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 at HMP Bure in March 2014

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 investigation report into the death of a man from heart disease at HMP Bure in March 2014. He was 55 years old. I offer my condolences to his family and friends.

A review of the clinical care the man received at HMP Bure was undertaken. The prison cooperated fully with the investigation.

The man was sentenced to eight years in prison since October 2010 and was sent to HMP Brixton. He was moved to HMP Bure in September 2013. He experienced recurrent pain from an old gunshot wound but, otherwise, had no apparent health issues. On the morning of 31 March, an officer found him unresponsive in his cell. Healthcare staff attempted resuscitation, but paramedics declared him dead shortly after they arrived.

I agree with the clinical reviewer that the man's sudden death could not have been foreseen or prevented. However, the investigation identifies a number of learning points, including the need for better healthcare assessments for prisoners over 55 and to improve emergency response procedures.

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 **November 2014**

CONTENTS

Summary

The investigation process

HMP Bure

Key events

Issues

Recommendations

SUMMARY

1. The man was sentenced to eight years imprisonment in October 2010 and sent to HMP Brixton. On 6 September 2013, he moved to HMP Bure.

2. A nurse carried out the man's initial health screen when he arrived at Bure. The nurse noted that he had an old gunshot injury to his left leg which caused him pain; he smoked cigarettes and had blood pressure within the normal range. No other health issues were recorded. A prison GP carried out a medication review and he was prescribed pain relief medication.

3. On 16 October, a healthcare support worker assessed the man for an older person's care plan (for prisoners over 55). She did not record any major health concerns and he said he did not wish to try and give up smoking.

4. For the next five months, there is nothing significant in the man's record.

5. One morning at the end of March 2014, an officer carried out the morning roll check. She noted the man appeared to be still asleep in bed and his friend said he would try and wake him. The friend called the officer back to the cell and she found the man unresponsive, with blood pooled in his elbow. At 8.05am, she called a code blue (an emergency call that signifies a prisoner is not breathing or is unresponsive).

6. Nurses and officers made their way to the man's cell and nurses began cardiopulmonary resuscitation (CPR). The Head of Healthcare asked the communications room to call an ambulance at 8.07am, records show this was called at 8.11am. A paramedic arrived at 8.24am and pronounced him dead.

7. A prison family liaison officer was appointed that morning, but as the man's family lived some distance away, staff from a nearby prison broke the news. The family liaison officer visited the family the same day.

8. We agree with the clinical reviewer that the man's clinical care was good in prison and that his death was not foreseeable. However, there is a need for healthcare assessments for those over 55 to be more age and disease appropriate. Although it would not have affected the outcome in his case, we are also concerned about the emergency response procedure at the prison which does not include a clear expectation that staff call an ambulance immediately. We are also concerned that nurses attempted resuscitation although it was clear he had been dead some time. We make three recommendations.

THE INVESTIGATION PROCESS

9. The investigator issued notices to staff and prisoners informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.

10. NHS England commissioned a clinical reviewer to review the man's clinical care in prison.

11. The investigator obtained copies of the man's prison medical record and relevant extracts from his prison record. She interviewed eight members of staff and two prisoners at HMP Bure on 16 June. She gave the Governor feedback on the preliminary findings of the investigation and followed this up in writing.

12. We informed HM Coroner for the Norfolk District of the investigation, who provided the post-mortem report. We have sent the Coroner a copy of this investigation report.

13. The man's family received a copy of the draft report. They raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

14. The prison considered our draft report and its recommendations and has accepted them. Some factual inaccuracies were raised and we have made amendments. 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 provided primary healthcare services at the time of the man's death (Virgin Healthcare has since taken over). Locum GPs provided medical services. Healthcare staff cover ran from 8.00am to 7.30pm Monday to Thursday and 7.00am to 6.00pm Friday to Sunday. There was also an out of hour's medical support and an on call healthcare manager system.

Her Majesty's Inspectorate of Prisons

17. The most recent inspection of HMP Bure was in May 2013. The Inspectorate said that healthcare outcomes were reasonable and that prisoners were very positive about the care and treatment they received from the healthcare department, particularly the nurses. However, there were some concerns about prisoners having to wait too long for their medication.

Independent Monitoring Board

18. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers who help to ensure that prisoners are treated fairly and decently. In their most recently published report for the year 2012/13, the IMB said that earlier issues regarding waiting times for medication had been resolved.

Previous deaths at HMP Bure

19. The man's was the third death from natural causes at HMP Bure since the start of 2011. We have raised the issue of the correct use of emergency codes before.

KEY EVENTS

20. On 8 October 2010, the man was sentenced to eight years imprisonment and sent to HMP Brixton. On 6 September 2013, he transferred to HMP Bure.

