# INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF A MAN IN HOSPITAL IN OCTOBER 2004 WHILST IN THE CUSTODY OF HMP BULLINGDON

**Report by the Prisons and Probation Ombudsman for England and Wales**

**August 2005**

This is the report of an investigation into the circumstances of the death of a man in hospital in October 2004. The man was a serving prisoner at HMP Bullingdon and, at the time of his death, was four years into a 13-year sentence.

The post mortem revealed that the cause of death was sepsis, pneumonia and haemangioblastoma (brain tumour). The man had been taken to the local hospital on 25 July 2004. On 4 August, he was transferred to another hospital, where he began a course of radiotherapy. He continued to be unwell and remained in hospital until he died.

The investigation was carried out on my behalf by one of my colleagues and my deputy ombudsman carried out the clinical review. The investigator and one of my family liaison officers met with the man's elderly mother and the family liaison officer kept in touch by telephone. I offer my sincere condolences to the man's relatives and friends.

The findings of this report speak for themselves. Having recovered well from brain surgery in January 2001, the man was only required to attend hospital on a regular basis for scans. In May 2002, a scan revealed a further growth. No further treatment was deemed necessary at the time but it remained imperative that regular scans were undertaken to monitor developments. After Bullingdon failed to ensure his attendance for five rescheduled scan appointments in 2003-04, his consultant wrote to the prison in February 2004 to express his concerns. When a scan finally took place in June 2004, the tumour was found to have grown and surgery was immediately undertaken. However, the extent of the growth meant the man never fully recovered.

I make six recommendations.

**Stephen Shaw**
**Prisons and Probation Ombudsman** **August 2005**

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**Summary**

The man died in hospital in October 2004, aged 61. He was serving a 13-year sentence at HMP Bullingdon. He died from sepsis, pneumonia and a recurrent brain tumour. At the time of his death, he had been outside of the prison in two hospitals since 25 July 2004.

In January 2001, the man had been diagnosed with a brain tumour and was operated on immediately. He recovered well, and by March the only ongoing treatment required was six monthly MRI scans to monitor any changes. A scan in May 2002 showed some recurrence, although no treatment was deemed necessary at that time. However, between July 2001, when the first follow-up scan took place, and his admission to the local hospital on 15 June 2004, he had had only three scans, the last being on 23 October 2002.

The man did not attend a number of hospital appointments during this period. Records indicate that on a number of occasions the appointments were missed because the prison could not staff the escorts.

For some considerable time, he continued to suffer from headaches and other health problems. Given that he had to go for long periods of time without being scanned, it is not surprising that, according to his prison visitor, he felt 'powerless, and just had to wait'.

On 16 June 2004, he had a MRI scan, some 20 months after his last scan. The imaging revealed a sizeable tumour recurrence and so on 25 June he underwent surgery for the second time. Unfortunately, his lung collapsed during surgery and the operation was halted prior to the removal of the tumour. He declined to have further surgery opting instead to undergo radiotherapy. He returned to Bullingdon on 2 July. Another hospital appointment on 14 July did not go ahead as no escort had been arranged. On 25 July, he had a large rectal bleed and was taken to the Hospital Accident and Emergency Department. On 4 August, he was transferred to another hospital and assessed for radiotherapy. This commenced on 16 August. His condition continued to decline.

A clinical review of his treatment found that he was promptly referred to secondary services when he first began to experience symptoms that proved to be consistent with abnormal neurological pathology.

## Investigation Process

My investigator undertook a review of all the deceased's records, including his medical records. In addition, she visited HMP Bullingdon and spoke with staff from healthcare and detail. Formal interviews were not undertaken. The prisons Independent Monitoring Board (IMB) were contacted by telephone and did not raise any concerns in relation to his case or HMP Bullingdon in general.

In response to publicity material within the prison about the investigation, the man's prison visitor wrote to my office. Subsequently, she has spoken on a number of occasions with my investigator. In addition, my investigator has spoken with the secretary of the man's consultant neurosurgeon and with the man's solicitor.

The man's next-of-kin, his mother, was visited at home by my investigator and family liaison officer and has maintained contact by telephone. A clinical review was carried out by my deputy ombudsman and was based on a review of medical records.

