



**Independent investigation report by the
Prisons and Probation Ombudsman
Nigel Newcomen CBE
into the death of Mr Merrison,
a prisoner at HMP Bure,
in March 2015**

Our Vision

*To carry out independent investigations to make custody
and community supervision safer and fairer.*

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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Merrison died of a heart attack in March 2015, while a prisoner at HMP Bure. He was 84 years old. I offer my condolences to those who knew him.

When Mr Merrison first arrived at Bure, he had an outstanding cardiology referral, which was not pursued, and there were further times when GPs identified a need for a cardiology referral that were not actioned. Although he eventually saw a cardiology consultant, and the clinical reviewer was satisfied that the delay did not affect the outcome for him, it is important that referrals to specialists are dealt with promptly. Overall, I am satisfied that he received a good standard of care at Bure with frequent and committed input from the healthcare team, who could not have done anything to prevent his death.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

September 2015

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SUMMARY

Events

1. Mr Merrison was sentenced to life imprisonment in 1981 and spent time in a number of prisons. On 5 February 2013, he transferred from HMP Kingston to HMP Bure.
2. When Mr Merrison arrived at Bure, he had a number of health conditions including coronary artery disease, heart failure, cellulitis and leg ulcers. A nurse at Kingston had referred him to a cardiologist, on 17 September 2012, but he had not received an appointment by the time of his transfer. When he arrived, no one checked the progress of this referral or referred him to a local hospital, although a GP noted that he planned to do so.
3. During 2013 and 2014, healthcare staff treated Mr Merrison's leg ulcers, and in June 2014 referred him to a vascular specialist, but he was unsuitable for surgery. In June 2014, a locum GP suggested a referral to a cardiac specialist but this was not done until another GP referred him in September. In November 2014, he had an echocardiogram, which showed mild impairment of his heart.
4. Healthcare staff at Bure prescribed appropriate treatment for Mr Merrison's conditions and reviewed him frequently, often daily. However, he did not cooperate with healthcare advice and was a challenging and difficult patient. In February 2015, his health declined quickly and he was admitted to hospital on 18 February. He died in hospital in March.

Findings

5. The clinical reviewer concluded that the man received a good standard of care at Bure and commended the holistic approach by staff, their repeated efforts to improve his compliance and the provision of almost daily nursing care. He did not consider that the delays in referring him to a heart specialist materially altered the outcome. Nevertheless, these should have been acted on.

Recommendation

- The Head of Healthcare should ensure that prisoners are promptly and appropriately referred to specialists, as necessary and that referrals are followed up.

THE INVESTIGATION PROCESS

6. The investigator issued notices to staff and prisoners at Bure informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
7. NHS England commissioned a clinical reviewer to review Mr Merrison's clinical care at the prison.
8. The investigator obtained copies of relevant extracts from Mr Merrison's prison and medical records. She and the clinical reviewer interviewed five members of staff at Bure, and one member of staff at HMP Norwich, on 22 April 2015.
9. All staff working in prisons need to be aware of the role of the Ombudsman and that they are expected to cooperate fully with investigations into deaths. However, it was evident that Virgin Care was unaware of the level of cooperation required and the investigator encountered some difficulties obtaining statements from healthcare staff and getting them to attend interviews. These difficulties were resolved during the investigation.
10. We informed HM Coroner for Norfolk of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
11. The draft report was issued for consultation with the Prison Service. They provided an action plan to address the recommendation. This report has been amended accordingly.
12. Mr Merrison did not have any known family and did not name anyone as his next of kin. We were therefore unable to involve his family in this investigation.

BACKGROUND INFORMATION

HMP Bure

13. HMP Bure is a medium security prison near Norwich, which holds approximately 520 men, convicted of sexual offences.
14. Virgin Care provides healthcare services, commissioned by NHS England. Healthcare staff are on duty between 8.00am and 6.30pm, Monday to Friday and between 8.00am and 5.30pm at weekends. NHS 111 and Medicom provide out of hours services. There are five GP clinics each week.

Her Majesty's Inspectorate of Prisons

15. The most recent inspection of HMP Bure was in May 2013. The inspection took place before Virgin Care took over the healthcare contract. Inspectors found prisoners were very positive about the standard of healthcare and treatment they received, particularly from nurses.

