Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Brian Lucking, a prisoner at HMP Bure, on 21 January 2020

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.

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 Brian Lucking died in hospital on 21 January 2020, while a prisoner at HMP Bure. He died of multiple organ failure, caused by pulmonary oedema (excess fluid in the lungs) and heart failure. He was 73 years old. I offer my condolences to those who knew him.

Mr Lucking arrived at Bure with several long-term health conditions, including heart and lung disease. The clinical reviewer found that the care Mr Lucking received was of a reasonable standard and was at least equivalent to that he could have expected to receive in the community. However, she found that healthcare staff should have considered a formal mental capacity assessment when Mr Lucking repeatedly refused to take his medication. She also found some failings in clinical record keeping.

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

Sue McAllister CB
Prisons and Probation Ombudsman **August 2020**

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Summary

Events

1. On 15 August 2018, Mr Brian Lucking, who had been convicted of sexual offences, was recalled to prison for breaching his licence. On 3 October, he was sent to HMP Bure.

2. Mr Lucking had several long-term health conditions, including heart disease, hypertension (high blood pressure) and chronic obstructive pulmonary disease (COPD – the term for a group of serious lung diseases).

3. On 20 January 2020, after collecting his medication from the healthcare centre, Mr Lucking felt unwell and sat down on a bench in the prison grounds. An officer saw him and told him that he could not stay there and that he should return to the healthcare centre if he felt unwell. Mr Lucking started walking there but then fell into some bushes. The officer called a medical emergency code.

4. Healthcare staff attended quickly and an ambulance was called, but staff cancelled the ambulance after assessing that one was not needed. Staff took Mr Lucking to the healthcare centre, where his condition deteriorated very quickly. Staff called for an ambulance, which took Mr Lucking to hospital.

5. He died in hospital the next day from multiple organ failure, caused by pulmonary oedema (excess fluid on the lungs) and heart disease.

Findings

6. The clinical reviewer was satisfied that overall, the healthcare Mr Lucking received at Bure was of a reasonable standard and was at least equivalent to that he could have expected to receive in the community.

7. Mr Lucking often refused to take his medication. He had cognitive tests, the results of which were satisfactory, but the clinical reviewer found that as Mr Lucking repeatedly refused medication, healthcare staff should have considered arranging a more formal mental capacity assessment.

8. Some of the healthcare staff involved in Mr Lucking's care on 20 January failed to make full notes in his medical record.

9. The officer at the scene when Mr Lucking collapsed did not record the incident in his prison record.

Recommendations

- The Head of Healthcare should review the need for formal assessments of mental capacity for prisoners who fail to comply with treatment that is in their best interests.
- The Head of Healthcare should ensure that staff make full and accurate notes in a prisoner's medical record following involvement in their care.
- The Governor should remind staff of the need to make accurate and timely notes in the prisoner's NOMIS record following involvement in an incident.

The Investigation Process

10. 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. One prisoner responded and his comments are considered in this report.

11. The investigator obtained copies of the relevant extracts from Mr Lucking's medical and prison records.

12. NHS England commissioned an independent clinical reviewer to review Mr Lucking's clinical care at the prison.

13. We informed HM Coroner for Norfolk of the investigation. The coroner provided us with the cause of death. We have sent the coroner a copy of this report.

14. Mr Lucking had no named next of kin so there was no family involvement in the investigation.

15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HM Prison Bure

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

HM Inspectorate of Prisons

17. The most recent inspection of 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.

18. Prisoners were positive about the quality of the healthcare services. The vast majority of medications were supplied to prisoners to hold in their possession and there were appropriate risk assessments in place for this. Inspectors also found that there was effective learning from serious medical incidents.

19. At the time of the inspection, the healthcare was provided by Virgin Care. The provider was changed to Care UK in 2019 and there has been no inspection since that time.

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 31 July 2019, the IMB said that healthcare staffing levels had significantly improved. The report also noted that regular checks were made by the pharmacy technician regarding compliance with medication.

Previous deaths at HMP Bure

21. There were no other deaths at Bure in the two years before Mr Lucking's death.

Key Events

22. On 30 January 2015, Mr Brian Lucking was sentenced to four years imprisonment for sexual offences. He was released on 20 July 2018, but recalled to HMP Wandsworth on 15 August, for breaching his licence. On 3 October, he was sent to HMP Bure.

