Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Dunsby a prisoner at HMP Bure on 16 October 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*

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 Peter Dunsby died on 16 October 2017 of multi-organ failure caused by pneumonia and a rib fracture, while a prisoner at HMP Bure. He was 80 years old. We offer our condolences to Mr Dunsby's family and friends.

Mr Dunsby was an elderly man when he entered prison, and had a number of health concerns. During his last two years in prison, he had been undergoing treatment for bladder cancer. He was admitted to hospital after falling in his cell a few days before his death and died in hospital. Overall, I am satisfied that the care he received at Bure was equivalent to that which he could have expected to have received in the community.

However, I am concerned that Mr Dunsby was not discovered on the floor of his cell when his cell was unlocked on the morning of 11 October and that it was another hour before he was found. I am also concerned that an ambulance was not called as a matter of urgency when he was discovered.

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 **May 2018**

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Summary

Events

1. On 5 April 2013, Mr Peter Dunsby was sentenced to 16 years imprisonment for sexual offences. He was initially sent to HMP Bedford and on 18 April, was transferred to HMP Bure.

2. At his reception health screen, Mr Dunsby was noted as using a walking stick and being registered disabled. He had had a heart bypass operation 20 years earlier, had a history of high blood pressure and mildly decreased kidney function.

3. In September 2015, Mr Dunsby experienced a loss of feeling in his right arm and leg but declined an offer of a referral to see a specialist. At the same consultation, he declined the offer of a referral to see a urology specialist. In December, Mr Dunsby went to hospital following complaints of a weakness in his right-hand side. He was diagnosed with transient ischaemic attack (a temporary disruption in the blood supply to part of the brain resulting in a lack of oxygen, causing symptoms similar to a stroke).

4. In January 2016, Mr Dunsby declined a further offer of a urology referral, following concerns over urinary tract infections. In May, he agreed to a urology referral following increased urinary problems and, on 21 June, an ultrasound scan detected a mass near to his bladder. On 26 August, Mr Dunsby had surgery to remove a bladder tumour, and to widen his urinary tract to ease the passing of urine. He continued to be reviewed by the urology department, and in April 2017, had further surgery to remover bladder tumours.

5. Mr Dunsby's health gradually declined. On 2 July 2017, he went to hospital with decreased movement in his right arm and leg but was discharged two days later.

6. On 3 August, Mr Dunsby refused to attend a scheduled hospital appointment, because he did not want to be restrained.

7. On 11 September, a prison GP reviewed Mr Dunsby following a fall in his cell, and noted that a transfer to HMP Norwich should be considered. Five days later, Mr Dunsby went to hospital due to a loss of feeling on his right-hand side, but was discharged the next day. Two days later, a transfer to Norwich was agreed.

8. On 11 October, an officer found Mr Dunsby on the floor of his cell, conscious but in pain. A nurse attended and monitored Mr Dunsby until he was taken to the hospital by ambulance. On 16 October, Mr Dunsby died in hospital.

Findings

Emergency response

9. We are concerned that Mr Dunsby was not discovered on the floor until 8.58am – from what he told staff he had been there for some time - despite having been unlocked an hour earlier. While this may not have affected the outcome, we would have expected staff to have checked him when they unlocked his cell. We are also concerned that despite an emergency code being called at 8.58am, an ambulance was not requested for a further 15 minutes. However, we recognise that the prison has reviewed its policies in light of a recommendation in an earlier report.

10. We are also concerned that there is no clear record setting out what happened.

Clinical care

11. We agree with the clinical reviewer that the care Mr Dunsby received at Bure was equivalent to that which he could have expected to have received in the community. We find that staff appropriately cared for Mr Dunsby at Bure, and that when it became apparent they could no longer adequately look after him, they initiated the process of transferring him to Norwich without delay.

Family contact

12. We consider that Bure maintained good contact with Mr Dunsby's family throughout, and acted appropriately in respecting his wishes about contact.

Restraints and security

13. We find that the prison appropriately took the decision not to restrain Mr Dunsby on most of his escorts to outside hospital. However, we are concerned that he was restrained on one occasion, and that he refused to attend an appointment at the hospital on another occasion because he was going to be restrained.

14. We acknowledge that the prison have since updated their policy and procedures regarding restraints in light of previous recommendations from our office, and therefore make no recommendation.

