

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ernest Buchanan, a prisoner at HMP Ashfield, on 7 April 2020

A report by the Prisons and Probation Ombudsman

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 Ernest Buchanan died in hospital from heart and kidney failure on 7 April 2020, while a prisoner at HMP Ashfield. He was 74 years old. I offer my condolences to Mr Buchanan's family and friends.

In the early hours of 4 and 5 April, Mr Buchanan called for help from staff because he was struggling to breathe and could not get back into bed. When the same thing happened in the early hours of 6 April, staff called the out of hours GP who advised that Mr Buchanan did not need to go to hospital, but that he should be monitored. When he was seen by a nurse later that morning, she sent him to hospital where he died the next day.

The clinical reviewer was satisfied that the care Mr Buchanan received at Ashfield was of a good standard and equivalent to that which he could have expected to receive in the community.

However, the clinical reviewer was concerned that prison staff did not tell healthcare staff about the incidents on 4 and 5 April. There was also a lack of clear guidance given to prison staff about how they should monitor Mr Buchanan on the morning of 6 April.

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

October 2020

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Summary

Events

1. On 19 April 2012, Mr Ernest Buchanan was sentenced to 20 years in prison for sexual offences. He was moved to HMP Ashfield on 11 September 2015.
2. Mr Buchanan arrived at Ashfield with a range of health issues, including heart disease, kidney disease, type 2 diabetes, asthma and chronic obstructive pulmonary disease (COPD – the term for a group of serious lung diseases).
3. On 4 and 5 April 2020, Mr Buchanan pressed his cell bell in the early hours of the morning to tell staff that he was struggling to breathe and could not get himself back into bed. Prison staff helped him back into bed on both occasions but no one told healthcare staff.
4. On 6 April, prison staff called the out of hours doctor after Mr Buchanan pressed his cell bell in the early hours, saying he was struggling to breathe. The doctor assessed him over the telephone. She advised him to use his inhaler and told staff to monitor him until he could see a GP later that day.
5. A nurse assessed Mr Buchanan at around 7.30am on 6 April. He was struggling to breathe and had a high temperature so she called for an ambulance. Paramedics arrived at 8.20am and took Mr Buchanan to hospital.
6. Mr Buchanan's health deteriorated and he died in hospital on 7 April at 11.37pm. The hospital recorded his cause of death as heart and kidney failure.

Findings

7. The clinical reviewer considered that the care Mr Buchanan received at Ashfield was of a good standard and equivalent to that he could have expected to receive in the community.
8. However, the clinical reviewer had some concerns. There is no evidence that prison staff told healthcare staff about the incidents on 4 and 5 April, when Mr Buchanan pressed his cell bell because he was struggling to breathe. It was also unclear what guidance the out of hours GP gave to prison staff about monitoring Mr Buchanan during the early hours of 6 April.

Recommendations

- The Director and Head of Healthcare should ensure that, when a prisoner is taken ill out of hours:
 - prison staff tell healthcare staff;
 - healthcare staff give clear and detailed guidance to prison staff when they ask them to monitor a prisoner; and
 - staff make a full and accurate record of the incident, including details of any discussions with other staff and agreed actions.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Ashfield 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 Buchanan's prison and medical records.
11. NHS England commissioned an independent clinical reviewer to review Mr Buchanan's clinical care at the prison.
12. We informed HM Coroner for Avon of the investigation. The coroner gave us the cause of death. We have sent the coroner a copy of this report.
13. One of the Ombudsman's family liaison officers contacted Mr Buchanan's daughter to explain the investigation and to ask if the family had any matters they wanted the investigation to consider. She asked for a copy of the report but did not raise any issues.
14. We shared our initial report with Mr Buchanan's family. They did not identify any factual inaccuracies.
15. We shared our initial report with the Prison Service. The Prison service identified a minor factual inaccuracy on the clinical review but no changes have been made to our initial report.