23. Mr Lucking arrived at Bure with several long-term health conditions. He had experienced heart problems for many years and in prison he used a mouth spray prescribed to relieve his symptoms when he had angina (chest pains caused by a reduced flow of blood to the heart). He was clinically obese on arrival at Bure and steadily increased his weight while he was there. This added to his health problems, which included hypertension (high blood pressure), arthritis asthma and chronic obstructive pulmonary disease (COPD – the term for a group of serious lung diseases including chronic bronchitis and emphysema).

Compliance with his treatment

24. Mr Lucking frequently disagreed with his medical treatments and demanded alternatives to those the doctors thought appropriate. When he did not get what he wanted, he was often non-compliant with his treatment and was abusive to staff.

25. On arrival at Bure, Mr Lucking initially refused all his medications except a painkiller. In March 2019, his medical notes say that of the six medications prescribed to him, he was not using any of them as directed. In May, he was not allowed to keep his medication in possession for a while before being given permission to do so again. Permission was withdrawn in August when he was again found to be non-compliant.

26. After he was not allowed to keep his medications in his cell, Mr Lucking quite often refused to collect them from the pharmacy. In September, healthcare staff told Mr Lucking that his refusal to take medication was making his COPD worse, as was the incorrect use of his asthma inhalers. These were also withdrawn from his possession by December, but were available for his use at the pharmacy if required. On 6 December, staff made Mr Lucking aware of the need to take his medication and asked him to sign a refusal form, but he declined.

Recent history of code blues and alarms

27. On 28 October, staff called a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties that alerts healthcare staff and prompts the control room to call of an ambulance) when they found Mr Lucking had collapsed. The incident was treated as a non-emergency when it transpired Mr Lucking had fallen in some bushes while taking a short cut. A nurse assessed that he had no injuries.

28. On 22 November, staff called a code blue because Mr Lucking appeared to be in breathing difficulties. However, a nurse assessed him and found that his clinical observations were within normal ranges.

29. On 10 December, officers called a code blue in the early hours because Mr Lucking complained of chest pains. However, staff subsequently cancelled the ambulance after Mr Lucking said he did not need it and was physically well. Staff carried out extra checks for the rest of the night and there were no further issues.

30. On 12 December, Mr Lucking pressed the general alarm, and said that he had fallen because his legs were swollen and he could not walk. Staff assessed he had no injuries or bruises.

31. On 19 January 2020, staff called a code blue after an apparent collapse by Mr Lucking. Staff subsequently cancelled the ambulance. Mr Lucking said that he had activated the alarm as he fell, but witnesses said that he had pushed the alarm and then sat down. Staff thought this might have been related to an altercation he had had with healthcare staff earlier in the day. A nurse assessed him and found his clinical observations were within normal ranges.

20-21 January 2020

32. On the morning of 20 January, Mr Lucking was returning from collecting medication at the healthcare centre when he felt unwell. He sat down for a while on a bench in the prison grounds. An officer told him that he could not stay there and that he should go to the healthcare centre if he felt unwell. He started walking there but shortly afterwards he fell into some bushes and the officer called a code blue. Healthcare staff attended very quickly. They assessed that Mr Lucking did not need an ambulance and cancelled it at 8.46am.

33. Staff took Mr Lucking to the healthcare centre for further assessment. His condition deteriorated and staff called for an ambulance at 9.10am. It arrived at the prison at 9.33am and left the prison with Mr Lucking at 10.24am.

34. At around midnight, Mr Lucking was taken to the hospital's coronary unit, but he stopped breathing shortly after arriving there. Hospital staff attempted to resuscitate him, but he was declared dead at 2.58am on 21 January.

Contact with next of kin

35. Mr Lucking was estranged from his family and had no contact with anyone outside of prison besides his solicitor. Bure made every effort to establish contact with a next of kin, but the only relative they identified was a brother who had pre-deceased Mr Lucking.

36. The prison paid for Mr Lucking's funeral.

Support for prisoners and staff

37. After Mr Lucking's death, the duty governor debriefed the staff who had been with him at the hospital, to ensure they had the opportunity to discuss any issues arising, and offered the support of the care team, which they declined.

38. The prison posted notices to staff and prisoners informing them of Mr Lucking's death, and offering support.

Cause of death

39. There was no post-mortem examination as the coroner accepted the cause of death provided by the hospital. The hospital gave the cause of death as multiple organ failure, caused by pulmonary oedema (excess fluid in the lungs) and congestive heart failure (the heart's failure to pump blood around the body properly). Ischaemic heart disease (restricted blood supply to the heart due to blockages in the arteries), obesity and rheumatoid arthritis were listed as contributory factors.

