

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Roger Vanata a prisoner at HMP Bure on 5 May 2017

**A report by the Prisons and Probation Ombudsman
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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.

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

Mr Vanata died on 5 May 2017 of a ruptured abdominal aortic aneurysm (a rupture of the main blood vessel that runs from the heart down through the chest and stomach) caused by severely clogged arteries, while in the custody of HMP Bure. Mr Vanata was 67 years old. I offer my condolences to those who knew him.

The care Mr Vanata received at HMP Bure for his aortic aneurysm was equivalent to the care he could have expected to receive in the community.

However, we are concerned that Mr Vanata was not urgently referred to a specialist for suspected cancer when no cause could be found for his rectal bleeding, and that the care he received in relation to his rectal bleeding was not, therefore, equivalent to that which he could have expected to receive in the community. We have expressed similar concerns about delays in making a referral for suspected cancer in the case of another prisoner who died at Bure in May 2017.

We are concerned to see that a very ill and immobile man who posed minimal risk was restrained when he was taken to hospital. We have made recommendations to Bure about this issue on two previous occasions, and we will be doing so again in relation to the other death that occurred at Bure in May 2017. Effective action now needs to be taken to implement our recommendation.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman

November 2017

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Summary

Events

1. On 6 October 2016, Mr Roger Vanata was sentenced to 24 months for breach of a sexual offences order and was sent to HMP Bure on 12 October 2016. He had a history of chronic obstructive pulmonary disease, high blood pressure, coronary heart disease, chronic kidney disease and depression. Mr Vanata had previously had an operation to repair his aortic aneurysm in 2012, while in the community.
2. At his reception health screen, Mr Vanata told a prison nurse about his medical conditions. She took his clinical observations and recorded that his weight was 65kg, and referred him to a prison doctor for further assessment. The doctor noticed swelling in Mr Vanata's abdomen, which was due to his aortic aneurysm repair.
3. In January 2017, Mr Vanata complained to a prison nurse that he had blood in his stools. She booked him an appointment with a prison doctor. At the appointment, he said he had no rectal bleeding. The doctor examined him and sent him for a blood test and the results showed abnormalities. There is no record that these issues were followed up.
4. In March, a prison doctor saw Mr Vanata to discuss his weight loss. Mr Vanata looked frail and was no longer able to mobilise without assistance. The doctor prescribed a nutrition supplement and referred him for blood tests. The test results showed that Mr Vanata's potassium levels were below the normal range. The doctor prescribed Mr Vanata potassium tablets.
5. Mr Vanata saw a prison nurse in April, after he complained that he had not been able to eat. The nurse told him to try to eat and asked wing officers to support him. Mr Vanata spoke to another nurse to complain that he felt unwell. She decided that healthcare should review his weight weekly and referred him to a prison doctor who reviewed him three days later. Mr Vanata told him that he was not eating food or taking his nutrition supplement. The doctor advised him to take his supplements.
6. On 22 April, Bure sent Mr Vanata to hospital after he appeared unwell. Hospital consultants diagnosed Mr Vanata with low potassium levels. He was discharged from hospital and was returned to Bure.
7. On 1 May, a healthcare administrator recorded that Mr Vanata felt unwell, had vomited and had been incontinent of faeces. She asked that a nurse examine him. A prison nurse examined Mr Vanata, and recorded that he had blood in his stools, he was not in pain and denied vomiting. She arranged for him to go to hospital for assessment.
8. Mr Vanata attended hospital on 1 May and remained there until his death on 5 May 2017.

Findings

9. The clinical reviewer concluded that the overall care Mr Vanata received at Bure was equivalent to that which he could have expected to receive in the community. However, the care he received in relation to his rectal bleeding and his weight loss was not appropriately investigated and was not, therefore, equivalent to that which he could have expected to receive in the community.
10. When Mr Vanata went to hospital on 1 May, he was inappropriately restrained. The initial risk assessments did not fully take into account Mr Vanata's risk given his very poor health and limited mobility. The restraints were appropriately, removed the next day.

Recommendations

- The Head of Healthcare should ensure that GPs follow relevant National Institute for Health and Clinical Excellence (NICE) guidelines for suspected cancer and refer patients appropriately.
- The Governor and the Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Bure informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
12. The investigator obtained copies of relevant extracts from Mr Vanata's prison and medical records.
13. NHS England commissioned a clinical reviewer to review Mr Vanata's clinical care at the prison.
14. We informed HM Coroner for Greater Norfolk District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
15. The investigator wrote to Mr Vanata's son to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not respond to our letter.
16. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Bure

17. HMP Bure is a medium security prison near Norwich, which holds over 600 men, convicted of sexual offences.
18. Virgin Care provides healthcare services. Healthcare staff are on duty between 8.00am and 6.30pm on weekdays and between 8.00am and 6.00pm at weekends. Five GP clinics are scheduled each week. There is also an out-of-hours service.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Bure was in April 2017. Inspectors reported that the healthcare centre was clean and clinical rooms were fit for purpose. Healthcare equipment was checked and maintained regularly and healthcare staff received intermediate-level resuscitation training. Defibrillators were in place on all residential units, and rotas were arranged to ensure that first-aid-trained prison staff were consistently on duty. An appropriate range of primary care services was provided and waiting times were short. Routine GP appointments were available within two days and urgent appointments were facilitated based on clinical need. Long-term conditions and complex health needs were overseen by the GP, who coordinated their approach with healthcare staff.