Recommendations

- The Governor should ensure that staff are given clear guidance and reminded of their responsibilities when unlocking cells.

- The Governor and head of healthcare should ensure that staff are reminded of their duty to keep accurate records at all times, in particular, during emergencies and when prisoners' welfare is at issue.

The Investigation Process

15. The investigator issued notices to staff and prisoners at HMP Bure informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

16. The investigator obtained copies of relevant extracts from Mr Dunsby's prison and medical records.

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

18. We informed HM Coroner for Greater Norfolk of the investigation. There was no post-mortem in this case, but she confirmed Mr Dunsby's cause of death. We have sent the coroner a copy of this report.

19. The investigator wrote to Mr Dunsby's daughter to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. She did not respond to our letter.

20. 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. The action plan has been annexed to this report.

Background Information

HMP Bure

21. HMP Bure is a medium security prison near Norwich, which holds over 600 men, convicted of sexual offences.

22. Virgin Care provides healthcare services. Healthcare staff are on duty between 8.00am and 6.30pm on weekdays and between 8.00am and 5.30pm at weekends. Five GP clinics are scheduled each week. There is an out-of-hours service which is provided by the NHS 111 service.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Bure was conducted 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 a GP, who coordinated their approach with healthcare staff.

Independent Monitoring Board

24. 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 2017, the IMB reported that healthcare staffing levels were below target levels, but there was no evidence that this impacted on performance or delivery. The Board had reservations about the communication between the prison, healthcare, the NHS and social services, but overall they considered healthcare staff to be committed and dedicated to their work.

Previous deaths at HMP Bure

25. Mr Dunsby was the seventh prisoner to die of natural causes at Bure since January 2016. There are no similarities between his death and the previous ones.

Key Events

26. On 20 December 2012, Mr Peter Dunsby was remanded to HMP Bedford. On 5 April 2013, he was sentenced to 16 years imprisonment for sexual offences. He initially returned to Bedford, but on 18 April, he was transferred to HMP Bure.

27. A nurse reviewed Mr Dunsby at a health screen on his reception at Bure. He informed her that he had had heart bypass surgery 20 years earlier. The nurse recorded his history of high blood pressure, and noted that he was taking medication for it. She also recorded that he was retired and registered as disabled in the community but that he wanted to perform light work duties.

28. The following day, a nurse reviewed Mr Dunsby at a secondary health screen, and noted that he was unsteady on his feet and used a walking stick. On 25 April, a prison GP noted that Mr Dunsby had a mildly decreased kidney function. Over the next couple of years, Mr Dunsby had no significant health concerns, but attended monthly older prisoners' clinics.

29. On 20 September 2015, Mr Dunsby informed a nurse that he could not feel his right arm or leg. On 25 September, a prison GP reviewed Mr Dunsby and recorded that he could move all his limbs, had no facial weakness, and spoke without slurring. Mr Dunsby declined an offer of a referral for further tests. The GP also observed that Mr Dunsby had symptoms of a lower urinary tract problem, and suspected that he had an enlarged prostate. He offered Mr Dunsby a referral to the urology clinic, which he also declined.

30. On 6 November, a prison GP examined Mr Dunsby following complaints of numbness and heaviness on his right-hand side. The GP ruled out a stroke, but suspected a transient ischaemic attack. The GP noted that Mr Dunsby had many of the risk factors for a stroke, and planned for a referral to the hospital for checks.

31. On 13 December, a nurse saw Mr Dunsby following complaints of right-sided weakness. She monitored him for a while, but later sent him to hospital for checks. Mr Dunsby was diagnosed with transient ischaemic attack, and sent back to Bure the next day with instructions for managing his condition. During the following 18 months, Mr Dunsby had several minor ischaemic attacks from which he recovered fairly quickly.

32. On 14 December, a prison GP prescribed Mr Dunsby trimethoprim (an antibiotic used for bladder infections). This appears to be consequent to a urine test taken ten days earlier, which showed traces of protein and glucose. The GP reviewed Mr Dunsby on 22 January 2016, following concerns over urinary tract infections and increased urination at night. The GP offered Mr Dunsby a referral to the urology clinic, but he declined.

33. On 13 May, a nurse saw Mr Dunsby in his cell after he complained of increased urination during the night. Mr Dunsby told her that he had had difficulty passing urine that day and, when he managed to, passed a large blood clot. Three days later, a nurse followed this up, and Mr Dunsby agreed to a referral to the urology clinic.