**HMP Bullingdon**

Bullingdon Community Prison is a category B local and training prison for convicted and unconvicted adult male prisoners, serving courts in Oxfordshire and Berkshire. Opened in 1992, it is a 'new gallery' prison by design, with its four main houseblocks divided into three galleried units. The original house blocks have been supplemented by a fifth since April 1997. There are single, double and triple cells. Bullingdon has a healthcare centre that has 22 in-patient beds and provides 24-hour medical cover.

Edgcott wing, where the man resided, operates as the sex offender treatment unit and houses a population generally older than the rest of the prison. In 2005, the unit began operating a scheme which allowed the older (over 65) and infirm prisoners the opportunity to have additional time out of their cells, over and above association time, so that they could have access to the unit facilities during the core day. Such a development was prompted by the concern that in one period of association they were in competition with younger more able-bodied prisoners for the facilities available. This is a very welcome development. However, it was not in place when the man was a resident on the wing.

**The events leading up to the man's death**

The man was received into Bullingdon on 17 June 2000 and underwent a routine health screen. No physical health problems were recorded. However, he stated that his optician had told him that he had a tumour behind his right eye. This was subsequently followed up with a phone call to his optician who felt that any degeneration seen was likely to be age related.

Court staff had placed him on a suicide and self-harm monitoring system (F2052SH), because of the serious nature of his offences. During the reception process, he said that he suffered from depression and was very distressed to be in custody. He was therefore admitted to healthcare for a period of observation. On 26 June, he was deemed fit by the doctor and was placed on wing location. His F2052SH was subsequently closed on 14 July when the risk was deemed to have passed.

The man first started to complain of suffering from dizzy spells in August 2000. After further episodes of dizziness, vomiting and headaches, he was referred to a consultant neurologist on 20 November. On 22 November, he was admitted to healthcare for observation following a spell of vomiting. The man returned to ordinary location, at his own request, on 27 November. On 2 December, wing staff relayed their concerns to healthcare about him, as he was very unsteady on his feet, vomiting and losing weight. He was admitted again on 9 December. On 11 December, the consultant neurologist examined him in the prison and requested tests that were subsequently carried out. Unfortunately, there is no letter on file from the doctor and it is not clear what, if any, was his diagnosis. The man returned to the wing on 15 December. Records indicate that he preferred to be treated on the wing than stay in healthcare. This appears to have been because he favoured the relative comfort of his own cell.

On 1 January 2001, again following concerns expressed by wing staff, he was admitted to healthcare. On 8 January, the prison doctor contacted the consultant neurologist and it was agreed that the man needed to be transferred to the local hospital immediately for assessment. The man was found to have a brain tumour. The following day a shunt was inserted, and on 16 January a 'relatively benign' tumour was removed. The man returned to Bullingdon on 23 January, having progressed well following surgery. He told staff that he had no memory of the two months prior to his operation.

The man recovered well. A discharge report from the consultant neurosurgeon, dated 7 February, stated that the only further treatment required was monitoring using repeat MRI scans every six months. He was seen by the consultant neurosurgeon for a follow-up appointment on 28 February and was noted to be much improved since his admission to hospital. However, he was experiencing some persisting problems with dizziness, poor concentration and double vision. The surgeon hoped that these symptoms would gradually settle down.

In early March, the man was deemed fit to attend his trial. On 5 March, his solicitors wrote to the prison stating that the Judge had requested that an alternative, more comfortable, form of transport be arranged. The man had been finding that travelling in the custodial van was causing him a great deal of distress due to his recent surgery. The prison replied on 13 March stating the 'we have arranged for your client to be transported in a people carrier with our escorting agency'. It is not clear from when he started to be taken by people carrier.

In March 2001, the man was found guilty. Again he was placed on an open 2052SH, but this was closed the following day as he was not found to be expressing any self-harm intentions. On 22 March, following a further collapse he was referred again to the consultant neurosurgeon. He was admitted to hospital for three days on 24 March for further tests which did not reveal any abnormality. His solicitors requested a report from the medical staff at Bullingdon to assess whether there were any medical implications to consider prior to the Judge passing sentence. The report concluded that the man was 'completely fit to undergo any sentence' and on 11 April he was sentenced to 13 years imprisonment.

On 20 April, he was deemed fit for ordinary location. The man continued to experience problems with his vision, and being unsteady at times, but this was put down to his earlier difficulties. Following a visit to him on the wing on 26 April, there is an entry in his continuous medical records indicating that he had been finding it difficult to carry his food plate and manage the stairs. On 7 June, education staff contacted healthcare regarding his worsening double vision. The man had apparently been told to expect this when last in hospital. His healthcare notes indicate that wing staff were informed about the double vision. However, there was no corresponding entry in his wing history sheets.