Independent Monitoring Board

20. 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 2016, the IMB reported that there were concerns with the Virgin Care contract, their complaints system and the restriction on recruiting staff. Healthcare staff regularly worked additional days in order to provide a service but staff sickness and retention levels remained a cause for concern.

Previous deaths at HMP Bure

21. Mr Vanata was the third prisoner to die of natural causes at Bure since January 2016. We have expressed concern about the inappropriate use of restraints on very infirm prisoners in all three cases.

Key Events

22. On 6 October 2016, Mr Roger Vanata was sentenced to 24 months for breach of a sexual offences order and was sent to HMP Bure on 12 October. He had a history of chronic obstructive pulmonary disease, high blood pressure, coronary heart disease, chronic kidney disease and depression. Mr Vanata had previously undergone an operation to repair an aortic aneurysm in 2012, while in the community.
23. After Mr Vanata arrived at HMP Bure he attended his reception health screen with a nurse. He told her of his medical conditions and said that he was not receiving medication for his depression. She took his clinical observations and recorded that his weight was 65kg. She referred him to a prison doctor for further assessment.
24. A prison GP saw Mr Vanata on 14 October. He recorded that Mr Vanata had swelling in his abdomen, which was due to the emergency repair of his aortic aneurysm. The GP referred Mr Vanata for a blood test and for assessment by podiatry and chiropody.
25. On 20 October, a nurse created an older person's care plan. She referred Mr Vanata for transfer to the older persons' unit and his mobility was to be assessed as part of the care plan.
26. A prison GP reviewed Mr Vanata's blood test results on 24 October. Mr Vanata's potassium levels were low so the GP prescribed him potassium chloride. He recorded that Mr Vanata arrived at his appointment in a wheelchair. He referred Mr Vanata to physiotherapy for an assessment of his mobility.
27. On 27 October, a nurse recorded that Mr Vanata's physiotherapy assessment showed he would benefit from the use of a walking aid. She forwarded the results of the assessment to the safer custody team.
28. On 15 January 2017, a nurse saw Mr Vanata after he complained of blood in his stools. She booked him an appointment with a prison doctor and arranged for him to provide a stool sample for assessment. She assessed the sample and found no cause for concern.
29. The next day a prison GP saw Mr Vanata to discuss the blood in his stools. Mr Vanata denied that he had blood in his stools but complained of pain in his abdomen. The GP examined him and found that the lining of his stomach was inflamed. He referred Mr Vanata for an urgent blood test.
30. On 23 January, a nurse entered the blood test results into Mr Vanata's medical record. She recorded that the blood count report showed abnormalities and an appointment should be made for Mr Vanata to see a prison doctor. There is no record to show that healthcare booked an appointment or that they investigated Mr Vanata's rectal bleeding further.
31. On 27 March 2017, a prison GP saw Mr Vanata to discuss his continued weight loss. He examined Mr Vanata and noted that he looked frail and was not able to mobilise without assistance. He recorded that Mr Vanata had lost 4kg since he

arrived at HMP Bure. He prescribed Mr Vanata a nutrition supplement and referred him for physiotherapy and blood tests. The blood test results, received on 10 April, showed Mr Vanata's potassium levels were below the normal range and potassium tablets were prescribed.

32. On 15 April, Mr Vanata told a nurse that he had not been eating. She advised him about foods he could try to eat and spoke to wing officers to ask them to support Mr Vanata and encourage him to eat. Later that afternoon, Mr Vanata complained that he felt unwell. He saw a nurse and told her that he had not been able to eat his lunch. She recorded that a prison doctor should review him and that his weight should be reviewed weekly. A prison GP reviewed him on 18 April. Mr Vanata told him that he had not been taking his nutrition supplement or eating his food. He advised Mr Vanata to take his nutrition supplement and asked the prison kitchen to provide him with yoghurts.
33. On 22 April, Bure sent Mr Vanata to hospital after he appeared unwell. Hospital consultants diagnosed Mr Vanata with low potassium levels. He was discharged and was returned to Bure. The next day a nurse tried to take Mr Vanata's clinical observations, but he declined.
34. On 1 May, a healthcare administrator recorded that Mr Vanata felt unwell, had vomited and had been incontinent of faeces. She asked a nurse examine him. A nurse attended to examine Mr Vanata. She recorded that he had blood in his stools, was not in any pain and denied vomiting. She arranged for Mr Vanata to be sent to hospital for assessment.
35. The hospital admitted Mr Vanata on 1 May; he remained there until his death on 5 May 2017.

