offer our condolences to his family and friends.

Findings

Clinical care

4. The clinical reviewer concluded that the clinical care Mr Goldburn received at Littlehey was equivalent to that which he could have expected to receive in the community. The clinical reviewer made no recommendations.

Use of restraints

5. Mr Goldburn was restrained on both occasions he went to hospital in July 2023. This was despite medical objections to him being restrained on the basis of his breathing issues, poor health and compromised mobility. This was inappropriate and his restraints were only removed when he tested positive for COVID-19 and was placed in isolation.

Recommendations

- The Operational Security Group Director for HMPPS should monitor compliance with policy on the use of restraints during hospital escorts (for inpatient admissions and outpatient appointments), including at HMP Littlehey, and discuss the findings with the Ombudsman.

The Investigation Process

6. HMPPS notified us of Mr Goldburn's death on 2 August 2023.

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

8. The PPO investigator investigated the non-clinical issues relating to Mr Goldburn's care.

9. The PPO family liaison officer wrote to Mr Goldburn's next of kin to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.

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

Previous deaths at HMP Littlehey

11. In the three years before Mr Goldburn's death, there were 34 deaths from natural causes at Littlehey, four of which were related to COVID-19. There was also one self-inflicted death.

12. In investigations into the deaths of two prisoners at Littlehey in 2022, the Governor and Head of Healthcare accepted recommendations that prison managers should consider the health of a prisoner at the time and provide their reasons for the decision to apply restraints. In February 2023, prison managers changed the escort risk assessment document to reflect this.

Key Events

13. On 25 January 2023, Mr Brian Goldburn was sentenced to eight years imprisonment for sex offences. On 16 March, he transferred to HMP Littlehey.

14. Mr Goldburn had a history of heart disease, high blood pressure, aortic valve disease (heart valve disease) and triple vessel heart disease (an extreme form of heart disease where major blood vessels supplying the heart become damaged or diseased). In 2002, Mr Goldburn had heart valve replacement surgery. He also had high cholesterol and osteoarthritis (stiff and painful joints).

15. Healthcare staff referred Mr Goldburn to the long-term conditions clinic. He had regular blood tests and was prescribed warfarin to prevent blood clots.

16. On 4 July, a nurse saw Mr Goldburn because he felt unwell and had palpitations. The nurse noted that Mr Goldburn's National Early Warning Score (NEWS - a tool to detect and respond to clinical deterioration) was 0 (a low clinical risk) but saw that he was pale in colour. Mr Goldburn said that he did not have chest pains. Healthcare staff decided to send Mr Goldburn to hospital for further assessment.

17. Before Mr Goldburn went to hospital, prison staff completed an escort risk assessment. A nurse completed the medical section, objected to the use of restraints and noted that this was because Mr Goldburn was elderly and frail. The nurse noted that he used a wheelchair. A senior prison manager authorised that Mr Goldburn should be restrained with an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer) and noted that he was a wheelchair user but could be transferred out of the wheelchair. Two officers escorted Mr Goldburn to hospital.

18. Hospital staff said that Mr Goldburn had Barrett's Oesophagus (a condition where cells in the oesophagus (the tube between the mouth and stomach) grow abnormally). Hospital staff also treated Mr Goldburn for an infection and an acute kidney injury. (It is not known how he acquired this injury nor is there any further information about it.)

19. At 3.00pm on 5 July, the prison officers with Mr Goldburn asked a prison manager if they could remove the restraint because Mr Goldburn needed to shower. At 3.40pm, they removed the restraint and reapplied it after Mr Goldburn showered. That same day, Mr Goldburn had a blood transfusion because hospital staff said that he was anaemic (a low blood count). On 10 July, a prison officer noted that hospital staff had treated Mr Goldburn for inflammation in his stomach and that he was receiving IV antibiotics.

20. On 12 July, Mr Goldburn returned to Littlehey, having remained restrained with an escort chain for the whole time he had been in hospital.

21. On 24 July, a GP at Littlehey saw Mr Goldburn because he had had a cough for several days. Mr Goldburn was breathless, and his lungs sounded abnormal. The GP diagnosed him with a respiratory tract infection and prescribed him antibiotics.