At this juncture, it is worth noting that the medical records do not provide a clear record of events. Appointment letters were not always noted in the file and in some cases it was difficult to know whether appointments were attended or not. The Local Inmate Data System (LIDS) has been used by my investigator as a final check to see whether or not the man left the prison. In a couple of cases this provides the only confirmation of attendance at hospital appointments. In addition, my investigator spoke with the consultant neurosurgeon's office and they were able to provide further confirmation of attendances.

There is an appointment letter on file for a scan due for 4 July 2001 and an entry in the IMR which appears to read 'fit hosp appt'. LIDS indicates that the man attended the appointment. However, there are no other references to this appointment or what the results were. The man had another appointment on 25 July but the prison cancelled this on 9 July, as the hospital had sent the letter direct to him rather than to the healthcare department. This was entirely appropriate. According to the medical record, an appointment for 5 September was given over the telephone. However, it seems that he attended for follow up appointment on 8 August 2001 and the results of the (July) scan were good according to the report from the escorting officer.

Consequently, he was asked to attend another scan in six months. Once again there is no corresponding commentary in the medical record.

A scan appointment on 2 April 2002 again had to be cancelled as the hospital had sent the appointment directly to the man. The rearranged appointment went ahead on 20 May. The man had a follow-up outpatient appointment on 7 August 2002. There is no corresponding entry in his continuous medical record. A letter referring to that appointment, dated 5 September, states that 'his repeat MRI scan showed a recurrence of tumour. There has been an increase in size of cystic component with the previous scan done on 04.07.01.' However, as there was no immediate risk of clinical deterioration it was felt appropriate to scan again in six months. There is an appointment letter for a scan on 23 October but no indication in the IMR of him attending. However, LIDS confirmed that he did attend.

On 15 January 2003, the man attended for a follow up appointment for the October scan. The hospital escort report, which is completed by the officer who attends hospital with the prisoner, is detailed and lengthy. It states that 'as there are no adverse symptoms at present, the tumour will continue to be monitored, as there are dangers with potential surgery. If there are future problems such as worsening balance particularly on the left side then surgery would become necessary. There will be a future MRI scan to be arranged in summer 2003'. None of this information was transferred to his continuous medical records.

An entry on 28 January reads ' due repeat MRI scan Aug 03 – to watch symptoms in meantime'. The letter from his consultant neurosurgeon in relation to the scan states 'his difficulty with balance, memory and intermittent confusion continue...at this point in time it is unlikely that we will see any obvious improvement in that. We have been monitoring his general progress with repeat imaging and have been aware of some re-growth of the cerebellar haemangioblastoma on the left hand side...he would rather not have surgery done at the present time and he would rather wait and see if he should get any recurrence of symptoms.' The neurosurgeon finished by saying 'I have left it therefore that I will arrange for a repeat scan to be done in the summer but, should he get increasing problems meantime with balance, difficulty with his left side, any change in headaches or more confusion, then I would be grateful if you could let us know straight away then we can deal with it'. An entry in his medical record on 25 February states 'on Sat 23.2.03 – sudden loss of vision left eye – vision came back after 1 hour. Letter to the consultant NB NO DOUBLE CUFFS'. There is no letter to the consultant on file or any suggestion that a follow up telephone call was made.

The man reported that he was suffering from constant headaches and nausea on 23 April. On 25 April, a prison doctor, from Bullingdon, wrote to the consultant neurosurgeon, explaining that the man had experienced two periods of loss of vision in February and April. He asked whether it 'would be sensible to have an MRI scan of him before you see him on 9 July or sooner?' There was no reply on file or any indication that healthcare staff made a follow-up call. There was a letter for a scan on 7 July, which had been

crossed out and replaced with 21 July. There are no further entries in the medical record until 23 July 2003. On that day there is an entry which reads 'cock up did not attend OPA'. This entry is assumed to be related to the appointment on 21 July. There was a letter for an appointment for 9 July with the consultant neurosurgeon which had been crossed out, and 6 August put in. A note indicates that this was rescheduled by the hospital.

