PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in August 2013 at HMP Bure

Our Vision

‘To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision’

This is the report of the investigation into the death of a man at HMP Bure in August 2013. A post-mortem showed that he died from heart disease. He was 62 years old. I offer my condolences to his friends and family.

A clinical review of the man's medical care at the prison was undertaken.

The man had been in prison since October 2012. He had not seen a doctor for many years and had no apparent health issues. In June 2013, a health assessment for older prisoners identified that he had high cholesterol. He agreed to manage the condition through diet and exercise. He was found unresponsive in his cell at the beginning of August 2013. Resuscitation was not attempted as it was clear that he had been dead for some time.

The clinical reviewer considers the man's health care in Bure was of an equivalent standard to that which he could have expected in the community and I am satisfied that his sudden death could not have been foreseen or prevented. While it would not have changed the outcome for him, the investigation identified a need for improvements in emergency response procedures and notification of next of kin at the prison.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **February 2014**

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SUMMARY

1. The man was sentenced to five years imprisonment in October 2012 and was initially sent to HMP Wandsworth. On 21 November, he moved to HMP Bure.

2. The man had health screens when he arrived at both prisons. It was noted that he had no medical conditions, had not seen a doctor for many years and was not taking any medication.

3. On 24 November, healthcare staff assessed the man for an older person's care plan (for prisoners over 55). This found that his blood pressure was slightly high, but all other results were normal. He had an electrocardiogram test in December, which was normal. At a follow up health check in June 2013, he was found to have high cholesterol. He preferred not to take medication for this and agreed to consider changing his diet and doing more exercise.

4. An operational support grade (OSG) at the prison carried out the roll check at 5.30am one morning in August. He saw the man sitting on his bed in his single cell, with his back against the wall and his feet on the floor. At approximately 6.40am, he noticed that he was still in exactly the same position. He knocked on his door and called his name for several minutes, but got no response. An officer arrived to begin a shift at about 6.50am, and saw him outside the cell. He said he was concerned about him, so she looked through the observation hatch, turned on the night light and thought that his arms and legs looked dark and blotchy.

5. The officer radioed for the senior officer but did not use an emergency code. The senior officer arrived quickly with two other officers and went into the cell. Officers were unable to find the man's pulse and as rigor mortis was present did not attempt resuscitation. An ambulance was requested at 6.59am. Paramedics arrived at 7.15am and pronounced him dead at 7.16am.

6. A prison family liaison officer (FLO) was appointed that morning, but the prison asked the police to inform the man's family that he had died. The family liaison officer visited the family at a later date to offer support.

7. We agree with the clinical reviewer that the man's clinical care was well managed in prison and that his death was not foreseeable. Although it would not have affected the outcome in his case, we are concerned about the emergency response – there was a delay going into the cell and an emergency medical code was not used. We are also concerned that the man's next of kin was not informed of his death by a member of prison staff.

THE INVESTIGATION PROCESS

8. The investigator issued notices to staff and prisoners informing them of the investigation and inviting anyone with any relevant information to contact her. No one came forward.

9. NHS England commissioned a clinical reviewer to assess the man's clinical care in prison.

10. The investigator went to HMP Bure on 21 August 2013. She met the acting Deputy Head of Healthcare and the acting Governor at the time the man died. She spoke to representatives from the POA (prison officers' union) and the Independent Monitoring Board. She obtained copies of the man's prison and prison healthcare records.

11. The investigator interviewed the officer on 31 October and the OSG on 4 November.

12. HM Coroner for the Norfolk District was informed of the investigation and provided the post-mortem report. The Coroner has been sent this investigation report.

13. One of the Ombudsman's family liaison officers wrote and left telephone messages for the man's daughter to explain the purpose of the investigation, but received no response. She was also given the opportunity to consider our draft report. She has not raised any factual inaccuracies or issues.

14. The prison considered our draft report and recommendations and has accepted these. One factual inaccuracy was raised, relating to someone's name, and has been amended. The prison has also submitted an action plan detailing what they have done to address the issues we raised and this is included here, after the recommendations section.

HMP BURE

15. HMP Bure is a category C prison near Norwich which holds approximately 520 adult men convicted of sexual offences. (Category C prisoners are those who cannot be trusted in open conditions but who are unlikely to try to escape.)

16. Serco Health provides primary healthcare services. Medical services are provided by locum GPs. There are healthcare staff on duty from 8.00am to 7.00pm Monday to Friday and 8.00am to 6.00pm at weekends and on bank holidays.

