

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Harold Burnett a prisoner at HMP Garth on 16 December 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.

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

Mr Harold Burnett died in hospital of a lung infection (that he acquired in hospital) and lung disease on 16 December 2017 while a prisoner at HMP Garth. He was 83 years old. I offer my condolences to Mr Burnett's family and friends.

Mr Burnett had several chronic medical conditions, including lung disease and heart failure. He was appropriately referred for an urgent hospital appointment with a specialist after an x-ray showed problems with his heart, but healthcare administrators do not appear to have followed this up for nearly two months despite being asked to by GPs, and he had still not received an appointment date when he was admitted to hospital more than two months later. While this does not appear to have affected the outcome for Mr Burnett, in other cases, such a delay could be crucial and it is important that healthcare staff follow national guidelines for suspected heart failure.

We are concerned that the prison did not follow their guidance on non-emergency medical assistance. This meant that a nurse did not visit Mr Burnett in his cell in a timely manner. We are also concerned that the prison failed to inform Mr Burnett's next of kin when he was admitted to hospital.

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**

**July 2018**

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# Summary

## Events

1. On 2 November 2015, Mr Harold Burnett was sentenced to 12 years in prison for sexual offences and sent to HMP Doncaster. After spending time at other prisons, Mr Burnett was moved to HMP Garth on 26 May 2017.
2. Mr Burnett had several chronic medical conditions, including heart failure and lung disease. Healthcare staff reviewed him frequently and prescribed medication, as necessary.
3. On 20 July, a prison GP arranged for Mr Burnett to be referred urgently to a cardiologist after an x-ray showed problems with his heart. Despite requests from GPs, healthcare administrators did not chase this appointment up until 15 September, and Mr Burnett did not see a specialist.
4. At approximately 7.20am on 26 November 2017, Mr Burnett pressed his cell bell and complained of breathlessness. The prison officer went to the wing office to call the healthcare team to ask for a nurse to attend. Healthcare staff said that someone would visit when they were on the wing in approximately one hour. However, no one attended until wing staff asked a nurse to visit Mr Burnett in his cell. She examined him at 10.00am and radioed a code blue medical emergency code and the control room called an ambulance. Paramedics took Mr Burnett to hospital. Two officers escorted him and appropriately they did not apply handcuffs.
5. Hospital doctors diagnosed heart failure and lung disease. Mr Burnett's condition deteriorated and he died in hospital on 16 December 2017.

## Findings

6. The clinical reviewer considered that overall, the care Mr Burnett received at Garth was equivalent to that which he could have expected to receive in the community. However, she said that staff failed to follow up a hospital referral for Mr Burnett which had been delayed. This meant that hospital specialists did not see Mr Burnett within the published guidelines.
7. When Mr Burnett was unwell in his cell, we would have expected the wing officers to alert a manager and to have monitored him more closely to check on his wellbeing. We would also have expected healthcare staff to have made arrangements to see Mr Burnett.
8. In addition, we are concerned that the prison did not inform Mr Burnett's next of kin when he was admitted to hospital seriously ill, as they should have done.

## Recommendations

- **The Head of Healthcare should ensure that staff monitor any urgent referrals to a hospital specialist to avoid delays.**
- **The Governor and Head of Healthcare should ensure that all prison and healthcare staff are made aware of and understand Garth's Information**

**Notice 106/15 and their responsibilities following requests for medical assistance.**

- **The Governor should ensure that staff notify a prisoner's next of kin as soon as possible when a prisoner becomes seriously ill.**

## The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Garth informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
10. The investigator obtained copies of relevant extracts from Mr Burnett's prison and medical records.
11. The investigator interviewed one member of staff by telephone on 30 January 2018.
12. NHS England commissioned a clinical reviewer to review Mr Burnett's clinical care at the prison.
13. We informed HM Coroner for Lancashire and Blackburn with Darwen of the investigation who gave us the cause of death. We have sent the Coroner a copy of this report.
14. The investigator contacted Mr Burnett's family, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They did not respond.
15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

# Background Information

## HMP Garth

16. HMP Garth holds up to 846 men, many serving indeterminate sentences for public protection (IPP), life sentences, or other long sentences. Lancashire Care Foundation Trust provides health services. Nurses are on duty between 7.00am and 9.00pm every day. Chorley Medics provide a service outside these times. GP clinics are held every day, normally from 9.00am to 1.00pm but occasionally from 1.00pm to 5.00pm. There is no inpatient unit.

## HM Inspectorate of Prisons

17. The most recent inspection of HMP Garth was in January 2017. Inspectors reported that the range of primary healthcare clinics was appropriate but waiting times were unacceptably long for GP appointments, at around 5 weeks. Prisoners with urgent health needs were seen promptly and access to the community out-of-hours GP service was appropriate and prisoners with acute health needs or injuries could access daily nurse assessment clinics.

