

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Smith a prisoner at HMP Bure on 10 August 2017

A report by the Prisons and Probation Ombudsman

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Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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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 David Smith died in hospital of a lung infection and stroke on 10 August 2017 while a prisoner at HMP Bure. He was 68 years old. We offer our condolences to his family and friends.

We agree with the clinical reviewer that Mr Smith received a good standard of care for his chronic health conditions at Bure. Staff could not have anticipated or prevented his sudden death. However, we are concerned that the prison did not radio a medical emergency code, in line with national instructions or keep full and accurate records of what happened during the emergency response.

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

March 2018

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Summary

Events

1. On 2 April 1971, Mr David Smith was sentenced to life in prison and sent to HMP Brixton. After spending time at other prisons, Mr Smith was moved to HMP Bure on 22 March 2013.
2. Mr Smith had several chronic medical conditions, including diabetes, high blood pressure and osteoarthritis. Healthcare staff created care plans to manage these. They reviewed him frequently and prescribed medication as necessary. Mr Smith was not compliant. He refused to take medication and refused tests as he said that he was scared of needles. He did not welcome or follow medical advice.
3. At approximately 9.30pm on 8 August 2017, Mr Smith pressed his cell bell and complained of breathlessness. The night support officer radioed for assistance and went to the wing office to obtain Mr Smith's information and to wait for staff. A prison manager and two officers went to the office and after the night support officer had updated them, the manager asked the communications room to call an ambulance and they went into Mr Smith's cell.
4. Mr Smith was having trouble breathing. Staff offered reassurance as they waited for the ambulance. Paramedics attended and took Mr Smith to hospital. Mr Smith's condition did not improve. He died on 10 August from a lung infection and stroke.

Findings

Clinical care

5. The clinical reviewer concluded that the healthcare Mr Smith received at Bure was equivalent to that which he could have expected to receive in the community.

Emergency response

6. When Mr Smith reported breathing problems, no one radioed a medical emergency code immediately, as they should have. While there is no evidence that this affected the outcome, such a delay might be critical in other cases.
7. Staff involved in the emergency response for Mr Smith did not complete the required incident report forms or complete written statements, as they should have.

Recommendations

- The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including radioing the appropriate emergency code immediately.
- The Governor should ensure that staff record all incidents of illness and injury in line with PSI 64/2011 and that all staff who are first on scene complete incident report forms as soon as is practicable.

The Investigation Process

8. 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.
9. The investigator obtained copies of relevant extracts from Mr Smith's prison and medical records.
10. The investigator interviewed three members of staff at HMP Bure on 12 September 2017.
11. NHS England commissioned a clinical reviewer to review Mr Smith's clinical care at the prison. He conducted joint interviews with the investigator.
12. 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.
13. The investigator contacted Mr Smith's family to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They did not respond.
14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Bure

15. HMP Bure is a medium security prison near Norwich, which holds over 600 men, convicted of sexual offences.
16. 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 an out of hours service.

HM Inspectorate of Prisons

17. 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. An appropriate range of primary care services were provided and waiting times were short. Routine GP appointments were available within two days and urgent appointments were facilitated based on clinical need. A GP oversaw long-term conditions and complex health needs.

Independent Monitoring Board

18. 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 Health Care Contract, their complaints system and the restriction on recruiting staff. Healthcare staff regularly worked additional days to provide a service but staff sickness and retention levels remained a concern.

