Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anthony Madden, a prisoner at HMP Bure, on 1 August 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*

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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 Anthony Madden died on 1 August 2020 at HMP Bure of dehydration caused by vomiting due to acute pancreatitis. Mr Madden was 38 years old. I offer my condolences to Mr Madden's family and friends.

Mr Madden told officers he had a sore stomach and felt bloated on the evening of 31 July. He pressed his cell bell three more times overnight and the next morning. An officer found him collapsed on the toilet at 10.14am.

Healthcare staff did not assess Mr Madden's condition, but told officers to monitor him. The clinical reviewer concluded that the care Mr Madden received on the day he died was not equivalent to the care he could have expected in the community. It is also concerning that high temperatures in prisoner accommodation during a heatwave could have contributed to the dehydration linked to Mr Madden's death. Finally, staff did not have sufficiently urgent access to personal protection equipment during the medical emergency.

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 **April 2021**

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Summary

Events

1. In August 2019, Mr Anthony Madden was remanded into custody for breaching a sexual harm prevention order and sent to HMP Forest Bank. In September, Mr Madden was sentenced to 26 months in custody. On 24 February 2020, he transferred to HMP Bure.

2. At 11.33pm on 31 July, Mr Madden pressed his cell bell and told an Operational Support Grade (OSG) he had stomach pains and bloating. The OSG noticed that Mr Madden was hot and sweating.

3. Mr Madden pressed his cell bell twice more, at 12.13am and 2.02am the next morning, 1 August. A prison manager visited Mr Madden when he pressed his bell at 12.13am. The manager did not think Mr Madden was particularly uncomfortable and told him to press his cell bell again if he felt worse. The OSG did not contact the prison manager when Mr Madden pressed his bell for the third time at 2.02am and said he could not remember what happened on this occasion.

4. At 7.31am, Mr Madden pressed his cell bell again. He told an officer that he had vomited overnight. The officer telephoned the healthcare department and recorded that a nurse said that Mr Madden should stay in his cell and someone from the healthcare team would see him that morning.

5. Healthcare staff visited the wing later that morning for routine checks but did not see Mr Madden. At roughly 10.14am, an officer went to Mr Madden's cell and found him unresponsive on the toilet. The officer immediately radioed a medical emergency code. Mr Madden was not breathing. Neither healthcare staff nor officers had sufficient personal protection equipment. Other healthcare staff arrived quickly and attempted resuscitation. The ambulance first responder arrived at 10.40am, followed by paramedic staff at 10.46am. At 11.41, a senior paramedic confirmed Mr Madden had died.

6. On 4 October, the pathologist reported the cause of death as dehydration, caused by vomiting, resulting from acute pancreatitis. She commented that the high temperatures experienced on 31 July and 1 August could have contributed to the dehydration which caused Mr Madden's death.

Findings

Clinical care

7. The clinical reviewer found that Mr Madden received a good standard of healthcare at Bure before 1 August 2020 and during the resuscitation efforts.

8. However, the clinical reviewer found there were missed opportunities for Mr Madden to be clinically assessed on 1 August, the day he died. Healthcare staff should have taken medical observations, such as blood pressure and pulse, that might have supported an escalation of care. The clinical reviewer concluded that

Mr Madden's clinical care that day fell below the standard of care he could have expected to receive in the community.

Cell conditions

9. There is evidence that it was hot in Mr Madden's cell immediately prior to his death. The IMB report for the year ending July 2020 said that prisoners were living in very hot conditions in the summer and air quality was poor. A prison manager confirmed that high temperatures on the wings were a known problem. The prison had not published advice to prisoners about hydration before Mr Madden died.

Personal Protective Equipment (PPE)

10. Because of the risk of infection with COVID-19, prison staff were advised to use Personal Protective Equipment (PPE) when dealing with incidents that required them to breach social distancing guidelines. However, prison staff did not have access to appropriate PPE during the emergency response. The first responder nurse had to wait for other healthcare staff to bring the healthcare emergency bags to Mr Madden's cell before being able to access PPE.

Recommendations

- The Head of Healthcare should ensure that there is an adequate triage system to support the prompt assessment of unwell prisoners.