22. On 25 July, Mr Goldburn's condition deteriorated. Mr Goldburn had abnormal lung sounds and could not speak in full sentences. Mr Goldburn had low blood oxygen

saturation and healthcare staff gave him oxygen. Mr Goldburn tested negative for COVID-19. A GP at Littlehey decided he needed to go to hospital.

23. Before Mr Goldburn went to hospital, staff completed an escort risk assessment. A nurse objected to the use of restraints and noted that Mr Goldburn had reduced physical ability which would affect him being restrained because of his age and mobility. Again, the senior prison manager authorised the use of restraints with no explanation as to why it was justified against medical advice. Two officers escorted Mr Goldburn and restrained him with a single cuff (the prisoner is handcuffed to a prison officer).

24. In hospital, Mr Goldburn tested positive for COVID-19. Hospital staff treated Mr Goldburn in an isolation room. A senior prison manager authorised that his restraints were removed as Mr Goldburn was now in isolation.

25. On 2 August, Mr Goldburn's condition deteriorated, and hospital staff said that he was end-of-life and placed him on a palliative care pathway. He died later that day.

Cause of death

26. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Goldburn's cause of death as COVID pneumonitis. Ischaemic heart disease, hypertension and aortic valve disease were listed as contributory factors.

Inquest

27. The inquest, held on 16 February 2024, concluded that Mr Goldburn died from natural causes.

Non-Clinical Findings

Restraints, security and escorts

28. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. It said that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

29. On 4 July, when Mr Goldburn was taken to hospital, staff completed a risk assessment. In the section filled in by the security department, they assessed Mr Goldburn as a medium risk to the public and low risk of escape. The nurse who filled in the medical section of the risk assessment, in response to the question "Does the prisoner have reduced physical ability that would affect the use of standard cuffs?", she circled 'yes', and gave the explanation "elderly and frail". The prison manager authorised the use of an escort chain to restrain Mr Goldburn, accompanied by two officers. In the comment section he wrote, "wheelchair user but could transfer, escort chain to be used". Mr Goldburn remained restrained until he returned to Littlehey on 12 July.

30. On 25 July, Mr Goldburn was sent back to hospital. In the section of the risk assessment completed by the security department, officers again assessed Mr Goldburn as a medium risk to the public and a low risk of escape. The nurse who filled in the medical section of the risk assessment, in response to the question "are there any medical objections to restraints?", answered "yes" and as an explanation wrote "frail, elderly and unwell." She also noted that Mr Goldburn used a wheelchair. A prison manager authorised that Mr Goldburn should be restrained with a single cuff. Staff later removed this restraint once Mr Goldburn had tested positive for COVID-19 and needed to be in isolation.

31. The investigator asked the senior prison manager why he had authorised restraints for Mr Goldburn. He said that if healthcare staff objected to restraints, he would speak to them to understand more before authorising restraints. He could not remember specifically making this decision on either occasion. On 4 July, he wrote that Mr Goldburn could transfer out of his wheelchair in the justification section on the form and on 25 July, he left this section blank.

32. It is hard to understand how the use of restraints could be justified with the presence of two able bodied prison officers in attendance. There were medical objections to restraints on 4 July and 25 July. The risk assessment should have spoken to the actual presentation of Mr Goldburn at the time of the assessment. The decision for Mr Goldburn to be restrained from 4 July to 12 July was excessively precautionary and an inappropriate use of restraints.

33. Following our investigations into two deaths at Littlehey in 2022, when both prisoners were unnecessarily restrained, HMPPS accepted our recommendations to ensure that restraint risk assessments considered the health and mobility of prisoners. They noted that healthcare and security departments would work closely to ensure restraints were proportionate. It is therefore particularly disappointing that Mr Goldburn was restrained. We make the following recommendation:

The Operational Security Group Director for HMPPS should monitor compliance with policy on the use of restraints during hospital escorts (for inpatient admissions and outpatient appointments), including at HMP Littlehey, and discuss the findings with the Ombudsman.

Good practice

34. The support and compassion provided by the family liaison officer during the deterioration of Mr Goldburn's health and after his death was commendable. The family liaison officer demonstrated efforts that went above and beyond in her communication with the next of kin.

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

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