Previous deaths at HMP Bure

19. Mr Smith was the fifth prisoner to die of natural causes at Bure since January 2016. There are no similarities with the previous cases. There have been two subsequent deaths, which are under investigation

Key Events

20. On 2 April 1971, Mr David Smith was sentenced to life in prison for murder and sent to HMP Brixton. After spending time at other prisons, he was transferred to HMP Bure on 21 March 2013.
21. Mr Smith had a history of type 2 diabetes, high blood pressure and osteoarthritis. Mr Smith frequently saw nurses and doctors to monitor these. Prison GPs prescribed antibiotics and pain relief. Mr Smith often refused medical treatment and occasionally his medication. He refused to take tablets for his blood pressure a number of times as he denied having high blood pressure. In 2012, doctors diagnosed him as having an Autistic Spectrum Disorder.
22. Mr Smith attended the over 55s clinics and healthcare staff saw him frequently as he complained that he had headaches and dizziness. However, he declined blood tests as he said he was scared of needles. Healthcare staff monitored his diabetes through urine tests. Healthcare staff arranged hospital appointments but he frequently refused to attend. Throughout his medical record, healthcare staff noted that Mr Smith had the mental capacity to refuse medical treatment.
23. In June 2015, Mr Smith told a nurse that he had pain in his arms, shoulders and elbows and that his medication did not help. He agreed to use diclofenac gel (an anti-inflammatory gel).
24. On 22 April 2016, Mr Smith complained to a podiatrist, of numbness in his feet. She told him that diabetes was the likely cause. Mr Smith said he refused to take any medication for diabetes because of the side effects.
25. On 23 May, a prison GP, reviewed Mr Smith's medication as Mr Smith said that he did not believe he had high blood pressure and refused medication. The prison GP told him his blood pressure was raised and he would benefit from taking his medication. Mr Smith only accepted a cream to help with a rash on his elbow.

2017

26. On 22 May, a prison GP noted that Mr Smith was pale and offered to refer him to hospital and for blood tests but Mr Smith declined. He noted Mr Smith had mental capacity and understood the risks of refusing examinations.
27. On 17 June, Mr Smith told a nurse that he had vertigo and had nearly collapsed. She took his basic observations, which were all in the normal range.
28. On 23 June, Mr Smith told a prison GP that he felt lightheaded but he refused to be referred to hospital or for blood tests.
29. On 30 June, Mr Smith told a physiotherapist, that movement aggravated his vertigo and caused him strong headaches. She suggested exercise and a hospital referral but Mr Smith said that he only wanted to relax in his cell and be left alone.

30. On 2 August, Mr Smith told a prison GP that his headaches and vision were worse. He had already seen an optician and declined to be referred to hospital.

8 August 2017

31. Mr Smith was in a single cell in a residential unit (Res 2). At approximately 9.30pm, he pressed his cell bell. A night support officer, was in the office and responded to Mr Smith. He said that he opened the cell door observation panel and saw Mr Smith sitting on his bed. He said that Mr Smith said that he could not breathe. He radioed for assistance.
32. The night support officer said that he returned to the office (to obtain electronic details of Mr Smith's cell and prison number) and telephoned a night support officer in the communications room to call the medical emergency code blue (which indicates a prisoner is unconscious or has breathing difficulties). He did not use his radio for this.
33. A manager, said that he heard the call for assistance at Res 2. When he arrived at the unit, the night support officer told him that Mr Smith was unwell. Two officers, who arrived at Mr Smith's cell, went back to the communications room to prepare the escort bag. The manager said that he had telephoned the communications room to ask for an ambulance.
34. The manager, the two officers and the night support officer went to Mr Smith's cell. The manager opened the cell door and they went in. Mr Smith was standing up in his cell. He said Mr Smith was sweating, hot, restless and agitated. The manager helped Mr Smith to sit on the bed and offered him reassurance. He said he asked one of the night support officers to collect the defibrillator and place it outside the cell.
35. Records showed that the communications room staff called an ambulance at 9.30pm. The Ambulance Service record noted that Mr Smith was short of breath and had coughed up blood. It also noted that prison staff had collected a defibrillator but no one could confirm if it was being used for Mr Smith or whether anyone was available to use it. Paramedics took Mr Smith to hospital. Appropriately, he was not restrained.
36. Hospital doctors diagnosed Mr Smith as having had a stroke. His condition deteriorated and he died in hospital on 10 August.