- The Head of Healthcare should share this report with a Nurse A and discuss the Ombudsman's findings with her.

- The Governor should ensure that all prison cells at Bure are a comfortable temperature and in line with HMIP expectations.

- The Governor should ensure that notices are posted to remind prisoners to stay hydrated when the temperature in the cells is high.

- The Governor and Head of Healthcare at HMP Bure should ensure that all staff follow the procedures for PPE use in medical emergencies

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Bure informing them of the investigation and asking anyone with relevant information to contact her. One prisoner wrote to her.

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

13. The investigator interviewed 12 members of staff and four prisoners on 18 August and 1, 2 and 10 September 2020. One prison officer wrote to her. NHS England commissioned a clinical reviewer to review Mr Madden's clinical care at the prison. The investigator and clinical reviewer jointly interviewed staff. All the interviews were conducted by telephone because of the COVID-19 restrictions in place.

14. We informed HM Coroner for Norwich of the investigation. She provided the results of the post-mortem examination which included a supplementary report from a consultant histopathologist. We have sent the coroner a copy of our report.

15. One of the Ombudsman's family liaison officers contacted Mr Madden's mother, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. We did not receive a reply to our letter.

16. Mr Madden's mother received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.

17. 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.

Background Information

HMP Bure

18. HMP Bure is a medium security prison near Norwich and can hold approximately 650 men. The accommodation is a mix of new buildings and converted RAF accommodation and service buildings. Healthcare services are available between the hours of 8.00am – 7.00pm and provided by Practice Plus Group, previously known as Care UK. The prison uses the NHS 111 service for out-of-hours care.

HM Inspectorate of Prisons

19. The most recent inspection of Bure was in March/April 2017. Inspectors found that Bure remained an overwhelmingly safe and respectful prison. New arrivals were properly inducted, and levels of violence were low. Living conditions were decent and respectful, but ventilation and temperature control could be problematic, and some cells were too warm or too cold.

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 period August 2019 – July 2020, the IMB reported that, prior to the COVID-19 restrictions, prisoners felt safe and morale was high, with low levels of violence. They noted the impact of COVID-19, with prisoners locked in their cells for up to 23 hours a day and said that it had been difficult both for staff and prisoners.

21. The IMB raised concerns about the ventilation in several residential wings. They found that, despite work completed in previous years to improve the ventilation in cells, prisoners found themselves in very hot conditions during the summer. Prisoners could be confined to cells for up to 23 hours a day because of the COVID-19 pandemic and the IMB described the air quality as poor.

22. The IMB considered that healthcare staff, including the mental health team, delivered a service equivalent to that expected in the local community. Due to the COVID-19 restrictions, clinics had had to be cancelled, but the healthcare team had face-to-face meetings with prisoners, using appropriate personal protective equipment in urgent cases.

Previous deaths at HMP Bure

23. Mr Madden was the fourth prisoner to die at HMP Bure since August 2018. Of the three previous deaths, two were due to natural causes and one was self-inflicted. One prisoner has died since Mr Madden's death. There are no similarities with Mr Madden's death.

COVID-19 (coronavirus)

24. COVID-19 is an infectious disease that affects the lungs and airways. It is mainly spread through droplets when an infected person coughs or sneezes. The first

reported case of COVID-19 in the UK was in February 2020. On 11 March, the World Health Organisation (WHO) declared COVID-19 as a worldwide pandemic.

25. On 13 March, the National Health and Justice team issued an interim notice providing advice on preventing and controlling outbreaks of COVID-19 in prisons. HMPPS issued further instructions over the following weeks with guidance on the appropriate use of personal protective equipment (PPE), hygiene, cleaning schedules and stock checks. The guidance outlined the importance of effective preventative measures and that methodical cleaning would help prevent infection spread.

26. On 24 March, HMPPS issued an instruction, in line with Government advice, to all prisons to introduce social distancing and to implement a restricted regime and supported enforcement of social distancing of two metres for staff and prisoners wherever possible. The most vulnerable prisoners were identified and put into protective isolation. While Mr Madden's death was not related to COVID-19 he was subject to restrictions put in place to stop the spread of the disease.