Background Information

HMP Ashfield

16. HMP Ashfield is a specialist medium security adult male prison for prisoners convicted of sexual offences. It accommodates approximately 400 men and is managed by Serco.
17. Health services are provided by Bristol Community Health Community Interest Company. An integrated team from Avon and Wiltshire Mental Health Partnership Mental Health Trust provide mental health and substance misuse services. There are no healthcare staff in the prison at night.

HM Inspectorate of Prisons

18. The most recent inspection of Ashfield was in March and April 2019. In HMIP's survey, 84% of respondents said they felt healthcare was quite or very good. Primary care was delivered to a good standard both in the healthcare unit and on the wings if required. Access to appointments was good and prisoners with long-term conditions were managed by either a GP or a nurse and had good care and support. Referrals for external hospital appointments were made promptly.

Independent Monitoring Board

19. 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 June 2019, the IMB reported that Ashfield was still a very well-run prison which continued to improve. The IMB noted that the healthcare department was run professionally and efficiently, exceeding the equivalent level of service that would be provided in the community.

Previous deaths at HMP Ashfield

20. Mr Buchanan was the third prisoner at Ashfield to die since April 2018. Both the previous deaths were from natural causes. There are no similarities between our findings in this investigation and our findings from the investigations into the previous deaths.

Key Events

21. On 19 April 2012, Mr Ernest Buchanan was sentenced to 20 years in prison for sexual offences. He was sent to HMP Parc.
22. In September 2015, Mr Buchanan was moved to HMP Ashfield. The reception nurse noted that Mr Buchanan had a range of serious health conditions including Type 2 diabetes, heart disease, chronic kidney disease, asthma and chronic obstructive pulmonary disease (the term given to a group of serious lung diseases including emphysema and chronic bronchitis). He noted that Mr Buchanan was registered blind with hearing problems and mobility issues. The nurse referred Mr Buchanan for a social care assessment and a medication review.
23. Mr Buchanan was seen by the GP for a medication review and had a social care assessment.
24. He was provided with a package of care and regular medication to meet his needs. This included dietary advice, managing his cardiovascular risk and glucose levels, blood tests, catheter changes, dressing ulcers and daily administration of his medication, including insulin injections. Mr Buchanan was allocated a single cell for prisoners with disabilities, and healthcare staff saw him in his cell two or three times a day.
25. On 19 November 2019, Mr Buchanan was admitted to hospital with an exacerbation (flare up) of COPD. He remained in hospital until 2 December. The Head of Healthcare ensured there was an enhanced social care package in place to meet his needs on his return to Ashfield.

4-5 April 2020

26. On 4 April 2020 at around 4.25am, Mr Buchanan pressed his cell bell. He told prison staff that he was short of breath and was having difficulty getting back into bed. Staff helped him back into bed and noted in the wing observation book that they would monitor him at regular intervals. We found no evidence that this information was shared with healthcare staff.
27. On 5 April at around 2.35am, Mr Buchanan pressed his cell bell, saying that he was having difficulty getting back into bed. Staff helped him into bed. We found no evidence that this information was shared with healthcare staff.

6 April

28. On 6 April at around 2.55am, a Custodial Operation Manager (COM) answered Mr Buchanan's cell bell. Mr Buchanan said he had wet himself. He said he needed help to get to his chair and he was struggling to breathe. The COM advised Mr Buchanan to use his inhaler to help his breathing and to use his walker to get to the chair.
29. The COM contacted the out of hours GP by telephone. The GP asked the COM to ask Mr Buchanan about his symptoms. Mr Buchanan said that he was short of breath but he was not coughing and he did not have a temperature. The GP assessed that he did not have COVID-19 but an exacerbation of COPD. She

advised him to use his inhaler as often as he needed it but she did not think it was appropriate for him to go to hospital. She made an appointment for him to see the doctor the next morning and asked the COM to contact her again if he had further concerns.