Contact with Mr Smith's family

37. On 9 August 2017 the prison appointed a family liaison officer (FLO) when Mr Smith was in hospital. A custodial manager, telephoned Mr Smith's mother to tell her that Mr Smith was seriously ill in hospital. She said that she was in a nursing home and Mr Smith was her only contact.
38. After Mr Smith died, the FLO contacted HMP Ford (which was the nearest prison to Mr Smith's mother's address). A family liaison officer at Ford, was appointed and visited Mr Smith's mother in her nursing home to tell her that Mr Smith had died. As he was arranging to visit Mr Smith's mother, Norfolk Police had telephoned her and broken the news. The FLO from HMP Bure met Mr Smith's mother to offer her condolences and support.

39. Mr Smith's funeral was on 24 August. The prison contributed to the costs in line with national policy.

Support for prisoners and staff

40. After Mr Smith's death, a prison manager debriefed the escort staff to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
41. The prison posted notices informing other prisoners of Mr Smith'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 Smith's death.

Cause of death

42. The Coroner gave the cause of death as aspiration pneumonia (a lung infection) and posterior circulation ischaemic stroke, and noted that Mr Smith's diabetes was a significant contributing factor.

Findings

Clinical care

43. Mr Smith often refused medical treatment and did not comply with his medication or blood tests. Healthcare staff saw him frequently to discuss and try to resolve the issue but without success. They considered that he had the mental capacity to understand the risks involved in refusing treatment and not engaging fully with healthcare staff.
44. We agree with the clinical reviewer that Mr Smith's care was equivalent to that which he could have expected to receive in the community, and we are satisfied that he received appropriate support.
45. Prisoners have the right not to accept medical treatment. The clinical reviewer considered that Mr Smith's health problems were complicated by his poorly controlled diabetes and high blood pressure.

Emergency response

46. Bure's policy on entering a cell at night for emergency medical assistance says that cells must not be unlocked, other than to save a life, unless the night manager is present and safe levels of staff are available.
47. Mr Smith rang the cell bell because he had breathing difficulties. The night support officer responded promptly, spoke to Mr Smith and radioed for staff assistance. He then left to go to the office to obtain Mr Smith's personal information. Mr Smith was left alone in his cell while staff who were in the office discussed what to do. The night support officer should have remained at the cell door to offer Mr Smith reassurance and to monitor his condition.
48. Ambulance staff noted in their report that Mr Smith was short of breath and was coughing up blood. They were also told that someone was collecting the defibrillator. The report noted that no one was available to use it. There was no system in place for prison staff to pass current information about Mr Smith's condition to the Ambulance Service as staff were in the office when the ambulance was called and no one was with Mr Smith. The first person on the scene should have shared information with the Ambulance Service but this did not happen.
49. It became apparent during the investigation that the night support officer and the prison manager did not radio a medical emergency code. The night support officer said that he telephoned the communications room to call an ambulance, instead of using the radio. The prison manager said that he asked for an ambulance when he was in the office.
50. Prison Service Instruction (PSI) 03/2013 on medical emergency response codes, gives clear guidance on when staff should use emergency codes and that a code blue should prompt the immediate request of an emergency ambulance. The night support officer and prison manager should have radioed a medical emergency code blue to alert communication room staff to call an ambulance.

While there is no evidence that the delay in calling an ambulance on this occasion made any difference to the outcome for Mr Smith, on another occasion, it might. We therefore 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, including radioing the appropriate emergency code immediately.

Record keeping

51. PSI 64/2011 on Safer Custody says that staff directly involved in an incident, particularly those who were first on scene, must complete incident report forms (Form F213) as soon as is practicable. When Mr Smith reported feeling unwell on 8 August, staff directly involved in the emergency response did not keep full and accurate records of what happened. All staff involved in the emergency response should also complete the incident report forms about what happened. There is no evidence that this happened, other than a report by the prison manager which briefly outlined events. This meant that there was no record of each person's role during the emergency response. We therefore recommend that:

The Governor should ensure that staff record all incidents of illness and injury in line with PSI 64/2011 and that all staff who are first on scene complete incident report forms as soon as is practicable.

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