Independent Monitoring Board

16. 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 July 2014, the IMB reported that since Virgin Care had taken over, there had been a number of problems with the provision of healthcare, including a lack of GP cover, a considerable shortage of nursing staff, irregular pharmacy supply and a further change in provider for mental health team. Existing staff worked hard to provide a healthcare service, but the IMB had serious concerns about the ability of the contract to provide adequate services.

Previous deaths at HMP Bure

17. Mr Merrison was the third prisoner at Bure to die of natural causes since 2013. There were no significant similarities with the circumstances of previous cases.

KEY EVENTS

18. In 1981, Mr Merrison was sentenced to life imprisonment for sexual offences. He spent time in a number of different prisons. In 1999, he had a heart attack.
19. In 2007, while at HMP Kingston, Mr Merrison showed symptoms of heart failure, such as oedema (swollen ankles), persistent cellulitis and ulcers in his legs. These conditions became chronic. He often refused to attend healthcare appointments or take prescribed medication and his behaviour towards staff was sometimes challenging. On 1 July 2010, the clinical lead nurse at Kingston noted his poor compliance with healthcare advice and that he had said he wanted to die in prison.
20. On 17 September 2012, the modern matron at Kingston referred Mr Merrison to a cardiologist, as he was concerned about his oedema. Staff chased this up on 3 October, but he did not receive an appointment while he was at Kingston.
21. On 5 February 2013, Mr Merrison was transferred to HMP Bure as Kingston was closing. At his initial health screen that day, a nurse noted his heart problems and other health conditions. His medical records included a note that he was waiting for a cardiology appointment. There is no record that anyone followed this up.
22. On 11 February, a prison GP prescribed medication for Mr Merrison's heart failure. He told him that he did not want to take the medication and the GP explained the risks of him not doing so.
23. On 19 February, a prison GP tested Mr Merrison's blood and found signs of cardiac dysfunction. He noted that he planned to refer him to a specialist, but there was no record that he made a referral.
24. During 2013 and 2014, healthcare staff treated Mr Merrison's leg ulcers, a symptom of heart failure. The ulcers did not improve and, on 11 June 2014, staff referred him to a vascular specialist. (The specialist subsequently found his condition was unsuitable for surgery and recommended specialist bandaging.)
25. On 17 June 2014, a locum GP gave Mr Merrison a blood test, which again showed cardiac dysfunction. The GP noted he needed an echocardiogram and proposed a referral to a specialist, but does not appear to have made the referral.
26. On 10 September, a prison GP examined Mr Merrison and noted that his chest was clear, although he had raised blood pressure. She referred him for a chest X-ray and an echocardiogram. The chest X-ray, taken on 14 October, showed his heart size was within normal range and his lungs were clear.

27. A cardiology specialist examined the echocardiogram and saw Mr Merrison on 3 November. He wrote to the prison confirming that the echocardiogram showed mild impairment of his heart's left ventricle.
28. On 2 February 2015, Mr Merrison told a nurse that he had a poor appetite but was eating well. Two days later, the nurse found he had lost 5kg in weight in the last week, but his vital signs were normal.
29. On 9 February, a nurse assessed Mr Merrison after wing staff said they were concerned about him. She told him to contact the healthcare department if he continued to feel unwell. The next day, a nurse recorded he had lost 2kg in two days. He looked unwell and told staff that he had lost his appetite and wanted to give up on life.
30. On 14 February, a nurse examined Mr Merrison and found that he had not eaten for a week and his blood pressure was low. She was concerned at the decline in his health and called an ambulance. Paramedics attended and an electrocardiograph (ECG - record of electrical activity of the heart) test was normal, as were his blood pressure and oxygen saturation levels. The paramedics said staff should encourage him to eat and drink and decided he did not need to go to hospital.
31. The next day, prison staff found Mr Merrison lying in bed, with urine on the floor. A nurse found he was unstable on his feet and appeared not to be able to understand what was being said to him. He drank some water but refused food. The nurse referred him for a GP review. There is no record that the GP physically examined him.
32. On 16 February, a nurse examined Mr Merrison and found his oxygen saturation levels were low, he had poor circulation and he had been incontinent. He told the nurse that he wanted to give up. The nurse referred him to the GP. Later that day, a locum GP prescribed a stocking, new bandages and a topical steroid, for his leg, but did not see him.
33. On 17 February, a nurse saw Mr Merrison in his cell. He did not want to eat or drink anything. Virgin Care's Norfolk Prisons' Operations Manager carried out a detailed assessment of him and recorded his poor intake of fluid and food, his need for assistance with hygiene and mobility and his general weakness. He devised a care plan, which included recording food and fluid intake, regular changing of his incontinence pad, weight monitoring and a referral for an external social care assessment.
34. Later that day, a GP examined Mr Merrison and concluded he was probably clinically dehydrated. The GP encouraged him to drink some milk.
35. On 18 February, three nurses reviewed Mr Merrison at different times. The decline in his condition led a nurse to call an ambulance at 11.20am. The ambulance arrived at 11.30am and paramedics took him to hospital.

