Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Colin Kidd a prisoner at HMP Bure on 5 September 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 Colin Kidd died on 5 September of heart failure at HMP Bure. He was 67 years old. We offer our condolences to Mr Kidd's family and friends.

This initial report is a re-draft of the original version circulated in January 2018. I am re-issuing our initial report as the clinical reviewer has retracted his original statement that it was 'unlikely that treatment for early diabetes would have prevented Mr Kidd's death from heart disease'. He has submitted a replacement report which does not offer an opinion on the impacts on Mr Kidd, and the NHS commissioners agree with this approach.

It is most unfortunate that I have had to do this and I offer my apologies to Mr Kidd's family, the prison and the coroner for this avoidable confusion and delay.

To conclude, the care Mr Kidd received was not equivalent to that which he could have expected to receive in the community as staff failed to identify that he had Type 2 diabetes.

I am also concerned that there was a 13-minute delay between staff establishing Mr Kidd was not responding and calling an ambulance.

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 **September 2018**

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Summary

Events

1. On 24 November 2014, Mr Colin Kidd was sentenced to six years imprisonment for sexual offences and sent to HMP Peterborough. He was transferred to HMP Bure on 23 December 2014. He was noted to have a history of high blood pressure and an enlarged prostate.

2. Mr Kidd was prescribed medication to treat these conditions. Healthcare staff completed 'over 55's' assessments in 2015, 2016 and 2017 and monitored his blood pressure.

3. Tests taken in January 2015 and January 2016 revealed blood glucose levels indicating Type 2 diabetes. Staff did not respond to these abnormal results.

4. On 14 August 2017, Mr Kidd told a prison GP that he was having difficulty breathing at night. An ECG, which took place on 18 August, did not highlight any concerns other than that Mr Kidd's heart was not receiving the optimum amount of blood but no urgent action was required. The GP wanted Mr Kidd to have a spirometry test to measure his lung function; this did not take place before he died.

5. At 3.35am on 5 September, a prisoner in the cell next door to Mr Kidd rang his cell bell because he had heard him being sick followed by silence. A member of staff attended immediately and looked through the observation panel into Mr Kidd's cell. He saw that Mr Kidd was face down on the floor and a chair had been knocked over. He did not go into the cell or use his radio to call an emergency code, but tried to rouse Mr Kidd by knocking on his cell door and calling him.

6. When Mr Kidd did not respond, the officer telephoned the control room who told the night orderly officer, who then went with other colleagues to the scene. The officers went into Mr Kidd's cell at 3.45 am and attempted to resuscitate him until one of them asked for an ambulance at 3.48am. Paramedics arrived at the prison at 4.17am and continued with resuscitation attempts until 4.41am before declaring Mr Kidd had died.

Findings

7. The clinical reviewer found that the care Mr Kidd received was not equivalent to that which he could have expected to receive in the community. Although his blood pressure was monitored and he frequently had assessments to check whether he needed any additional assistance, staff failed to identify that he had Type 2 diabetes. Staff delayed entering Mr Kidd's cell, did not use an emergency code and delayed calling an ambulance. The prison's local policy on staff entering cells alone for emergencies is also unclear.

Recommendations

- The Head of Healthcare should ensure that clinicians promptly and appropriately review and follow up abnormal blood test results, especially where the results may indicate a significant condition
- The Governor should ensure that the local policy on emergency entry to cells is clear and accurately reflects the provisions of the National Security Framework and that staff react appropriately when discovering a prisoner in need of urgent assistance.
- The Governor should ensure that all staff are familiar with the local policy on emergency codes and are confident in using them.

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. NHS England commissioned a clinical reviewer to review Mr Kidd's clinical care at the prison

10. 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.

11. The investigator contacted Mr Kidd's daughter, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She raised a number of concerns with the coroner and subsequently with us when our original initial report was issued. She was concerned that Mr Kidd's diabetes was not diagnosed or therefore treated, that an excess of medication was found in Mr Kidd's cell after his death and that an ECG result was not reviewed by a qualified individual.

12. In light of the clinical reviewer withdrawing views expressed in the initial clinical review, and in light of concerns coming to light about the prison's policy on entering cells, a revised version of the initial report was produced.

13. Mr Kidd's daughter received a copy of the revised initial report. She did not raise any further issues, or comment on the factual accuracy of the report.

14. The revised initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

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

15. 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

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 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 in order to provide a service but staff sickness and retention levels remained a cause for concern.

Previous deaths at HMP Bure

17. Mr Kidd was the sixth prisoner to die of natural causes at Bure since January 2016. There are no similarities with those cases.

Key Events

18. On 24 November 2014, Mr Colin Kidd was sentenced to six years imprisonment for sexual offences and sent to HMP Peterborough. He was transferred to HMP Bure on 23 December 2014. He was noted to have had had a history of high blood pressure and an enlarged prostate.

