Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Sibigam Ekprikpo, a prisoner at HMP Frankland, on 17 April 2020

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 020 7633 4141

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*

Summary

1. 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.

2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

3. Mr Sibigam Ekprikpo died of prostate cancer, which had spread to other parts of his body, on 17 April 2020 at HMP Frankland. He was 65 years old. We offer our condolences to those who knew him.

4. The clinical reviewer concluded that the clinical care that Mr Ekprikpo received at Frankland was reasonable and equivalent to that which he could have expected to receive in the community. She made a number of recommendations about clinical issues which are not directly related to Mr Ekprikpo's death but which the Head of Healthcare will need to address.

5. When prison staff saw that Mr Ekprikpo was not breathing, an officer radioed a medical emergency code blue and an emergency control room officer telephoned the ambulance service for an ambulance, unaware that Mr Ekprikpo had signed an order not to be resuscitated. We are satisfied that Frankland has reviewed the medical emergency procedures for prisoners who have such an order in place. An ambulance paramedic, who attended the emergency, confirmed that Mr Ekprikpo had died. While we note that Frankland has since trained a number of nurses to confirm death, we would like some reassurance that enough staff have received training.

Recommendations

- The Head of Healthcare should ensure that sufficient nursing staff are trained to confirm that a prisoner has died.

Investigation Process

6. NHS England commissioned to review Mr Ekprikpo's clinical care at HMP Frankland.

7. The PPO investigator has investigated the non-clinical issues in Mr Ekprikpo's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

8. The PPO family liaison officer wrote to Mr Ekprikpo's next of kin to explain the investigation. He did not respond.

9. We shared the initial report with the prison service. There were no factual inaccuracies and their action plan has been appended to this report.

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

Previous deaths at Frankland

11. There were eight deaths from natural causes and one self-inflicted death at HMP Frankland in the two years before Mr Ekprikpo's death. In our investigation into the death of a prisoner in February 2020, we found that there were no nurses trained to confirm that a prisoner had died. Although Frankland has since trained some nurses to confirm death, we wanted reassurance that enough staff had received training. This is again a concern in this case and as we have not yet received an action plan from Frankland in relation to the February 2020 case, we repeat our recommendation in this report.

Key Events

12. On 25 June 2012, Mr Sibigam Ekprikpo was sentenced to life in prison for murder. On 13 October 2017, he was transferred to HMP Frankland.

13. Mr Ekprikpo was diagnosed with prostate cancer in 2009. On 1 April 2019, after Mr Ekprikpo had a CT scan, a consultant oncologist confirmed that the cancer had spread to his bones. He decided that Mr Ekprikpo should receive palliative treatment.

14. Mr Ekprikpo's health remained fairly stable but when it deteriorated on 15 April 2020, he moved to the healthcare inpatient unit so that healthcare staff could monitor him more closely.

Events of 17 April 2020

15. At 5.43am on 17 April, an Operational Support Grade (OSG) was completing a roll check in the healthcare inpatient unit. When he looked through Mr Ekprikpo's cell observation panel, he saw that he was lying on the bed, staring at the ceiling with his mouth open. The OSG told a nurse who saw that he was not breathing. The OSG radioed a medical emergency code blue (which indicates that a prisoner is unconscious or having difficulty breathing).

16. A Senior Officer (SO) and a Custodial Manager (CM) went into Mr Ekprikpo's cell. The nurse and a Healthcare then went into the cell. The SO confirmed that Mr Ekprikpo was not breathing, that he did not have a pulse and was unresponsive.

17. An officer in the emergency control room telephoned the ambulance service. The officer told them that Mr Ekprikpo had bone cancer, was not breathing or responding and that he did not know if staff were trying to resuscitate him, whether he had an order in place not to be resuscitated or whether they needed someone to verify death. The ambulance service upgraded the call to an immediate response.

18. At 6.12am, ambulance paramedics were with Mr Ekprikpo and pronounced at 6.15am that he had died. A prison GP established that Mr Ekprikpo died of prostate cancer which had spread to other parts of his body.

Findings

19. The clinical reviewer concluded that the clinical care that Mr Ekprikpo received at Frankland was reasonable and equivalent to that which he could have expected to receive in the community.

20. The Head of Operations and Drug Strategy, said that after the death of a prisoner in February 2020 and the death of Mr Ekprikpo, both of whom had an order in place not to be resuscitated, she had reviewed the medical emergency procedures. She said that the emergency control room officer now had to check if a prisoner had an order in place not to be resuscitated when a code blue was called and that there was now a file in the emergency control room which contained this information. The Governor implemented these changes on 20 May. We therefore make no recommendation about this issue.

21. An ambulance paramedic confirmed that Mr Ekprikpo had died. The Head of Healthcare, said that since the death of a prisoner in February 2020, six nurses had been trained to confirm death. In our investigation into that death, we asked for assurance that a sufficient number of healthcare staff were now trained to meet Frankland's potential needs. As we await an action plan from Frankland in relation to that concern, we repeat our recommendation in this report:

    The Head of Healthcare should ensure that sufficient nursing staff are trained to confirm that a prisoner has died.

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

Annexes

1. Clinical review

Additional documents

2. Prison action plan