## 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 30 November 2016, the IMB at HMP Garth reported that GP waiting times had reduced from 4-5 weeks to 3 weeks. They also noted that because a medical mobile unit (used for CT scans, x-rays, MRI scans and ultrasound scans) attended the prison, there were fewer missed hospital appointments caused by a lack of escorts.

## Previous deaths at HMP Garth

19. Mr Burnett was the sixth prisoner to die from natural causes at Garth since January 2016. There were no similarities between Mr Burnett's death and the other deaths. However, there were previous investigations where we found that there were delays with contacting the next of kin.

## Key Events

20. Mr Harold Burnett was sentenced to 12 years in prison on 2 November 2015 for sexual offences and sent to HMP Doncaster. After spending time at other prisons, Mr Burnett was moved to HMP Garth on 26 May 2017.
21. Mr Burnett had several chronic medical conditions, including heart failure, lung disease, high blood pressure, rheumatoid arthritis, depression, an enlarged prostate gland, small growths on his bowel and heartburn. Healthcare staff created care plans to manage these. They reviewed him frequently and prescribed medication as necessary.
22. On 8 June 2017, Mr Burnett told a prison GP that for at least eight months he had shortness of breath when he walked up stairs. He arranged a chest x-ray and blood tests. Mr Burnett had the x-ray on 14 July.
23. On 20 July, a prison GP reviewed the results. He noted that the blood test results showed that Mr Burnett was anaemic and the x-ray showed heart muscle disease (cardiomegaly), heart failure and fluid around his lungs (pleural effusion). He discussed this with Mr Burnett and arranged for him to be referred urgently to the hospital cardiology department. A healthcare administrator, emailed the referral on 21 July.
24. On 17 August, a prison GP reviewed Mr Burnett. He noted that the urgent referral was outstanding and he asked administrative staff to check with the hospital. On 30 August, a prison locum GP examined Mr Burnett and noted that the cardiology referral was outstanding.
25. On 14 September, a prison GP noted the appointment was still outstanding. He again asked the administration team to follow this up. The next day, a healthcare administrator, told a prison GP that Mr Burnett was still on a hospital waiting list. There is no other record of administrative staff chasing the hospital about the urgent cardiology referral.
26. Mr Burnett frequently saw healthcare staff as he was generally unwell, and needed a lot of medication to manage his conditions. His condition remained stable until the end of November 2017.

### Events from 26 November 2017

27. Mr Burnett was in a single cell in a residential unit. At approximately 7.20am, he pressed his cell bell. An officer was working temporarily on the wing. He was in the office and responded to Mr Burnett. He said that he opened the cell door observation panel and saw Mr Burnett sitting on his bed. He said that Mr Burnett said that he had coughed up blood. He said that he could not see any blood around his mouth or on the floor so he told him that he would telephone the healthcare team for someone to visit him.
28. The officer said that he returned to the office and telephoned the healthcare unit. They told him that someone from the healthcare team would visit Mr Burnett at 8.30am when they visited the wing to dispense medication to prisoners. He said that he told Mr Burnett and the wing staff this. He also said that he returned to

the cell at approximately 7.50am and Mr Burnett appeared to be asleep as he was snoring. He left the wing to resume his duties at approximately 8.15am.

29. A nurse arrived at approximately 9.15am to administer medication on the wing. She said that when she was administering the medication, wing officers asked her to examine Mr Burnett as he was “struggling to breathe”. She said that she went to his cell.
30. Records show that at approximately 10.00am, two nurses visited Mr Burnett’s cell. Mr Burnett was on his bed and complained of shortness of breath. A nurse checked his observations. He had high blood pressure (145/60mmhg) and his oxygen saturation levels were low at 77%. (Normal is usually from 95 -100%.) At 10.03am, a nurse radioed a medical emergency code blue (which indicates a prisoner is unconscious or has breathing difficulties).
31. Records show that the communications room staff called an ambulance at 10.03am. Paramedics took Mr Burnett to hospital. Appropriately, he was not restrained.
32. Hospital doctors diagnosed Mr Burnett as having heart failure and lung disease. His condition deteriorated and he died in hospital on 16 December.

### **Contact with Mr Burnett’s family**

33. On 30 November 2017 while Mr Burnett was in hospital, he asked the prison escort staff whether his wife could be contacted. They told him that they would check with prison managers. On 1 December, prison managers gave permission for his family to visit him. They saw him frequently.
34. A primary healthcare manager, said that Mr Burnett’s condition was not considered life-threatening until 14 December when healthcare staff were told that his condition had deteriorated. Prison staff then arranged for a family liaison officer to be appointed.
35. On 15 December, the prison appointed an offender supervisor, as the family liaison officer (FLO). The FLO and a prison chaplain, visited Mr Burnett’s wife and offered support to the family.
36. On 16 December, hospital staff said that Mr Burnett had deteriorated and they had contacted his family to attend the hospital. Mr Burnett’s family were with him when he stopped breathing at 7.25am.
37. After Mr Burnett died, the FLO contacted Mr Burnett’s wife and offered her condolences and support. They arranged a convenient time for her to visit. As arranged, the FLO visited Mr Burnett’s wife on 18 December to offer her support.
38. Mr Burnett’s funeral was on 3 January 2018. The prison contributed to the costs in line with national policy.