The man was seen at the neurosurgeon's clinic on 6 August. The letter relating to this meeting was typed on 3 September. Having missed the MRI scan in July, the doctor suggests that he review him again after a rescheduled MRI on 1 September. There is no appointment letter on file for 1 September or any reference anywhere, so it is unclear whether the prison was aware of this appointment. There is a MRI appointment letter for 25 September. Again, this has been crossed out and 'already booked/needs changing/cancelled' written across it. A new appointment for 31 October is written in. The appointment letter for 31 October has 'cancelled' on it and 'detail can't staff'. The continuous records indicate that a new MRI appointment was made for 5 January 2004. A letter for an appointment with the neurosurgeon for 12 November is crossed out and 10 March 2004 is written. This appointment is to discuss the results of the scan on 5 January. Written across the appointment letter for the MRI scan on 5 January is 'didn't go – staff shortages, hospital to ring back with new date'.

On 4 February 2004, the neurosurgeon wrote to healthcare expressing concern that the man had 'been sent five appointments all of which have been cancelled by the prison, many of which I am told on the day of the scan'. He added that 'any difficulties regarding this (the next appointment) I would be happy to speak with Prison Authorities and explain the importance of carrying out these investigations'. He sent the governor a copy of the letter. The head of healthcare replied the same day saying 'we have been unable to escort the man to hospital due to security issues and/or more urgent medical escorts being prioritised'. On 19 February the clinical nurse manager, also replied to the consultant neurosurgeon. Having apologised for the cancellations, she explained that 'several of the cancelled appointments have been caused by staff shortages. This is a problem which we encounter on a regular basis and have to try to manage through rearranging hospital appointments'. The clinical nurse manager put an entry in the man's medical record stating that he must attend his out patient appointment on 10 March. The man's mother also wrote to the prison on 9 March complaining about the missed appointments. Although there is a reference to a reply in the paperwork, there is no copy of any letter in the medical records.

The man was seen on 10 March 2004 in the outpatient clinic. However, given that he had missed his last scan the consultant was unable to monitor any changes to the tumour. The doctor's letter explained 'need to make sure he attends the next appointment as it is very essential in order to follow up his tumour. He will be reviewed in the clinic after the MRI scan has been performed'. There are no further appointment letters on his file.

The continuous record sheet indicates that on 31 March the hospital were telephoned regarding an appointment .The hospital informed Bullingdon that a new scanner was being fitted and that they would contact the prison in May with a new appointment. On 13 May, staff rang the hospital again and were told that there was a backlog and they would receive an appointment within two months. On 3 June, the neurosurgeon's secretary was telephoned directly and a message left asking for help to speed up the appointment for the man. The MRI scanning unit at the hospital was also telephoned and prison staff were told that someone would look into the problem.

On the same day, 3 June, the man was seen on the wing and said he had not eaten for three days. Standing up seemed to make him feel worse so he remained in bed. The nurse said she would visit him the next day. There was no mention of a visit taking place in either the medical record or his wing sheet. In fact, after January 2003 there is only one entry in his history sheet relating to his ill health and that is on the 6 June 2004, 'nurse visited him at treatment time. Was vomiting and had been on a regular basis for 1 week. Said she would put this to the doctor for tomorrow'. The man was seen by the doctor on 7 June, but did not want to be admitted to healthcare.

Between 4 and 8 June, prison staff made a number of attempts to get through to the neurosurgeon's office. Eventually, on 8 June they did speak to his secretary and she agreed to speak to the doctor. Following several conversations, on 15 June it was decided that the man would be admitted to the local hospital that day. He reported suffering from headaches, nausea and some unsteadiness of gait. On 16 June, he had a MRI scan. This was some 20 months after his last scan. The imaging revealed a sizeable tumour recurrence. The man underwent surgery on 25 June. Unfortunately during surgery, his lung collapsed and the operation was halted prior to the removal of the tumour. Post operatively he was treated with intensive physiotherapy and his lung re-expanded. The man declined to have further surgery and wanted to try other methods of treatment. He was therefore referred for radiotherapy to explore whether this was a feasible treatment.

The man was discharged back to Bullingdon healthcare on 2 July. This seems a somewhat surprising course of action given that healthcare staff were told on 1 July by hospital staff that he 'remained unwell. Plan: The man will remain at the hospital Infirmary until he has had a further scan and his radiotherapy treatment has been decided'.

On 11 July, the man collapsed in his healthcare cell after losing his balance. He did not sustain any injuries. On 14 July, he was due to attend a hospital appointment. This did not happen because 'no escort was arranged'. On 21 July, the man saw the consultant regarding radiotherapy and he consented to treatment. It was expected to start in 4 – 6 weeks.