Personal Protective Equipment (PPE)

27. On 13 March, Public Health England's (PHE) National Health and Justice team issued an interim notice providing advice on preventing and controlling outbreaks of COVID-19 in prisons. HMPPS issued further instructions over the following weeks with guidance on the appropriate use of personal protective equipment (PPE), hygiene, cleaning schedules and stock checks.

Key Events

28. On 13 August 2019, Mr Anthony Madden was remanded into custody for breaching a previously issued sexual harm prevention order and was sent to HMP Forest Bank. On 10 September, Mr Madden was sentenced to 26 months in custody.

29. On 24 February 2020, Mr Madden transferred to HMP Bure. During an initial health screen, he told a nurse that he suffered from low mood and anxiety. He had no other health concerns.

30. On 16 March, Mr Madden attended an NHS health check for adults aged 40 to 74 aimed at spotting early signs of stroke, kidney disease, heart disease, type 2 diabetes or dementia. Mr Madden was assessed as having a low risk for cardiovascular disease.

Events of 31 July/1 August

31. At 11.33pm on 31 July, Mr Madden pressed his cell bell. An Operational Service Grade (OSG) answered and Mr Madden said he had stomach pains and felt bloated. Mr Madden was hot and was visibly sweating. He told the OSG that he had not been to the toilet or drunk very much that day. The OSG phoned the Night Orderly Officer, a Custodial Manager (CM), for advice. According to the wing observation book, the CM advised that Mr Madden should drink plenty of fluids and press his bell again if his condition deteriorated.

32. Mr Madden pressed his cell bell again 40 minutes later, at 12.13am on 1 August. The OSG phoned the CM, who came to the wing straight away. The CM and OSG went to Mr Madden's cell. When the CM opened the cell door to speak to him, Mr Madden was standing up and did not appear to be in any discomfort. The CM suggested that he might be more comfortable if he took his jeans off as it was a hot night. He told Mr Madden to press his cell bell if he felt more unwell during the night.

33. Mr Madden pressed his cell bell for a third time at 2.02am. The OSG answered the cell bell but told the investigator he could not remember why Mr Madden pressed his bell. The OSG did not record what happened in the wing observation book or contact the CM.

34. An officer started his shift at 7.15am. The OSG handed over the night's events before finishing his shift and explained that Mr Madden had said he was unwell. Mr Madden pressed his cell bell again at 7.31am. The officer answered the cell bell and spoke to Mr Madden through the cell door's observation panel. Mr Madden was lying on his bed and told the officer that he was sweaty and had vomited in the night.

35. The officer went back to the wing office and telephoned Nurse A, who had just started her shift. He recorded that she said that Mr Madden should stay in his cell for 48 hours and that someone from the healthcare team would come to see him during morning with medication to help his stomach pain. The officer told the investigator he then went back to Mr Madden's cell and told him what the nurse had said. He said Mr Madden was grateful that he had contacted healthcare so

quickly but that he did not seem to be in distress. The nurse recorded in Mr Madden's medical notes that she would book an appointment for him the following day. There is no evidence that she did.

36. Nurse A and a colleague visited the wing later that morning for a routine check of the defibrillators. They did not see Mr Madden. At roughly 10.05am, Officer A called the pharmacy department (based in the healthcare centre) to ask about another prisoner's medication. While on the phone, he asked why nurses had been on the wing but had not visited Mr Madden. He was told by someone in the pharmacy department that "healthcare would be dealing with him".

37. Officer A finished his call and, at 10.14am, walked to Mr Madden's cell to update him. He found Mr Madden sitting on the toilet, naked and unresponsive with his head against the wall. He immediately called a code blue (an emergency response code), alerting officers to Mr Madden's collapse. A Supervising Officer (SO) arrived at the cell and found the officer blocking the doorway, visibly shaking. She walked him away from the cell, allowing other officers access.

38. Officer B arrived at the cell, closely followed by two other officers. Officers who arrived at the cell were not wearing personal protective equipment (PPE) and only had access to latex gloves. Officer B felt for a pulse but could not find one. Mr Madden was not moving or breathing.