Her Majesty's Inspectorate of Prisons

17. In the report of an inspection of HMP Bure in May 2013, HM Inspectorate of Prisons assessed that healthcare outcomes were reasonable, although there were some concerns about prisoners having to wait too long for their medication. The Inspectorate reported that provision for the sizeable group of older prisoners was well developed, including a good range of activities in the gym.

Independent Monitoring Board

18. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the community, who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. In its latest published annual report for 2011/12, the IMB highlighted that many of the facilities were unsuitable for an ageing prison population.

Previous deaths at HMP Bure

19. There has been one previous death at Bure, in July 2011. In that case we also made recommendations about emergency response codes and calling an ambulance.

KEY EVENTS

20. On 26 October 2012, the man was sentenced to five years imprisonment and sent to HMP Wandsworth. When he arrived at Wandsworth, he said that he had not seen a doctor for many years and was not taking any regular medication. He told a nurse that he had no health problems.

21. On 21 November 2012, the man transferred to Bure. At his initial health screen, a nurse noted that he was not registered with a GP and that he said he did not have any health issues. She referred him to the community nurse for older people.

22. On 23 November, a nurse opened an older person's care plan for the man (for prisoners over 55). The next day, a nurse completed a secondary health screen, which included an assessment for his care plan. He did not report any serious problems, but his blood pressure was described as the high side of normal. On 10 December, he had an ECG as part of his older person's care plan and the doctor noted that no further action was required.

23. The man settled into the prison, worked in the prison gardens and did not have any reported health problems over the next few months. On 19 June, he attended a routine follow-up health check which identified that he had high cholesterol. His risk of having a heart attack or stroke in the next ten years was assessed as 25.8 per cent using a cardiovascular risk assessment tool. He referred to a nurse practitioner for further assessment.

24. On 23 June, a nurse practitioner discussed the man's high cholesterol with him, including his risk of having a heart attack or stroke. The nurse noted that he did not have any other risk factors apart from his age and the fact he smoked. They discussed lifestyle changes that would reduce his risk, including advice on giving up smoking. He did not want to take medication to lower his cholesterol, but said he would consider changing his diet and doing more exercise. He did not stop smoking. The nurse planned to review him in six months.

25. The day before his death, the man watched television with another prisoner during the day, who said he did not have any concerns about him. Another prisoner who said he was a close friend of the man's said they had laughed and joked together that evening and he did not notice anything unusual about him.

26. An Operational Support Grade (OSG) carried out the evening roll check. He recalled that the man was in bed, watching television. He remembered that he had nodded at him when he looked through the observation panel.

27. The prisoner in the cell next to the man's said he heard a bang on the wall at about 11.10pm, which was louder than his television. He thought it was an unusual noise to come from his cell. He decided to ask him about it the next day, but did not report it to staff.

Day of the incident

28. At 5.30am on a morning in August, the OSG carried out the morning roll check. He noticed that the man had changed position from the night before. He was sitting on top of his bed, side on, with his back against the wall and both feet on the floor. He did not speak to him at this time.

29. At 6.40am, the OSG went to investigate a noise and passed the man's cell on the way. He decided to check him again. He noticed that he was in exactly the same position as he had been at 5.30am. He thought this was odd, so he tapped on the cell door and quietly called his name. He did not get any response, so he called and knocked more loudly.

30. An officer said that she arrived on the wing at about 6.50am. The OSG thought it was no more than a couple of minutes after he had started knocking on the man's cell door. She joined him outside the cell and he told her that he was worried because he was not responding. She looked through the observation panel, knocked on the door and called his name. She turned on the cell night light and noticed that his arms and legs were blotchy and dark.

31. The officer radioed the officer in charge of the prison, SO 1, but did not use an emergency code. Two SOs and another officer got to the cell shortly after the radio call. SO 1 also tried unsuccessfully to get a response from the man and he and SO 2 then went into the cell. They considered that he was dead as his body was showing signs of rigor mortis and did not therefore attempt resuscitation.

32. At 6.59am, SO 2 asked the control room to call an ambulance. Paramedics got to the cell at 7.15am and confirmed that rigor mortis was present. They pronounced the man dead at 7.16am.

Contact with the man's family

33. The duty governor appointed a prison family liaison officer (FLO) at about 8.15am. The man's daughter was recorded as his next of kin, but she lived in Hertfordshire, about 100 miles from the prison. The duty governor was concerned that prisoners on the wing had access to the telephones and might inform the family about his death before prison staff could break the news to them.