Findings

Clinical care

40. Mr Lucking arrived at Bure with several serious health conditions. The clinical reviewer found that the care he received was of a reasonable standard and at least equivalent to that which he could have expected to receive in the community. However, she identified some areas of concern.

Mental capacity

41. Mr Lucking did not always comply with his prescribed treatment. His offender manager, in assessing Mr Lucking's lack of insight into his offending and his failure to comply with his licence conditions, suggested cognitive tests should be undertaken before release.

42. Mr Lucking had memory tests in 2019, and in the last of them on 26 September, he scored 28/30, showing a normal memory. However, he repeatedly refused to comply with his treatment. The clinical reviewer concluded that healthcare staff should have considered arranging a more formal mental capacity assessment to ensure that Mr Lucking was making decisions with a proper understanding of his best interests. We make the following recommendation:

    The Head of Healthcare should review the need for formal assessments of mental capacity for prisoners who fail to comply with treatment that is in their best interests.

Clinical record keeping

43. Some healthcare staff failed to update Mr Lucking's medical record with details of the emergency response on 20 January 2020. A nurse failed to record that an ambulance was originally cancelled before being called again a short time later. A nurse who also attended the incident, made no notes at all. We make the following recommendation:

    The Head of Healthcare should ensure that staff make full and accurate notes in a prisoner's medical record following involvement in their care.

Failure to update prison record

44. Prison Service Instruction (PSI) 23/2014 on NOMIS says that staff should complete NOMIS case notes to cover a prisoner's behaviour, progress or other information of note. Both the incidents on 19 January, referred to by the officer involved in the investigation described below, were recorded on NOMIS. There was also an entry from him about bad behaviour from Mr Lucking on 17 January. However, he made no entry following the serious incident on 20 January, although he was closely involved. We make the following recommendation:

    The Governor should remind staff of the need to make accurate and timely records on the prisoner's NOMIS record following involvement in an incident.

Complaint investigation

45. A prisoner at Bure wrote to the PPO to say that he was not happy with the way Mr Lucking had been treated on 20 January. He also submitted a Discrimination Incident Reporting Form (DIRF) to the prison saying that Mr Lucking had been discriminated against on the grounds of disability.

46. He said that he had encountered Mr Lucking on a bench at around 8.35am, and stopped to ask him how he was. Mr Lucking said that he was having difficulty breathing, but was speaking in a normal manner. He said that shortly after this, an officer arrived and told Mr Lucking that he could not stay there and insisted that he moved. Mr Lucking reluctantly got up without any physical assistance from the officer, but collapsed shortly afterwards. The complainant said that more consideration should have been given to Mr Lucking's state of health and he should have been taken to the healthcare centre in a wheelchair.

47. The prison investigated the DIRF complaint and interviewed the complainant, the officer and another prisoner who had witnessed the incident. The complainant was not familiar with Mr Lucking and did not know his name at the time. The officer said that he knew of two incidents the previous day, where Mr Lucking was checked by healthcare staff, and his clinical observations were normal. He said that as a trained first aider, he assessed the situation and thought it was safe to walk Mr Lucking to the healthcare centre.

48. Although with the benefit of hindsight, the use of a wheelchair might have been more appropriate, there is nothing to suggest that this would have affected the outcome. Given Mr Lucking's previous history, the officer's assessment was not unreasonable, especially as after the initial assessment of two nurses, the ambulance was cancelled. The other witness was a prisoner healthcare representative for the area where Mr Lucking was located. He said that in his opinion, healthcare and wing staff had always tried their best with Mr Lucking and had dealt with him caringly.

49. Mr Lucking was sometimes a very difficult prisoner who often did not act in his own best interests, both in refusing treatments and in his behaviour. His records show numerous incidents where emergency procedures were initiated, but then his clinical observations were found to be within the normal range. There were also incidents where he told staff that he had symptoms to try to get the response from staff that he wanted.

50. We consider that it is understandable that it was difficult for staff to distinguish the incident on 20 January from previous ones. However, once Mr Lucking was taken to the healthcare centre shortly after his fall, a full set of observations were taken. It was evident that he needed to go to hospital and there was no significant delay in this happening.

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