34. On 21 June, Mr Dunsby had an ultrasound scan at the urology clinic. This scan detected a mass near his bladder. This was thought to be vascular (that is relating to a blood vessel blockage). On 6 July, a prison GP informed Mr Dunsby that he required a cystoscopy (a thin camera examination of the inside of his bladder) and a biopsy to determine what this mass was.

35. On 26 August, Mr Dunsby had surgery to remove a bladder tumour, and to widen his urinary tract to ease the passing of urine. The consultant urological surgeon explained that the tumour was extensive and occupied most of Mr Dunsby's bladder. On 28 August, Mr Dunsby was discharged back to Bure. Three days later, a nurse saw him in his cell after he complained about pain, blood in his urine, and of feeling blocked. She consulted the registrar urologist, who advised that Mr Dunsby had a urinary tract infection, and advised a course of trimethoprim. Following surgery, and over the next few months, Mr Dunsby continued to be monitored and reviewed by the hospital urology department.

36. On 28 March 2017, an appointment was made for further surgery in April. On 7 April, a nurse observed that Mr Dunsby had had two urinary tract infections in three weeks. Later that day, a prison GP reviewed Mr Dunsby's urine test, and prescribed a course of trimethoprim.

37. On 25 April, Mr Dunsby had surgery to remove further bladder tumours, and a cystoscopy. Four days later, he was sent back to Bure. The discharge letter stated that he had an acute kidney injury while he was in hospital (sudden damage to the kidneys, normally as a complication of another serious illness, that causes them not to work properly). On 2 May, a prison GP reviewed Mr Dunsby. He noted the acute kidney injury he had in hospital, and instructed healthcare staff to monitor him.

38. On 15 June, the consultant urological surgeon wrote to the healthcare unit at Bure, and advised them to manage Mr Dunsby conservatively. The letter added that a further cystoscopy was arranged for November that year.

39. On 2 July, a nurse reviewed Mr Dunsby after he became ill during a visit. Mr Dunsby said his "right hand side felt heavy and tingly". The nurse noted that he had no facial droop, but had decreased movement in his right arm and leg. Mr Dunsby went to hospital, but on 4 July, he returned to Bure. The discharge letter stated that he "remained medically well during inpatient stay".

40. On 27 July, a nurse issued a renewed older person's instruction for Mr Dunsby, to advise staff of changes in his condition. She stated that his observations needed to be performed more regularly due to his recent ill health and immunotherapy treatment. (This is a type of treatment that boosts the body's natural defences to fight the cancer.)

41. On 3 August, a nurse noted "Mr Dunsby has refused to attend his hospital appointment this afternoon due to him having to be cuffed." The following day, the nurse saw Mr Dunsby, who told her that he "has been to hospital in the past where he has not been cuffed by officers. States he will not be attending any hospital appointments in the future if he has to be cuffed."

42. On 11 September, a prison GP saw Mr Dunsby after he fell in his cell. Mr Dunsby said that he fell as he was trying to dress, and that he was unable to get anyone to wash him due to staff shortages. The GP recorded that Mr Dunsby had a bruise to his chest from an accidental fall, and prescribed him pain killers. He also recorded that a transfer to HMP Norwich should be considered, due to their superior healthcare facilities. The following day, a nurse reviewed Mr Dunsby's falls risk assessment due to his increased risk of falling.

43. On 16 September, a nurse saw Mr Dunsby following complaints that he had lost feeling in his right-hand side and was unable to stand. Mr Dunsby was sent to hospital but discharged the following day. A nurse reviewed him on his return, and noted that he was confused and had very poor mobility. She spoke to the deputy head of healthcare at Norwich, and two days later they agreed to Mr Dunsby's transfer.

44. On 11 October, at approximately 8am, an officer unlocked Mr Dunsby's cell. A little under an hour later, Officer A and Officer B attended to Mr Dunsby in his cell after being told he was in distress. They found him on the floor, conscious but in a lot of pain. Mr Dunsby told Officer A that he had fallen and banged his head, back, ribs and hip. Officer B called a code blue. (This is an emergency radio code which indicates someone is unconscious or having trouble breathing and immediately alerts healthcare staff and the control room to call for an ambulance.)