Contact with Mr Vanata's family

36. HMP Bure appointed two officers as family liaison officers. One of the officers attempted to contact Mr Vanata's son and a friend after Mr Vanata was admitted to hospital on 1 May. Mr Vanata had not provided a contact number for his son so the officer was unable to make contact. He made contact with Mr Vanata's friend on 2 May and arranged for him to visit Mr Vanata in hospital. The Head of Safer Custody and both family liaison officers went to the hospital to introduce themselves to Mr Vanata's friend and to offer support. On 2 May, one family liaison officer contacted the police to ask them to inform Mr Vanata's son of his illness. The police visited Mr Vanata's son at 9.30pm and told him to contact the prison. The next day, the other family liaison officer called Mr Vanata's son to inform him of his father's condition and to offer support.
37. On 5 May, at 8.30am one family liaison officer called Mr Vanata's friend to inform him of Mr Vanata's death. At 8.45am, both family liaison officers left to visit Mr Vanata's son to inform him of his father's death. They remained in regular contact with Mr Vanata's son and friend and continued to offer support.
38. Mr Vanata's funeral was held on 13 June 2017, and the prison contributed to the costs in line with national guidance.

Support for prisoners and staff

39. After Mr Vanata's death, a prison manager debriefed the staff involved in Mr Vanata's hospital admission to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
40. The prison posted notices informing other prisoners of Mr Vanata's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Vanata's death.

Post-mortem report

41. A post-mortem examination found that Mr Vanata died of a ruptured abdominal aortic aneurysm (a rupture of the main blood vessel that runs from the heart down through the chest and stomach) caused by severely clogged arteries.

Findings

Mr Vanata's Clinical Care

42. When he arrived at HMP Bure Mr Vanata told healthcare staff he had several medical conditions and had undergone an aortic aneurysm repair in 2012. In response to this information, healthcare staff at Bure asked the screening staff if Mr Vanata would have to undergo screening for an aortic aneurysm. They were informed that he was exempt from screening as he had a repair in the past. There is no record to show if healthcare staff regularly reviewed Mr Vanata after this. Mr Vanata's aortic aneurysm was unusual with no abdominal or back pain. The clinical reviewer, the clinical reviewer concluded the care Mr Vanata received for his aortic aneurysm was equivalent to the care he could have expected to receive in the community.
43. Mr Vanata first complained to a prison nurse of painful rectal bleeding in January. She referred him to a prison doctor. During his appointment with the prison doctor Mr Vanata denied he had any blood in his stools. The prison doctor did not examine him to determine the cause of his symptoms. The clinical reviewer concluded that, if no cause for the bleeding was found, the prison doctor should have arranged an urgent referral for suspected colorectal cancer. The care Mr Vanata received in relation to his rectal bleeding was not equivalent to that which he could have expected to receive in the community. We make the following recommendation:

The Head of Healthcare should ensure that GPs follow relevant National Institute for Health and Clinical Excellence (NICE) guidelines for suspected cancer and refer patients appropriately.

44. The clinical reviewer has also made a number of recommendations which we do not repeat in this report but which the Head of Healthcare will wish to address.

Restraints

45. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.
46. Mr Vanata was taken to hospital on 8 March (at the eye clinic), 16 March (for a routine appointment) and 22 April 2017. Each time he was restrained using an escort chain despite his use of a wheelchair.
47. On 1 May, Mr Vanata was sent to hospital again. A nurse indicated on his escort risk assessment that there were no medical objections to the use of restraints but

that he may need to undergo tests that would require their removal. An Operational Support Grade recorded that Mr Vanata had no behavioural issues and that, although his risk to children was high, his risk to public and staff was not. A prison manager authorised the use of restraints and recorded that Mr Vanata should be escorted by two officers and restrained using an escort chain, despite being in a wheelchair.

48. Mr Vanata presented little risk of escape, was very ill and his mobility was poor to the extent that he relied on a wheelchair. It is hard to see that the legal requirements justifying restraint were met. We are not satisfied that the risk assessment properly took into account how Mr Vanata's health and impaired mobility affected his already low risk of escape. We note that managers reviewed the risk assessment appropriately the next day and removed Mr Vanata's restraints.
49. We are concerned that this is the third time we have expressed concern about the inappropriate use of restraints on very infirm prisoners at Bure. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

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