The man remained in the healthcare centre at Bullingdon. Following a large rectal bleed, he was taken to the Accident and Emergency department of the local hospital on 25 July. A nurse telephoned his mother to explain about his admission and passed on the hospital's phone number. On 26 July, the

prison undertook a hospital escort risk assessment. It was decided that as the man was deemed too ill to attempt escape, only one bedwatch officer was required. On 28 July, the man underwent a laporotomy and the bleeding artery was sealed. However, he was very weak due to the amount of blood lost. He was unable to walk or stand unaided and was suffering from painful pressure sores.

On 4 August, he was transferred to another hospital to undergo an assessment for radiotherapy. In light of his poor condition, the consultant wanted to start the radiotherapy as soon as possible and he was admitted to the Cancer Unit. Given the move to another hospital, a further risk assessment was undertaken by the prison and it was felt that that the escort arrangements should remain unchanged. The man remained physically weak and developed a chest infection. However, he was able to begin his radiotherapy sessions on 16 August. The bedwatch report indicates that he was able to leave his bed in a wheelchair for the first time on 25 August.

On 1 September, a Sister visited the man in hospital. The Sister noted that he had received eleven sessions of radiotherapy and was having physiotherapy. He was frail and unable to walk. The Sister telephoned his mother after the visit. The next contact with the hospital was on 13 September by telephone. It was noted that he was very tired from the radiotherapy, and that physiotherapy was not being undertaken as he was too weak. On 24 September, a review of the escort arrangement was undertaken following a view that there was a change in his medical circumstances, as he was bed bound. The escort remained unchanged. The document indicates that the reviewing governor had 'asked the resettlement manager to review the prisoner's security category based on his positive behaviour with a view of downgrading'.

The next entry in his medical record is on 30 September, after he is reported to have suffered a seizure. On 1 October, release on temporary (compassionate) licence (ROTL) was considered by the prison and not recommended. On the same day, an application for him to be re-categorised from a B to a C category prisoner was considered and rejected. On 5 October, the hospital contacted staff to say that the man's condition had deteriorated. The man was unresponsive and the hospital had withdrawn active treatment. Another review of the escort arrangements was undertaken. It concluded that the bedwatch officer should no longer stay in the room but be available for hospital staff if needed. The hospital had contacted his mother to advise that if she wanted to visit she should do so now. His mother was able to visit. Her son died on 7 October.

## Issues considered during the investigation

Medical records

The man's medical records were sometimes difficult and time consuming to review. The continuous medical record does not provide a commentary of all that happened to him and on occasions it was difficult to know what happened.

Missed hospital appointments

In January 2001, the man underwent surgery to remove a 'relatively benign' tumour. In May 2002, a further growth was found. The table below shows the various appointments for both MRI scans and outpatient appointments made for him from February 2001 to June 2004. The system that the consultant neurosurgeon, chose to adopt was for him to have a MRI scan and for the results of this scan and future treatment options to be reviewed in an outpatient appointment shortly after the scan. It was therefore important for him to attend the two 'types' of appointments. They were scheduled at approximately six monthly intervals.

| Narrative | Date of MRI scan | Attended? | Date of outpatient follow up | Attended? |
|---|---|---|---|---|
| Surgery to remove tumour | 08/01/01-23/01/01in hospital | | | |
| 1st follow up appointment | | | 28-Feb-01 | YES |
| Admitted to hospital for tests | | | 24/03/2001 for 3 days | |
| 2nd follow up appointment | 04-Jul-01 | YES | 25-Jul-01 rescheduled 08-Aug-01 | NO (hospital wrote direct to the man) YES |
| 3rd follow up appointment | 02-Apr-02 Rescheduled 20-May-02 | NO (hospital wrote to the man direct) YES | 07-Aug-02 | YES |