39. Staff were trying to lift Mr Madden off the toilet so they could begin CPR when Nurse A arrived within minutes and asked officers to lift Mr Madden to the floor. Aware of the current risk of COVID-19, and unsure of the cause for Mr Madden's collapse, she asked prison staff if she could have a face mask, but prison staff said they did not have any. She started chest compressions while she waited for other nurses to arrive with the medical emergency bags containing a defibrillator and PPE.

40. More healthcare staff arrived minutes later with the defibrillator and other medical equipment. A defibrillator was attached but advised healthcare staff to continue with resuscitation. Oxygen was administered via a bag valve mask and suction was used to remove vomit blocking his airway.

41. The ambulance first responder arrived at 10.40am, followed by paramedics at 10.46am. Paramedics administered adrenaline and continued resuscitation attempts. An air ambulance crew arrived at 11.16am. At 11.41, a senior paramedic confirmed that Mr Madden had died.

Contact with Madden's family

42. Mr Madden's mother, his next of kin, lives in Rochdale, some distance from the prison. On 1 August, due to her location and COVID-19 restrictions, a prison manager asked Rochdale Police to visit Mr Madden's mother's and break the news of Mr Madden's death. The police contacted his mother on 2 August to inform her of her son's death.

43. The prison's family liaison officer contacted Mr Madden's mother later that day to offer support. The prison offered a contribution to Mr Madden's funeral, in line with national instructions.

Support for prisoners and staff

44. After Mr Madden's death, a prison manager debriefed staff involved in the emergency response to offer support. The staff care team also offered support. Some officers told the investigator that they did not feel well-supported after Mr Madden's death, a matter which the Governor will want to look into and address.

45. The prison posted notices informing other prisoners of Mr Madden'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 Madden's death.

Post-mortem report

46. The post-mortem report dated 23 September 2020, initially found no obvious cause of death and concluded that the cause was 'unascertained'.

47. On 4 October, the pathologist re-examined the post-mortem findings and the circumstances of Mr Madden's death. In her supplementary report she said:

> "It is possible that Mr Madden was suffering from acute interstitial oedematous pancreatitis, the symptoms of which are vomiting and abdominal pain, and in the process of being sick, became dehydrated, developed acute renal tubular necrosis, and died."

She concluded that, in the absence of any other causes of death, and on the balance of probabilities, the cause of death was dehydration caused by vomiting, caused by acute interstitial oedematous pancreatitis (an acute inflammation of the pancreas).

Cell conditions

48. A police constable who searched Mr Madden's cell at about 1.30pm on the day of his death, recorded in a statement written on 13 October, that 1 August was a warm day and although the temperature in the prison was comfortable and normal, the temperature in Mr Madden's cell was "slightly above comfortable" and that she began to sweat in the cell.

49. A prisoner on Mr Madden's wing contacted the investigator complaining about temperature levels in the cells. He was concerned that excess heat during the heatwave that week could have contributed to Mr Madden's death. When interviewed, he said that due to COVID-19 restrictions, prisoners were locked in their cells for roughly 22 hours a day. He explained that the wings at Bure get extremely hot because of the building design, with enclosed landings and windows that do not open. He claimed that during the heat wave the week Mr Madden died temperatures in the cells recorded by one prisoner reached 40ºC.

Findings

Clinical Care

50. Mr Madden had little interaction with healthcare services at HMP Bure. The clinical reviewer concluded that Mr Madden received a good standard of clinical care at Bure before 1 August 2020, and during the resuscitation efforts.

Healthcare response on 1 August 2020

51. An officer telephoned Nurse A at approximately 7.39am on 1 August to report that Mr Madden had been unwell in the night with stomach pains and vomiting. He recorded that someone from the healthcare team would review Mr Madden that morning and give him medication to ease his discomfort. This did not happen. The nurse recorded in Mr Madden's medical notes that she had asked that he remain isolated in his cell for 24-48 hours and she would book an appointment for him the following day. There is no evidence in the medical records that an appointment was booked.

52. At interview, Nurse A said that she would not tend to give medication to someone vomiting, as they may not be able keep the medication down. She said that when she visited the wing later that morning, she did not think to see Mr Madden because he "wasn't in the front of my mind at that time" as she had not understood his situation to be urgent from the information she had been given during the call that morning.