36. Mr Merrison was admitted to hospital with an infected leg ulcer and acute renal failure. Over the following days, healthcare staff frequently contacted the hospital for updates on his condition. He died in hospital in March.

Contact with Mr Merrison's family

37. The Head of Safer Custody acted as the prison's family liaison officer. Mr Merrison had refused to nominate anyone as next of kin and the prison's attempts trace any family were unsuccessful. Both before and after his death, another prisoner at Bure claimed to be his brother, but this could not be proved and Mr Merrison had always denied it.
38. The prison arranged and paid for the funeral.

Support for prisoners and staff

39. After Mr Merrison's death, the Governor of Bure debriefed the staff involved in his care to ensure they had the opportunity to discuss any issues arising. Managers and the care team offered support.
40. The prison posted notices informing other prisoners of Mr Merrison's death, and offering support.

Post-mortem report

41. A post-mortem examination found that Mr Merrison had died from myocardial infarction (heart attack) due to severe coronary artery atherosclerosis (blockages in the heart's arteries).

FINDINGS

Clinical Care

42. Mr Merrison arrived at Bure with existing heart failure. His medical record showed that he had an outstanding cardiology referral at the time, but healthcare staff did not follow this up or make a referral to a local hospital.
43. Additionally, on two occasions, 19 February 2013 and 17 June 2014, GPs saw Mr Merrison and indicated that referrals to a cardiologist were required. These referrals were not made. A GP eventually referred him to a cardiologist in September 2014. The clinical reviewer did not consider this delay this would have altered the outcome for him. However it is important that referrals are made to specialists promptly when indicated. We make the following recommendation:

The Head of Healthcare should ensure that prisoners are promptly and appropriately referred to specialists, as necessary and that referrals are followed up.

44. Mr Merrison had a number of symptoms linked to his heart condition, including cellulitis and leg ulcers. Although there was a delay in obtaining specialist bandaging for his leg ulcers, healthcare staff appropriately managed and treated these conditions, throughout his time at the prison. In spite of the missed referrals, the clinical reviewer concluded that he received a good standard of care at Bure. Particularly in the last five years of his life, he did not follow medical advice and often declined to take his medication. The clinical reviewer commended the repeated efforts that healthcare staff made to encourage him to cooperate with his treatment.
45. For much of the last three years of his life Mr Merrison received nursing care almost every day. The clinical reviewer noted that the healthcare team took practical and constructive action to allocate resources to support him, but there was some lack of clarity about the boundary between social and clinical care, which caused tensions between prison and healthcare staff. While these matters and other organisational issues were not directly related to the circumstances of his death, the clinical reviewer has made further recommendations, which the Head of Healthcare will need to address.

ACTION PLAN

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that prisoners are promptly and appropriately referred to specialists as necessary and that referrals are followed up.	Accepted	The Governor will liaise with the contractor at the Healthcare Partnership Board to ensure that the Virgin Care Healthcare Contract Manager at HMP Bure implements a system to provide assurance that prisoners are appropriately referred to specialists and that referrals are followed up.	30 th October 2015, Healthcare, (Virgin Care) & The Governor	