30. An entry in the wing observation book showed that prison staff were attending to Mr Buchanan between 2.55am and 3.45am. The COM noted that the GP had asked that staff check on Mr Buchanan 'periodically' and that he relayed this message to staff on duty. He did not specify how often Mr Buchanan should be checked but records show that Mr Buchanan was last checked by an officer at 4.00am. Staff recorded that Mr Buchanan was breathing normally after using his inhaler and was moving around his cell.
31. At around 7.30am on 6 April, staff spoke to Mr Buchanan during the morning welfare check and asked healthcare staff to come and see him. A nurse attended and found that Mr Buchanan was half out of bed, holding onto his chair, he had wet himself, and he was struggling to breathe. The nurse helped him to sit in his chair and assessed him further. She administered oxygen and noted that he had a high temperature, but he said he felt cold. At 8.02am, the nurse called a code blue (a medical emergency code which tells the control room that a prisoner is unresponsive or is having difficulty breathing and an ambulance is required immediately).
32. Paramedics arrived at 8.20am and took Mr Buchanan to hospital. He remained conscious throughout. Mr Buchanan was accompanied by two prison staff but no restraints were used.
33. Mr Buchanan arrived at hospital around 9.30am. Records show that he was treated for exacerbation of COPD, chronic kidney failure and heart disease. While there was a suspicion that he may have had COVID-19, he tested negative for the virus. Mr Buchanan's condition deteriorated and he declined further treatment. He died at 11.37pm on 7 April.

Contact with Mr Buchanan's family

34. On 6 April, when Mr Buchanan was taken to hospital, the prison appointed a family liaison officer (FLO). The FLO contacted Mr Buchanan's daughter by phone to tell her that her father had been taken to hospital. Mr Buchanan's family were unable to visit the hospital due to COVID restrictions but his daughter spoke to him on the phone and staff kept her updated on his condition. The FLO informed Mr Buchanan's daughter of her father's death at around 11.50pm on 7 April.
35. The prison paid for Mr Buchanan's funeral in line with national guidelines.

Support for prisoners and staff

36. After Mr Buchanan's death, a prison manager debriefed the escorting staff to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

37. The prison posted notices informing other prisoners of Mr Buchanan'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 Buchanan's death.

Cause of death

38. The Coroner accepted the cause of death provided by the hospital and no post-mortem examination was carried out. The hospital recorded that Mr Buchanan died of heart and kidney failure, caused by diabetic and hypertensive nephropathy (kidney disease), ischaemic heart disease, type 2 diabetes and hypertension (high blood pressure). Infective exacerbation of COPD was listed as a contributory factor.

Findings

Clinical Care

39. The clinical reviewer concluded that the clinical care Mr Buchanan received at Ashfield was of a good standard and equivalent to that which he could have expected to receive in the community.
40. Mr Buchanan had complex medical needs and staff put in place suitable care plans to meet his needs. He was appropriately supported by the prison's primary care service, various hospital consultants and social care. When Mr Buchanan was admitted to hospital in November 2019, the Head of Healthcare at Ashfield ensured that an enhanced social care package was put in place for him before he returned to the prison. The clinical reviewer highlighted this as an example of good practice.
41. However, we share the clinical reviewer's concerns about communication between prison and healthcare staff. Prison staff failed to tell healthcare staff about the incidents on 4 and 5 April, when Mr Buchanan used his cell bell in the early hours of the morning to tell staff that he was short of breath and needed help to get back into bed.
42. We are also concerned about the apparent lack of clear guidance given to prison staff by the out of hours GP, about how they should monitor Mr Buchanan overnight. The GP's entry in Mr Buchanan's medical record did not say what she had advised in terms of monitoring (for example, how frequently he should be checked, what they should be looking for and when they should seek further medical advice). The COM noted that the GP had told him to monitor Mr Buchanan 'periodically' and that he had passed this onto staff, but it did not say how frequently Mr Buchanan should be checked. We note that a nurse called a medical emergency code within 30 minutes of seeing Mr Buchanan the following morning, which suggests that there may have been grounds for seeking further medical advice during the night. We therefore make the following recommendation:

The Director and Head of Healthcare should ensure that, when a prisoner is taken ill out of hours:

- **prison staff tell healthcare staff;**
- **healthcare staff provide clear and detailed guidance to prison staff when they ask them to monitor a prisoner;**
- **staff make a full and accurate record of the incident, including details of any discussions with other staff and agreed actions.**

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