19. On 23 December 2014, a nurse conducted Mr Kidd's first night health screen. He was already on medication to treat his high blood pressure (amlodipine) and enlarged prostate (tamsulosin) and these were re-prescribed. On 24 December, a nurse conducted the second health screen and arranged for a medication review on 29 December, which went ahead with no changes to his treatment plan.

20. On 5 January 2015, a member of healthcare staff carried out an over 55's assessment. He noted that Mr Kidd was an ex-smoker and his blood pressure was 125/80 (ideal is 120/80, so it was only slightly elevated). There were no issues with his mobility, speech or mental capacity.

21. On 13 January, a routine blood test revealed that Mr Kidd's cholesterol level was 3.5, which was not a concern. However, his HbA1c levels (which give a picture of blood sugar levels over the month) were abnormally high at 51mmol/mol (millimoles of glucose in the blood). Levels of 48 and over indicate that an individual is diabetic. Staff did not take any follow up action.

22. Mr Kidd was seen throughout 2015 by various healthcare professionals at the prison who monitored his blood pressure and tended to his other general health needs including flu vaccinations, aortic aneurysm screenings, shoulder pain and skin issues.

23. On 6 January 2016, a member of healthcare staff completed another over 55's check, which did not reveal any issues.

24. On 14 January 2016, a nurse conducted a QRisk2 assessment on Mr Kidd. QRisk2 predicts the likelihood of an individual developing cardiovascular disease over the next ten years. A score of over 10% should prompt a formal review. Mr Kidd scored 15.82% and on 26 January 2016, he had some blood tests. A prison GP recorded a normal cholesterol level of 3.6 but Mr Kidd's HbA1c result was 63mmol/mol, again, abnormally high and indicating diabetes. There is no evidence that healthcare staff followed up these results.

25. Throughout the rest of the year, Mr Kidd received physiotherapy for ongoing shoulder pain and had another flu vaccination. He continued taking amlodipine and tamsulosin.

26. On 13 March 2017, a member of healthcare staff completed Mr Kidd's yearly over 55's assessment. He referred Mr Kidd to an optician (who saw him on 26 April) and advised he also make an appointment with a prison GP to help him address his snoring (there is no record that Mr Kidd did this). He did not note any other issues. Mr Kidd's blood pressure was 130/78 (partially raised).

27. On 14 August 2017, Mr Kidd saw a prison GP and reported episodes of difficulty in breathing during the night. The doctor examined him and arranged for him to

have an electrocardiogram (ECG) and spirometry test. ECGs measure electrical activity in the heart and spirometry tests measure lung function. The ECG was carried out on 18 August and, although it was not reviewed at the time, the results indicated that Mr Kidd's heart muscles were not receiving the optimum amount of blood they needed but no urgent interventions were required. The spirometry test was not carried out before his death.

Events on 5 September 2017 and the emergency response

28. On 5 September, at 3.35am, a prisoner in the cell next to Mr Kidd rang his cell bell. He had heard noises coming from Mr Kidd's cell that night suggesting he was being sick but was concerned that Mr Kidd had been completely silent for a few minutes. An operational support grade (OSG) answered the cell bell call and after speaking to the prisoner next door to Mr Kidd, went to Mr Kidd's cell. He said the prisoner told him that since he had pressed the cell bell he had heard some noise coming from Mr Kidd's cell.

29. He looked through the observation panel and turned the cell light on. Mr Kidd was on the floor face down with a sheet over his lower body. A chair was on its side. The OSG knocked on the cell door several times calling Mr Kidd's name but did not get a response. He did this for 'a few minutes' and, although he had a radio, went to the wing office and phoned the control room at 3.39am. The OSG spoke to an OSG in the control room and told him what had happened. The control room OSG, in turn, told the night orderly officer, a custodial manager (CM). The OSG returned to Mr Kidd's cell and continued to try to rouse him but did not actually go into his cell.

30. The CM and three officers went immediately to Mr Kidd's cell arriving at approximately 3.45am. The OSG passed the CM the key to Mr Kidd's cell from his sealed pouch. The CM opened the cell door, went in with his colleagues and checked Mr Kidd for signs of life. Mr Kidd's arm was warm but neither CM nor an officer could detect a pulse. The CM rolled Mr Kidd on his back and checked for signs of breathing but there were none. The CM asked an officer to fetch a defibrillator from the lower lobby of the wing. He returned with it at approximately 3.46am. The CM asked an officer to contact the control room to call an ambulance, which he did immediately. The control room OSG called an ambulance at 3.48am.

31. The CM and an officer started manual cardiopulmonary resuscitation (CPR – a life saving technique) as the defibrillator did not advise that they administer an electric shock. At 4.17am paramedics arrived at the prison. Their attempts at CPR were unsuccessful and they declared Mr Kidd dead at approximately 4.41am.

Contact with Mr Kidd's family

32. At 6.00am on 5 September, the prison appointed two officers as family liaison officers. They left the prison at 8.20am and informed Mr Kidd's next of kin of his death at 11.05am. They maintained contact with the family to offer support and advice.