34. To avoid any delay, the duty governor decided that local police should break the news to the man's daughter. The police were contacted at 8.55am but did not inform her until 11.21am.

35. The man's ex-wife rang the prison at 11.55am to speak to the FLO. At the time the FLO was not aware that the man's daughter had been informed by the police. She did not take the call, but asked the communications room to take her number. The FLO intended to call her back when she had confirmed his daughter, his next of kin, had been informed. Unfortunately, the man's ex-wife had hung up before her number could be taken. At 11.59am, the FLO

called the police for an update. They said that the man's daughter had been informed of her father's death at 11.21am.

36. At 12.10pm, the man's daughter called the prison and spoke to the FLO. They spoke very briefly, but she handed the phone to her mother as she was too upset to continue the conversation. The FLO arranged to visit the family on 6 August. At the visit, they discussed plans for a memorial service and the prison offered a financial contribution to funeral costs in line with national guidelines.

37. On 13 August, the family attended a memorial service at the prison and visited his cell. The funeral was held on 23 August and the FLO and the duty governor attended.

Support for staff and prisoners

38. The duty governor, held a debrief for staff involved in the emergency response at 9.10am that morning. He reminded staff of the support available to them. Another debrief was held that afternoon, and the Acting Governor followed this up with a letter to staff with details of support available.

39. The prison's care team went to the wing and spoke to the man's close friends in a private room. They went on to speak to everyone on his wing and also visited every wing in the prison along with the Samaritans.

40. Officers who knew the man's friends particularly well were asked to come on duty so that they could offer support. All prisoners who being monitored as a risk of suicide and self-harm were reviewed in case they have been adversely affected by his death.

Post-mortem report

41. The post-mortem report concluded that the man died of ischaemic heart disease (narrowing of the arteries) caused by coronary atherosclerosis (thickening of the artery walls).

ISSUES

Clinical Care

42. The clinical reviewer considers that the man's initial health assessments at Bure were comprehensive, and the older person's care plan was appropriate and well managed.

43. Once the man's high cholesterol was identified, the clinical reviewer finds that he was referred appropriately and given reasonable advice about the risks and how best to manage them. He did not want to take medication to lower his cholesterol, but preferred to manage it through his diet and exercise. He did not give up smoking.

44. The clinical reviewer concludes that the man's care was of an equivalent standard to that he could have expected in the community. He considers that his death was neither preventable nor foreseeable.

Delay entering the cell

45. The OSG observed the man at 5.30am, but did not think he saw anything unusual. It was only when he passed his cell at what he thought was approximately 6.40am that he decided to look in on him and noted that he had not moved. He then started to call his name and knock on the door. He said he was only outside the cell on his own for about two minutes, but the officer said she arrived at 6.50am.

46. The local instruction for entering a cell at night says:

> "where there is, or appears to be, immediate danger to life, cells may be unlocked without the authority of the [night manager]".

47. When interviewed, the OSG said he understood that he could go into a cell on his own if he felt a prisoner's life might be in danger and if there was a low security risk, but he thought that he would have to tell the night manager first. He said it was quite dark in the cell. It was only when he got no response that he began to consider the seriousness of the situation, but then the officer arrived. She turned the night light on and was immediately concerned by the man's skin tone. She radioed the night manager, who then arrived with two other members of staff.

48. The officer told the investigator that she thought she could not go into a cell if she was on her own, or if only accompanied by an operational support grade. She did not know that she could go into the cell on her own if she felt that a prisoner's life was in danger and there was little security risk.

49. Although the local instruction is clear, staff did not understand their responsibility to place the preservation of life above security, where this would not put themselves or others in unnecessary danger. Both the OSG and the officer recognised that there were serious concerns, but waited for the night

manager to attend. As it was apparent that the man had been dead for some time, this would not have changed the outcome in his case, but any delay could make a difference in different circumstances. We therefore make the following recommendation:

The Governor should ensure that all staff understand that, subject to a personal risk assessment, they should enter a cell at night in an apparent life-threatening situation.

Emergency response

50. The OSG did not radio for assistance and the officer did not use an emergency response code, but radioed for assistance from the night manager. Two supervising officers and an officer arrived quickly and an ambulance was called at 6.59am. However, this was nearly 20 minutes after the man was first found. As noted, it is apparent that he had died, but in other circumstances such a delay could be crucial.

51. PSI 03/2013 was issued at the beginning of February 2013 and required governors to have a medical emergency response code protocol based on the instruction by 28 February 2013. This should instruct staff how to communicate the nature of a medical emergency using agreed emergency codes and ensure that the control room calls an ambulance automatically as soon as an emergency code is called.