21. A nurse conducted the man's initial health screen and recorded that he had an old gun shot injury to his left leg which caused him pain, his blood pressure was within the normal range and he was a cigarette smoker. She referred him for a secondary screening, a medication review with the GP and an over 55's assessment.

22. On 9 September, a nurse carried out the man's secondary health screen and did not identify any further issues with his health. A prison GP reviewed his medication on 16 September and re-prescribed pregabalin (used to control nerve pain) and co-codamol (pain relief) for his leg pain.

23. On 16 October, a healthcare support worker completed the man's over 55's health assessment. She did not identify any major issues with him and noted that, although he was a moderate smoker, he did not wish to attempt to give up while he was in prison.

24. Over the next five months there is nothing significant in the man's records.

25. At 7.45pm on 30 March 2014, an operational support grade carried out the roll count. He could not remember specifically checking the man (in a single cell on the third landing), but said that nothing unusual happened on the wing that evening. He told us that he always made sure he has sight of the prisoners' faces at evening roll check and that he also completed routine checks through the course of that particular night.

26. At about 1.30am, a prisoner in the cell next door to the man's, heard the sound of retching coming from another cell, a toilet flushing and then deep breathing. He said he was not sure at the time which cell the noises came from and thought that if the person had needed assistance they would have been able to ring the cell bell. He heard nothing further.

27. Between 5.00am and 6.00am, the operational support grade did the morning roll check. He told us that he could not remember checking the man's cell specifically that morning, but he usually just checked someone was in the cell. At 6.55am, he recorded in the wing book that he had briefed an officer who was coming on duty and that there were no overnight issues to report.

28. At approximately 8.00am, an officer was doing the morning unlock. She got to the man's cell and called out to him; he did not reply and appeared to be asleep in bed. A prisoner in the opposite cell, and a friend of his, said he would get him up for the officer. He quickly realised that something was wrong and called to the officer to come back.

29. The officer returned to the man's cell and saw that he was still in bed with his arm hanging out of it. Blood had pooled in his elbow which had turned black. She attempted to radio for healthcare assistance, but there was too much

‘traffic’ for her to make the call. She did not realise that a button on her radio would have cut through the traffic and prompted someone in the communications unit to contact her. She checked his pulse and could find no signs of life, and shouted to another prisoner to alert staff. At 8.05am, she radioed a code blue.

30. An operational support grade in the control room heard the code blue and immediately contacted the healthcare unit. Two nurses were already on their way with an emergency bag (containing a defibrillator) and some oxygen. The operational support grade also contacted the duty manager and the duty governor.

31. At 8.06am, a nurse, who had been giving out medication on the wing, arrived at the cell having heard the code blue call. She shook the man but got no response. She noted his chest was not moving and his neck was so stiff that it was difficult for her to establish an airway; despite this she commenced cardiopulmonary resuscitation (CPR). An officer arrived just after the nurse and provided the nurse with a resuscitation mask. Shortly afterwards more staff arrived.

32. A nurse attached a defibrillator to the man and it advised no shock. An officer arrived and assisted with CPR. Staff attempted to move him down the bed but they were unable to do so because rigor mortis was present.

33. The control room log shows that, at 8.07am, the Head of Healthcare asked the control room to contact an ambulance. She also told us that at some point she told the operational support grade in the control room to ensure that the ambulance had a paramedic on board who could certify death, but was not clear at exactly which point this was. Ambulance service records show the call was received at 8.11am.

34. A first response vehicle arrived at Bure at 8.20am and the paramedic declared the man dead at 8.24am.

Informing the man’s family

35. At 8.30am on 31 March, at 8.30am on 31 March, a prison manager was appointed as the prison’s family liaison officer assisted by an officer. The man’s named next of kin was his mother, but she had died and he had been too upset to nominate another family member. His sister’s details were recorded; however she lived some distance away. The prison asked for a family liaison officer from a local prison to attend and break the news of his death.

36. The family liaison officers also made their way the man’s sister’s address so that they could also speak directly to her.

37. Unfortunately, she was not in and the family liaison officers were directed to the man’s partner’s address instead. They also went to his partner’s address. They gave her information and a bereavement pack, and said they would assist the family with any formalities and stay in contact.

38. A member of the man’s family contacted the Governor the next day to explain that details of another deceased prisoner were in the bereavement pack left for the family and this had caused some distress. The officer visited the family in person the same day to apologise for any distress the error had caused.

39. On 25 April, a memorial service for the man was held at HMP Bure. The funeral was on 30 April. At the request of the family, no one from the prison attended. The prison offered a financial contribution towards funeral costs in line with national guidance.