### **Support for prisoners and staff**

39. After Mr Burnett's death, a prison manager debriefed the bedwatch staff to ensure that 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 Burnett'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 Burnett's death.

#### **Cause of death**

41. The Coroner gave the cause of death as hospital-acquired pneumonia, interstitial lung disease and heart failure. Ischaemic heart disease was identified as a significant contributory factor.

# Findings

## Clinical care

42. The clinical reviewer said that Mr Burnett received appropriate responsive care for his many medical conditions. She said that healthcare staff appropriately responded to any deterioration and sought specialist advice and support when required.
43. We agree with the clinical reviewer that overall, Mr Burnett'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.
44. However, the clinical reviewer also said that the National Institute for Health and Care Excellence (NICE) Guidance requires patients with suspected heart failure and previous heart attack to be seen by a specialist within two weeks. A prison GP arranged for Mr Burnett to be referred urgently to the hospital cardiology department on 20 July. GPs asked for the hospital to be chased on three occasions but the only record of prison healthcare staff doing so is on 15 September. This meant that specialists did not see Mr Burnett within the timescales specified in the national guidelines. The clinical reviewer said that this may not have impacted on the eventual outcome for Mr Burnett, but in other circumstances, it might. We therefore recommend that:

**The Head of Healthcare should ensure that staff monitor any urgent referrals to a hospital specialist to avoid delays.**

## Non-emergency medical assistance

45. The local procedures for dealing with emergency and non-urgent medical procedures are outlined in Garth's Information Notice 106/15, which was published in August 2015. This says that if a person discovering a casualty deems that emergency treatment is not required, they should telephone the healthcare team or the control room and ask to speak to the duty nurse. The notice says that the healthcare team, in conjunction with a member of staff, will agree the appropriate course of action to treat and support the prisoner. (This will either be for the prisoner to attend the healthcare unit for treatment or for a member of the healthcare team to attend the scene.) It also says that in all instances, the duty manager must be informed and should attend the scene and if on duty, the manager of the department/unit should be informed.
46. Mr Burnett rang the cell bell because he was feeling unwell. An officer responded promptly, spoke to Mr Burnett and telephoned for healthcare assistance. He told the investigator that he told his colleagues and then left to continue with duties away from the wing. Mr Burnett was left alone in his cell. There was no evidence until a nurse arrived at the cell, that anyone checked on Mr Burnett after an officer checked him.
47. We would have expected the wing officers to alert a manager and to have monitored Mr Burnett more closely to check on his wellbeing. Healthcare staff should have contacted wing staff to let them know that no one was available to

attend at 8.30am. They should also have told the attending nurse about an officer's request. We agree with the clinical reviewer that this was a missed opportunity to intervene more promptly. While there is no evidence that on this occasion, this made any difference to the outcome for Mr Burnett, on another occasion, it might. We therefore make the following recommendation:

**The Governor and Head of Healthcare should ensure that all prison and healthcare staff are made aware of and understand Garth's Information Notice 106/15 and their responsibilities following requests for medical assistance.**

#### **Informing a prisoner's next of kin**

48. Prison Rule 22(1) says that when a prisoner becomes seriously ill, the Governor should inform the prisoner's next of kin at once. Prison Service Instruction (PSI) 64/2011 on safer custody requires prisons to ensure that staff engage with the next of kin of prisoners who are seriously ill. It says that this should be done in a timely manner.
49. Records show that when Mr Burnett was in hospital, prison staff did not try to contact his family. When the investigator asked why, the prison said that, for security reasons, they did not routinely advise prisoner's families that they were going to hospital unless the situation was life-threatening. The duty manager on the day that Mr Burnett went to hospital, said that although Mr Burnett left in ambulance, it was not deemed an emergency or life-threatening at the time.
50. PSI 64/2011 requires staff to encourage prisoners who have an unpredicted or rapid deterioration in their physical health to engage with their families, and the head of safer custody, said that unless a prisoner had a life-threatening illness or injuries, prisoners in hospital would contact their family themselves. She said that until 14 December, Garth did not have any information to suggest Mr Burnett had a life-threatening condition.
51. We acknowledge that the prison permitted Mr Burnett to call his family when he asked to be allowed to do so on 30 November. However, he was an elderly, seriously ill prisoner whose health had deteriorated and warranted an emergency hospital admission, and we consider that his family should have been informed when he was admitted hospital on 26 November. We make the following recommendation:

**The Governor should ensure that staff notify a prisoner's next of kin as soon as possible when a prisoner becomes seriously ill.**

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