52. Bure has two separate local instructions, one about the use of emergency codes to call healthcare staff to a medical emergency and a separate instruction for staff to request an ambulance if they have any concerns about the seriousness of a prisoner's condition. Both sets of instructions were issued in February 2013. Reminders were sent to staff in August and September about the content of those instructions.

53. We are not satisfied that the two instructions are compliant with PSI 03/2013 as the emergency codes seem to be restricted to communicating with healthcare staff. They do not require an ambulance to be called automatically when an emergency code is used. While it would not have made a difference to the outcome for the man, we make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Bure has a Medical Emergency Response Code protocol which:

- **Provides guidance to staff on efficiently communicating the nature of a medical emergency; and**
- **Ensures there are no delays in calling, directing or discharging ambulances.**

Family Liaison

54. A family liaison officer was appointed promptly and she in turn quickly identified the man's next of kin as his daughter. As she lived 100 miles away, the duty governor was concerned that other prisoners would break the news of his death before she could be told by the prison. He therefore arranged for local police to inform her of his death. It is understandable that the duty governor was concerned about the news reaching her before prison staff could get there, but in practice the police did not inform her any sooner than prison staff might have done.

55. Prison Service Instruction (PSI) 64/2011 Safer Custody, states:

> "Wherever possible, the FLO and another member of staff must visit in person the next of kin or nominated person to break the news of the death. Time will be of the essence in order to try to ensure that the family do not find out about the death from another source.
>
> "Where the prisoner had been located a long distance from their next of kin, consideration must be given to requesting the assistance of a FLO from the nearest prison."

56. PSO 1400 'Incident Management' states that although the police should be told about a death in custody, it is the prison's responsibility to notify the next of kin. Police should only ever be used as a last resort when trying to contact bereaved families, the prison should try to deliver the news themselves or at the very least via prison staff from a prison local to the next of kin.

57. The fact that prison staff did not deliver the news directly contributed to the confusion when the man's ex-wife called for information and the prison incorrectly believed that no one else could be informed until the next of kin had been told. This confusion might well have been avoided had the prison broken the news themselves, or asked a nearer prison to break the news on their behalf.

The Governor should ensure that in the event of a death, prisoners' families are informed quickly and in person by a member of Prison Service staff in line with national guidance.

RECOMMENDATIONS

1. The Governor should ensure that all staff understand that, subject to a personal risk assessment, they should enter a cell at night in an apparent life-threatening situation.

2. The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Bure has a Medical Emergency Response Code protocol which:

    - Provides guidance to staff on efficiently communicating the nature of a medical emergency; and
    - Ensures there are no delays in calling, directing or discharging ambulances.

3. The Governor should ensure that in the event of a death, prisoners' families are informed quickly and in person by a member of Prison Service staff in line with national guidance.

ACTION PLAN: The Man – HMP Bure

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and Function Responsible	Progress (to be updated after 6 months)
1	The Governor should ensure that all staff understand that, subject to a personal risk assessment, they should enter a cell at night in an apparent life-threatening situation	Accepted	All staff who work at night at HMP Bure will be reminded in writing of the requirement to enter a cell in an emergency, subject to a personal risk assessment. In addition all staff who work at night will be required to re-read the prison's night orders and sign to say that they have done so.	31st March 2014 Security and Operations	
2	The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Bure has a Medical Emergency Response Code protocol which: • Provides guidance to staff on efficiently communicating the nature of a medical emergency; and • Ensures there are no delays in calling, directing or discharging ambulances.	Accepted	Local Instructions regarding the use of medical response codes and the calling of an ambulance will be reviewed to ensure that they are fully compliant with PSI 03/2013. This revised instruction will be highlighted to staff through a prison wide notice as well as through verbal briefings. Night orders will be reviewed to reflect or include the above revised instruction. Duty Managers will monitor the correct utilisation of the revised protocols going forward and take corrective actions or provide advice where required.	31st March 2014 Safer Custody and Equalities	
3.	The Governor should ensure that in the event of a death, prisoners' families are informed quickly and in person by a member of Prison Service staff in line with national guidance.	Accepted	Duty managers will be reminded that in the event of a death in custody, it is the prison's responsibility to notify the next of kin. The Police will only ever be used as a last resort when trying to contact bereaved families. Local Instructions and Contingency Plans will be checked to ensure compliance and reviewed if necessary.	28th February 2014 Security and Operations	