| | | | | |
|---|---|---|---|---|
| 4th follow up appointment | 23-Oct-02 | YES | 15-Jan-03 | YES |
| | | | | |
| The man complaining of headaches and nausea | Letter written from Bullingdon to consultant neurosurgeon 25 April 03 suggesting Summer scan brought forward | | | |
| | | | | |
| 5th follow up appointment | 07-Jul-03 | NO (no reason given) | 09-Jul-03 | NO (cancelled by hospital) |
| | rescheduled (once) | | rescheduled | |
| | 21-Jul-03 | NO (prison error, stated mis-filed and therefore overlooked) | 06-Aug-03 | YES (but neurosurgeon states needs results of scan to assess) |
| | rescheduled (twice) | | | |
| | 25-Sep-03 | NO (not clear, escort staff may already have been fully booked) | | |
| | rescheduled (three times) | | | |
| | 31-Oct-03 | NO (cancelled due to escort staff shortages) | 12-Nov-03 | NO (cancelled due to escort staff shortages) |
| | rescheduled (four times) | | rescheduled | |
| | 05-Jan-04 | NO (cancelled due to escort staff shortages) | 10-Mar-04 | YES (but consultant neurosurgeon states needs results of scan to assess) |
| | | | | |
| This last cancellation resulted in a letter from the consultant (dated 4 Feb 04) to the in charge medical officer complaining about the cancellation of five scans and stressing the importance of the man attending. | | | | |
| Reply from clinical nurse manager apologises for the missed appointments and states that several of the cancellations were due to escort staff shortages. She indicates that she has given instructions that the man must attend his next appointment on 10 Mar 04. | | | | |
| The man's mother also wrote (9 Mar 04) to the prison complaining about the hospital appointments that her son had missed. It is not clear what reply was sent, if any. | | | | |
| | | | | |

The table shows that in 2001 and 2002, the man had two appointments rescheduled because the hospital had, by mistake, written directly to the man. Appointments for prisoners to attend hospital are not normally disclosed to the prisoner until the day of their appointment. This is in order to reduce the risk of an escape attempt being planned in advance for a particular day. The man's last MRI scan in 2002 was on 23 October.

In 2003, stretching into January 2004, the man had five appointments for a MRI scan. All five were cancelled by Bullingdon. It is not clear what the reasons for the cancellations were, but there were several entries in his medical file indicating that it was due to escort staff shortages. My investigator spoke to the detail manager (responsible for day to day escort staff arrangements) and administrative staff who work in healthcare. The healthcare administrative staff are responsible for providing the detail office with the paperwork relating to an outside hospital appointment, and the detail office are then responsible for providing the necessary staff for the escort. My investigator specifically looked at two of the missed appointment dates with the detail manager, 31 October 2003 and 5 January 2004. The reply sent by healthcare to the neurosurgeon's letter in February 2004, expressing concern about the number of appointments the man had missed, indicated that the reason he was not taken to hospital was staff shortages. The detail manager checked the staffing levels on the two dates and said that staff were available to take the man to hospital. The detail manager went on to say that even if there were staff shortages, escorts would not be cancelled. He said that another element of the prison regime would be curtailed instead.

Whatever the reason, it is unacceptable that the man was not taken to hospital on any of the five dates on which he had appointments made for him.

The current escort arrangements at Bullingdon allow for two hospital appointments each day, one in the morning and one in the afternoon, and if these are already booked healthcare have to try to book another appointment with the hospital. Problems arise when the appointments are deemed urgent and it becomes imperative that the prisoner attends. If this is the case, the paperwork is sent to the healthcare manager or clinical staff and if necessary a decision has to be made regarding which is the most urgent. Frequently, it will be necessary for both prisoners to attend their appointments and negotiations will take place with detail.

Decisions about cancelling a hospital escort versus curtailing an element of the prison regime in order to free up additional staff should only be taken by the duty governor. The duty governor should consult with medical staff who are appropriately qualified to determine the level of urgency of the appointment.

Incentives and Earned Privileges Scheme

Some documents in the man's file indicate that he was on the enhanced level of the Incentives and Earned Privileges Scheme (IEPS) at the time of his death. However, upon examination of his file my investigator found that he was on standard level at the time he was taken to hospital in July 2004.

Consideration of the IEPS is an issue about the quality of life rather than one thought to have had a direct impact on his death. However, I believe it should be examined given the nature of the man's on-going illness which impeded both his ability to engage in any out of cell activities and to take adequate care of himself. These factors do not consistently appear to have been considered when reviewing his sentence planning targets in relation to which IEPS level he should be on. My investigator, therefore, examined the documents in the man's file relating to the IEPS scheme and his sentence planning, as well as Prison Service guidance and Bullingdon's own policy.