33. Mr Kidd’s funeral was held on 6 October 2017. One of the family liaison officers attended and the prison contributed to the costs in line with national policy.

Support for prisoners and staff

34. After Mr Kidd’s death, the duty governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

35. The prison posted notices informing other prisoners of Mr Kidd’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 Kidd’s death.

Post-mortem report

36. The coroner concluded that the cause of Mr Kidd’s death was ischaemic and hypertensive heart disease.

Findings

Clinical care

37. Mr Kidd had screenings and vaccinations in line with NHS policy and staff prescribed medication to help lower his blood pressure, although it appears that he was not always compliant with medication (a post-death cell inspection revealed an excess of prescribed medicines).

38. We asked the clinical reviewer about the implications of Mr Kidd not taking his medication and he told us that Mr Kidd was receiving medications to help shrink his prostate and to help lower his blood pressure. He said that if Mr Kidd was not taking his blood pressure medication regularly it would not have had the optimal effects to treat his hypertension.

39. Mr Kidd's daughter told us that Mr Kidd had made a serious suicide attempt with paracetamol in the past and questioned whether he should have had any quantity of medication in his own possession. Mr Kidd's medical notes state that his suicide attempt was in excess of 30 years ago. Although he had refused food while in prison in 2014, the medical notes say that this was until he got a single cell and there are no recent concerns documented about his mental health or suitability for in possession medication.

40. Mr Kidd's daughter was also concerned that no qualified person had reviewed Mr Kidd's ECG in August 2017. The clinical review states that, although the ECG revealed that not quite the expected amount of blood was reaching the heart muscles, the results did not show anything that would have prompted urgent intervention.

41. However, the clinical reviewer found that the care Mr Kidd received was not equivalent to that which he could have expected to receive in the community in that on two occasions staff failed to act on blood results which indicated that Mr Kidd had diabetes. Results in January 2015 and 2016 should have prompted further action. They did not. As a result, staff did not appropriately diagnose or treat Mr Kidd's diabetes - The clinical reviewer has not formed an opinion as to whether it is likely or unlikely that treatment for early diabetes would have prevented Mr Kidd's death from heart disease. He said that 'it would be expected that the diagnosis of type two diabetes be made from abnormal blood results with the aim to initiate measures to decrease the development of complications including heart disease'.

    The Head of Healthcare should ensure that clinicians promptly and appropriately review and follow up abnormal blood test results, especially where the results may indicate a significant condition.

The Emergency Response

42. The prison's local policy on entering cells in a medical emergency says that staff should assess the risk of entering alone and use the key in the sealed packet. The examples of emergencies it gives include an individual being found 'hanging' or 'seriously cut and bleeding profusely'. The National Security Framework *'Nights Function – Management and Security of Nights'* refers to the importance

of the ‘preservation of life’ and does not cite specific examples other than where there is ‘immediate danger to life’.

43. The local instruction talks both about staff entering cells on their own and in the same section the need for staff to ‘wait for the approach of a second member of staff’.

44. The OSG established that Mr Kidd could not respond to his calls very shortly after 3.35am. He did not go into the cell to help and did not contact anyone else for help until 3.39am. In the OSG’s additional statement, submitted after we issued the original initial version of our report, he said that he conducted a risk assessment before deciding not to enter Mr Kidd’s cell. He said he decided not to go in because he believed his personal safety was at risk; according to the OSG, Mr Kidd’s neighbour said he had heard Mr Kidd moving about three minutes beforehand.

45. We do not consider that the local instructions properly reflect the provisions of the National Security Framework and that, given what he could see, the OSG should have considered Mr Kidd’s situation to be an emergency where life was at risk.

46. Prison Service Instruction (PSI) 03/2013 requires prisons to have a medical emergency response code protocol, which should ensure that an ambulance is called immediately when a medical emergency is called. The PSI notes that it is better to act with caution and request an ambulance that can be cancelled later if it is not needed. The prison’s local policy on emergency responses is in line with the national policy in that it sets out what emergency codes should be used and that ambulances should be called immediately.

47. The OSG did not call an emergency code. Although he had a radio, he chose to contact the control room and the night orderly officer (a CM) by phone and describe what he had seen. Having heard the OSG’s description, the CM did not instruct the control room to call an ambulance at that point either. Instead, he and several other officers went to see what had happened. Although the officers went into the cell and established that Mr Kidd was unresponsive, it was a further three minutes before an officer asked control room staff to call an ambulance. In total, thirteen minutes had passed since a prisoner had initially raised the alarm. This is not consistent with local or national policy.

The Governor should ensure that the local policy on emergency entry to cells is clear and accurately reflects the provisions of the National Security Framework and that staff react appropriately when discovering a prisoner in need of urgent assistance.

The Governor should ensure that all staff are familiar with the local policy on emergency codes and are confident in using them.

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