45. An entry in the control room log made at 8.58am records that a code blue emergency was called. Officer A made the sole entry in Mr Dunsby's prison record, and noted that he arrived at Mr Dunsby's cell at 9.10am. He further noted that healthcare staff were informed and attended promptly, but did not record that a code blue had been called

46. At 11.18am, a nurse made an entry on Mr Dunsby's medical notes, and noted a contact time of 120 minutes. She recorded that she arrived at Mr Dunsby's cell in response to a code blue call. She noted that she "found patient laying on his right side on the floor, head by the safe which was open (heavy strong metal) head felt, no blood present, patient unable to move, told me his back hurt and his legs were feeling numb. He said he had been there since it was dark." She performed full observations, and observed that Mr Dunsby was unable to maintain his own oxygen. She noted that an ambulance was called.

47. An entry in the control room log made at 9.13am records that an ambulance was called for Mr Dunsby. A further entry at 10.15am noted that an ambulance was on its way to Mr Dunsby's residential block. A final entry made at 11.15am, records that the ambulance had left with Mr Dunsby on route to Norfolk and Norwich University Hospital.

48. On 12 October, a nurse spoke to the hospital for an update. She recorded that Mr Dunsby had fractured his ribs, was on oral antibiotics, and was receiving oxygen as he was unable to maintain adequate saturation. The following day, a nurse recorded: "Staff nurse states that it was not an emergency situation and its not life threatening at present."

49. On 16 October at 9.50pm, after several days during which his condition was recorded as “unchanged”, Mr Dunsby died in hospital.

Contact with Mr Dunsby’s family

50. Mr Dunsby’s next of kin was his daughter. On 9 August 2016, following his diagnosis of bladder cancer, the prison appointed two family liaison officers (FLOs). The next day, one of the FLOs introduced herself to Mr Dunsby, and arranged for him to speak to his daughter in private.

51. On 8 October, Mr Dunsby told the FLO of his concern for his daughter, given his condition and the recent death of her mother. The FLO introduced herself to Mr Dunsby’s daughter and maintained contact with her from that point. On several occasions during the year, Mr Dunsby asked for his daughter not to be informed when he went into hospital, so as not to worry her.

52. On 13 October 2017, following a request from Mr Dunsby, a Custodial Manager (CM) informed Mr Dunsby’s daughter that her father was in hospital. The CM also advised Mr Dunsby’s daughter of the visiting arrangements.

53. On 16 October, a prison manager briefed the FLO of the situation on her return to work after leave. He informed her that Mr Dunsby’s daughter was aware and had been visiting her father. Later that day, the FLO visited Mr Dunsby in person at the hospital. Mr Dunsby informed her that his daughter would be visiting the next day, so the FLO agreed to meet her in person at the hospital.

54. On 16 October, at 7.10pm, a CM informed the FLO “that Mr Dunsby had taken a turn for the worse” and that she needed to inform his daughter. Shortly afterwards, an officer informed the FLO that the doctor had already told Mr Dunsby’s daughter of the situation and that she was on her way to the hospital. Mr Dunsby’s daughter arrived at 9.10pm, and was by her father’s side when he died. Shortly after 10pm, the FLO introduced herself to Mr Dunsby’s daughter in person and offered her support.

55. Mr Dunsby’s funeral was held on 3 November. The prison contributed to the cost in line with national guidance.

Support for prisoners and staff

56. After Mr Dunsby’s death, a prison manager debriefed the staff involved with Mr Dunsby, to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

57. The prison posted notices informing other prisoners of Mr Dunsby’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 Dunsby’s death.

Post-mortem report

58. There was no post-mortem in this case. The cause of death was given by the Consultant in Anaesthesia and Critical Care at the hospital. He gave the cause of death as multi-organ failure caused by pneumonia and a rib fracture. He

added that bladder cancer, chronic kidney disease, cerebrovascular accident and myocardial infarction, were also all contributing factors to Mr Dunsby's death.

Findings

Emergency response

59. In October 2016, HMP Bure issued a notice to remind staff of their responsibility according to Prison Service Instruction (PSI) 75/2011, *Residential Services*:

> It is a requirement that staff satisfy themselves of a prisoner's welfare/well-being during or shortly after unlock…. Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process."

60. There is no record of which officer unlocked Mr Dunsby on 11 October, but the prison has confirmed that this happened at approximately 8.00am. Mr Dunsby was not discovered for about an hour after being unlocked. Given that he told the nurse who attended to him that he had been on the floor since it was dark, this suggests that the officer who unlocked his cell did not check on his wellbeing. We cannot say whether a more thorough check would have affected the outcome for Mr Dunsby, but we would have expected the officer who unlocked Mr Dunsby's cell to have done more, in line with the prison's policy.