According to the Prison Service Order (PSO) 4000 (p.17), 'Incentives and privileges need to be compatible with sentence planning objectives, appropriate to the needs and capabilities of the prisoner and set by staff involved in both activities. In particular when linking incentives and privileges with sentence planning the following questions need consideration:

- is the sentence plan appropriate in terms of the prisoner's needs and what can be realistically expected of him/her?

- have efforts been made to engage the prisoner in sentence planning and to motivate him/her?

Thus a prisoner who participates in and complies with the sentence planning and targets set should reasonably expect to advance to, or retain, higher levels of privilege. Conversely, someone failing to cooperate may reasonably be downgraded in accordance with local criteria.' Bullingdon's own policy reiterates that the 'scheme will be linked to assessments, sentence planning and prisoner compacts'.

On 4 April 2002, the man did achieve enhanced status. This seemed to have been a controversial decision for some officers on his wing. Eight entries in his wing history sheet at the time comment on his unsuitability for enhanced status mainly because he was '*not addressing his offending behaviour'*. At a review of his enhanced status in June, one officer ticked 'yes' to the question 'is he complying with his sentence planning?' and 'no' to the questions 'is his cell/appearance acceptable?', and 'is his behaviour to an acceptable standard of an enhanced prisoner?' At the next review in July, an officer had answered 'yes' to the questions where the previous officer had answered 'no', and given a 'no' answer where previously there had been a 'yes' answer. There are no other reviews on file. On 16 October 2002, the man was returned to standard '*due to refusing SOTP'*.

The man's first sentence plan in June 2001 set targets for attending courses associated with his offending. The man was appealing against his conviction. However, there is no evidence to suggest that this was viewed as incompatible with attendance on the courses. The man also agreed to attend. However, at that time these courses were unavailable on his wing within the prison. Consequently, one of the targets centred on a transfer to HMP Rye Hill where the courses were available. However, he was on a 'medical hold' and therefore unable to be moved until this was lifted.

At his sentence planning review in June 2002, it was acknowledged that none of his targets had been met due to his health problems. By this stage he had reached enhanced status. There is no sentence planning review on file for 2003. In his sentence planning review in March 2004, his personal officer stated that 'he isn't a problem on the wing…his health problems are his main problem and because of this he can't address his offending behaviour and also has an appeal pending'. One of the targets set was to reapply for enhanced status.

Entries in the man's wing history sheet in October and December 2002 indicate that he was not happy about being downgraded to standard. Records indicate that he applied again in June and October 2003 and January 2004 and continued to be unsuccessful. In June 2003, enhancement was refused because 'he is usually to be found in his bed and rarely leaves the cell'. In October 2003 and January 2004, his lack of attendance on offending courses was given as the reason. However, his DCR review in June 2002 stated that 'due to his health it was felt it was an inappropriate time to attend SOTP' and with regard to any long term action plan stated 'due for operation – no date as yet. Long term plan very dependent on results of above.'

The man's record indicates that the last time he applied for enhanced was on 16 March 2004. His wing senior officer recommended his application. On 1 April he was informed that it had been denied 'due to personal hygiene reasons. Re-apply 28 days.' According to Bullingdon's policy, those on the standard regime '*will receive a regime review every four weeks'.* There is no evidence to suggest that he was subject to any further reviews whilst he remained at Bullingdon.

The tidiness of his cell and his personal presentation were commented on in his history sheets with varying degrees of emphasis and with some recognition that at times there were improvements. The impact of his poor health on his ability to look after himself, and present positively, do not appear to have been considered or views sought from healthcare. In 2001, records indicate that wing staff were very proactive in contacting healthcare in relation to the man's deteriorating health. However, if advice was sought after 2001, it is not recorded and therefore difficult to assess whether wing staff were aware of any behavioural implications of his illness.

I note that in her 2004 inspection report, HM Chief Inspector of Prisons recorded that the prison had recognised that the IEPS required a thorough review which it had started to develop. However, HM Chief Inspector said that

‘there was no consistency across the wings in the standards required from prisoners or how suitability to be upgraded was decided’. She also found ‘evidence that IEPS reviews were not held regularly’.

Release on temporary licence

Prison records indicate that the man’s release on temporary (compassionate) licence (ROTL) was considered on 1 October 2004. The form indicates that ‘the man has been seriously ill in hospital for several weeks now with the minimum of supervision. He is to remain in hospital for the foreseeable future and poses no threat to himself, victims or hospital staff’. Given that he had been in hospital since 25 July with the same escort arrangements, it is somewhat surprising that this had not been considered earlier. Part of the ROTL process involved gathering information from a number of sources, including wing staff. The paperwork indicates that wing staff supported the application for ROTL. The board have to take into account a wide range of factors and the chair of the board did a ‘for’ and ‘against’ list.