Support for staff and prisoners

40. The deputy governor held a debrief for staff involved in the emergency response at 1.00pm on 31 March. He reminded staff of the support available to them.

41. The prison chaplain and the care team went to the wing and spoke to the man’s close friends to offer support. Staff and prisoners were informed of his death by way of a Governor’s notice, which included information about the support available if required. Prisoners identified as at risk of suicide and self-harm were reviewed in case they had been adversely affected by the news of his death.

Post-mortem report

42. The post-mortem report concluded that the man died of ischaemic heart disease (narrowing of the arteries) caused by coronary artery atheroma (thickening of the artery walls). Toxicology results showed concentrations of co-codamol which were within therapeutic levels.

ISSUES

Clinical Care

43. The clinical reviewer considers that the man’s clinical care at HMP Bure was good.

44. However, the clinical reviewer did identify that the prison’s over 55’s assessment does not actually reflect the health assessment needs of people who are 55 and over.

45. A healthcare assistant who went through the over 55’s assessment with the man, told us that she feels it was designed more for those who have problems with walking, standing and sitting. The clinical reviewer considered it was more geared towards the over 75’s and, therefore, does not reflect the health assessment needs of prisoners who are 55 and over. She says such as assessment should specifically seek to target those at risk of heart and vascular disease. We make the following recommendation:

    The Head of Healthcare should ensure that assessment templates are appropriately age and disease related and staff are trained to complete them effectively.

Emergency Response

46. 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 in place 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 prison control room calls an ambulance automatically as soon as an emergency code is called.

47. An officer tried to radio a code blue when she realised that the man was unresponsive. However she was not aware that her radio had a button to cut through other radio traffic. This caused a slight delay in the emergency call. When she eventually radioed a code blue, this did not prompt staff in the control room to automatically ring for an ambulance. The control room only did this when the Head of Healthcare made a request. The majority of staff we spoke to did not expect an ambulance to be called immediately if an emergency code was called.

48. We investigated another death at Bure in 2013, and we were not satisfied that Bure’s local instructions regarding emergency responses were clear enough or complied with the PSI. We made a recommendation about this which was accepted. As part of this investigation, we asked to see the latest emergency response protocol. Although the protocol has been updated, it is still not clear that an ambulance must be called automatically by the control room, immediately an emergency code is called. The majority of staff we spoke to were confused about how and when an ambulance should be called. 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, understand how to use their radios effectively, 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.**

Resuscitation

49. It was apparent from the evidence of the staff who found the man that he had been dead for sometime. There were no signs of life, pooling of blood and rigor mortis was present. We are concerned that despite these clear signs, nurses felt the need to attempt cardiopulmonary resuscitation and this continued until paramedics attended.

50. We consider the attempted resuscitation of the man was inappropriate in the circumstances and was unnecessarily distressing for those involved. The clinical reviewer says “the issue of futile CPR by nurses because they are too fearful of the consequences, must be stopped for the sake of all involved”. The European Resuscitation Council Guidelines 2010 state that “Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile …” It is distressing for staff and undignified for the deceased. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is inappropriate.

Family Liaison

51. Unfortunately, details regarding another deceased prisoner were left amongst the bereavement pack left by family liaison officers for the man’s family. This caused them some distress and is regrettable. We accept that this was human error and have been assured by the Governor that she has reminded staff about the importance of dealing with sensitive and confidential information appropriately.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that assessment templates are appropriately age and disease related and staff are trained to complete them effectively.

2. The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, understand how to use their radios effectively, 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 and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is inappropriate.

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 assessment templates are appropriately age and disease related and staff are trained to complete them effectively.	Accepted	The local Healthcare Contract Manager will review the templates to ensure that they meet the needs of relevant offenders and that each assessment is appropriately age and disease related. They will then ensure that staff are trained to complete each assessment effectively.	31 December 2014 Healthcare Contract Manager	
2	The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, understand how to use their radios effectively, 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	The Governor has reviewed and reissued local notices ensuring full compliance with PSI 03/2013 in order to brief staff on the required actions during medical emergencies, how to efficiently communicate and including instructions to ensure that there are no delays in calling, directing or discharging ambulances. Local NTS 185/2014 published and new procedures in operation at the establishment. Further local notice issued to remind staff of the functionality of their radios including how they can prioritise their transmission over others during a medical emergency. Local NTS 242/2014 published regarding radio use.	Completed Governor	

3.	The Governor and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is inappropriate	Accepted	The local Healthcare Contract Manager/NHS England and the Governor will ensure that staff receive guidance about the circumstances in which resuscitation is inappropriate.	31 December 2014 Healthcare Contract Manager/NHS England / Governor	