The Governor should ensure that staff are given clear guidance and reminded of their responsibilities when unlocking cells.

61. Prison Service Instruction (PSI) 03/2013, *Medical Response Codes*, requires prisons to have a two code medical emergency response system in place. In more serious cases, a code blue should be used to indicate an emergency when a prisoner is unconscious, or having breathing difficulties, and code red when a prisoner is bleeding. Calling an emergency medical code should automatically trigger the control room to call an ambulance.

62. Despite the control room log stating that a code blue was called at 8.58am, the ambulance was not requested until 9.13am. While this may not have affected the outcome in this instance, we are concerned that the proper emergency response protocol was not followed here. However, we are satisfied that the prison has reviewed its policies related to emergency response following a recommendation made in another case, and so make no recommendation on this occasion

63. We are concerned that the entry in Mr Dunsby's prison record does not record the time or details of this incident accurately. There was no record of the code blue being called other than in the control room log, and no record of which other officer or officers were in attendance at that time.

64. We also consider that the entry on Mr Dunsby's medical record was unclear. The entry was timed at 11.18am, not the time healthcare staff first arrived on scene. The record does not set out communication with the ambulance service, which might have helped to explain why they did not arrive until 10.15am despite being called an hour earlier.

65. The limited information in the records has made it difficult to fully understand the circumstances in which Mr Dunsby was found and the subsequent response.

The Governor and head of healthcare should ensure that staff are reminded of their duty to keep accurate records at all times, in particular, during emergencies and when prisoners' welfare is at issue.

Clinical Care

66. The clinical reviewer considered that the care Mr Dunsby received at Bure was equivalent to that he could have expected to have received in the community. He was regularly seen by healthcare staff and prison GPs while at Bure, and appropriately referred to external specialists when necessary. On several occasions, Mr Dunsby declined these referrals, and his wishes were respected.

67. As Mr Dunsby's condition deteriorated steadily during his time at Bure, staff cared for him there as well as they could. When it became apparent that they could no longer adequately look after him, a transfer to Norwich was initiated. Unfortunately, Mr Dunsby died before this move could be finalised. We agree with the clinical reviewer, and consider that Mr Dunsby was appropriately cared for during his time at Bure.

Family contact

68. As soon as Mr Dunsby's bladder cancer was confirmed, a family liaison officer (FLO) was appointed. The FLO remained in regular contact with both Mr Dunsby and his daughter for the duration of his stay at Bure.

69. When Mr Dunsby went into hospital in October 2017, his daughter was not contacted immediately. However, we recognise that his previous wish was for her not to be informed every time he went to hospital because he did not want her to be worried. Mr Dunsby had always made it clear when he wanted his daughter to be contacted and as soon as he asked for this his daughter was informed straight away. His daughter was by his bedside when he died. We consider that Bure acted appropriately in respecting Mr Dunsby's express wishes, and in the prison's contact with the family throughout.

Restraints and security

70. 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 of 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 such 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.

71. When Mr Dunsby went to hospital towards the end of April 2017, the initial decision to restrain him was reviewed by a manager following medical advice and input from security staff. It was appropriately considered that restraints were

not necessary due to his limited mobility. However, we are concerned that on Mr Dunsby's next escort six weeks later, there was no medical input, and a manager took the decision to restrain him. We are also concerned that Mr Dunsby refused to attend an appointment at the hospital at the beginning of August, because he was going to be restrained.

72. We note that Bure acted appropriately in not restraining Mr Dunsby on several further hospital escorts during the summer, following a full appraisal of the actual risk he posed. However, this served to emphasise the need for consistency at the prison concerning prison escorts.

73. We acknowledge that Bure have acted on previous recommendations and input from our office, and have reviewed the prison's procedure for restraints, especially in respect of elderly or infirm prisoners. In particular, Bure now keeps a database of prisoners with medical conditions, to help the prison make more consistent decisions as to whether to restrain prisoners on escort or not. The prison has also updated its risk assessment for restraints, to facilitate more comprehensive input from healthcare staff, so as to ensure any decisions are properly informed.

74. Given these developments (which we welcome), we make no recommendation.

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