The ‘for’ column listed – 1st custodial, has completed many SOTP (Sex Offender Treatment Programmes) assessments, is willing to complete OBP’s (Offending Behaviour Programmes) but has been unable to engage due to illness, no security information, he is very unwell and incapitated by his illness and has been supervised by one officer for a long period of time. The ‘against’ column listed – serious nature of offence, only 3 1/2 years into 13 year sentence, cat B until 1-10-05 – awaiting results of review, has not completed any OBP’s, nature of offence gives rise to concern from security department and risk protection team – risk of harm to children, duty of care to him – if he’s left unescorted and comes to harm whilst in our custody, media interest – potentially negative publicity if media become aware of this, no contact with outside probation.

On balance, having undertaken the risk assessment, the board did not recommend ROTL. Given all the evidence available to the board, this was a risk-averse but not an unreasonable conclusion. However, of concern is that it is not clear from the document whether the board had an up-to-date medical assessment or were given any detailed account of his prognosis by medical staff. There is nothing on file to indicate that they were. Such knowledge might have altered their decision.

Once the board has made their decision, the form has then to be passed to the governor in charge for their assessment and recommendation. The form is not countersigned and therefore it has to be assumed that a governor’s assessment was not sought. The ‘Notification of Decision on application for release on temporary licence’ is not completed and, as such, it is not clear whether the man would have been made aware of the decision.

On the same day, an application for the man to be re-categorised from a B to a C category prisoner was considered. The document suggests that his ill health prompted a review of his categorisation. The application was rejected. The reason given was ‘the man is only 3 and a ½ years into a 13 year

sentence for a very serious offence. He has not completed any offending behaviour programmes due to his illness and therefore there has been no significant reduction in risk.'

Contact with the man's next of kin

The man's mother was his next of kin. She is elderly, but had managed to visit her son in hospital a few days prior to his death and was informed of his passing by hospital staff. The duty governor faxed the man's mother local police station to request that they visit her as he was concerned that she might be on her own and distressed when receiving the news of her son's death. This was sensitively handled by the duty governor. Bullingdon's chaplain spoke with the man's brother who was supporting his mother. A member of the chaplaincy informed the man's friends within the prison.

However, the man's mother told my family liaison officer that she had not received any further contact with the prison subsequent to her son's death. She had not had a letter of condolence or any offer of help with funeral expenses. By the time my colleagues visited, the funeral had taken place and his mother was very anxious about how she was going to pay for the funeral. She then approached the prison and funds were forthcoming. However, it would have been right for the prison to have made the offer without waiting to be asked.

**Findings and recommendations**

Documentation suggests that a number of hospital appointments were cancelled due to staff not being available to cover the escorts. However, on at least two dates, there were adequate staff available in HMP Bullingdon.

**The governor, in partnership with the local Primary Care Trust, should develop and implement a clear policy for attending external hospital appointments, the circumstances in which an appointment may be cancelled and the action to be taken in this event**.

**Regular audits to monitor how many appointments have to be rebooked and how many are cancelled should be undertaken and staffing levels adjusted accordingly.**

Reviews of the man's level of incentives and earned privileges did not take account of information and judgements made in his sentence planning.

**In line with it's own policy, HMP Bullingdon must link the IEPS with sentence planning and regular audits should be undertaken to ensure that this is done.**

In accordance with PSO 2710, consideration should be given to communications with the family of the deceased. In this case, this was not done and his next of kin suffered unnecessary anxiety as a result.

**The governor should remind all her managers that contact with the next of kin must be given high priority and conducted in accordance with PSO 2710. Consideration should be given to select members of staff undergoing dedicated training in family liaison.**

The clinical review makes two additional recommendations:

**All nursing documentation must be completed in accordance with the NMC Guidelines for Records and Record Keeping. Audits of the quality and consistency of records and record keeping should be undertaken in partnership with the Primary Care Trust on a regular basis.**

**A significant event audit should be undertaken by the prison to establish why so many appointments were cancelled due to staff shortages, thus compromising the health of the man and to establish what lessons can be learnt to prevent recurrence.**