53. The Head of Healthcare said at interview that he would have expected Mr Madden to have had a face to face clinical assessment on 1 August.

54. The clinical reviewer considered that Mr Madden should have been clinically assessed on the day he died, and that a history of symptoms and medical observations, such as blood pressure and pulse, might have supported an escalation of care. The clinical reviewer concluded that Mr Madden's clinical care on 1 August 2020 was below the expected standard of care and not equivalent to that which he could have expected in the wider community. We make the following recommendation:

    The Head of Healthcare at HMP Bure should ensure that there is an adequate triage system to support the prompt assessment of unwell prisoners.

    The Head of Healthcare should share this report with Nurse A and discuss the Ombudsman's findings with her.

Cell conditions

55. There is evidence to suggest that the temperature may have been high in Mr Madden's cell at the time of his death: a prisoner on Mr Madden's wing contacted the investigator complaining about the temperature in the cells; a police officer who searched Mr Madden's cell after his death said that the temperature in the cell was "slightly above a comfortable level" and that she was sweating when

searching his cell, and Officer B said at interview that the upstairs landings in residential units 1 to 6 are "horrendous … they are quite hot" in hot weather. We also note that in August 2020, Bure received nine complaints from prisoners about the heat and ventilation in the cells, and that seven of the complaints were from prisoners on Mr Madden's wing.

56. In addition, the latest HMIP inspection report published in 2017 reported that "ventilation and temperature control could be problematic, and some cells were too warm or too cold", and that there were difficulties regulating cell temperatures. The most recent IMB report for the 12 months up to July 2020 also found that, despite some work being completed in previous years to improve ventilation, prisoners were still experiencing very hot conditions during the summer, with poor air quality.

57. The investigator contacted the coroner's office to ask whether the temperature in Mr Madden's cell could have contributed to his death. The pathologist told the coroner's officer:

> "According to Accu weather, the temperature on 31/07/2020 and 01/08/2020 was 15-31C and 17 – 26C, respectively for those two days. These are quite high temperatures and could have contributed to Mr Madden's dehydration."

58. The COVID-19 restrictions in place meant that prisoners at Bure remained in their cells for most of the day at the time of Mr Madden's death. They were unlocked for a minimum of 30 minutes exercise in the fresh air and a 45-minute period for a shower, laundry and phone calls every day, and were also unlocked to collect meals and medication twice a day. This meant that Mr Madden would have spent around 22 hours a day in his cell. In these circumstances we are concerned that prisoners had not been reminded to stay hydrated when the weather was hot.

59. HMIP's 2017 Human Rights Scoping document sets out criteria for assessing the treatment of prisoners and conditions in prisons. It says:

> "The accommodation provided for prisoners, and in particular sleeping accommodation, shall respect human dignity and, as far as possible, privacy, and meet the requirements of health and hygiene, due regard being paid to climatic conditions and especially to floor space, cubic content of air, lighting, heating and ventilation."

60. The investigator contacted the Head of Safer Prisons at Bure. He said that Bure consists of old converted buildings on the site of RAF Coltishall. As the accommodation units do not have a cooling system, the cells "can reflect the external temperatures" during the summer. He said that heat on the wings is a known problem, and in previous years staff had published notices in the summer reminding prisoners to stay hydrated and protected from the sun. This

information was not published during the heat wave around 1 August 2020, before Mr Madden's death.

61. The Head of Safer Prisons also said that officers could activate the smoke venting system which temporarily opens vents on the landings, allowing air from the outside to circulate and operate the fans. This was installed as part of the fire protection system and was not intended to control the temperature on the wing. He also said that when the external temperature is just as hot, this measure is less effective.

62. The Head of Safer Prisons told the investigator that the issues highlighted by HMIP in 2017 related to the heating system and a number of cell windows which did not operate properly. He said that since then, the heating system had been repaired and last year a local project repaired all cell windows that were not operating effectively.

63. However, it is clear from the most recent IMB report that that, while some improvements have been made, the problem of high temperatures and poor ventilation in cells had not been resolved at the time of Mr Madden's death.

64. We consider it is unacceptable that, despite concerns being raised since 2017, prisoners and staff continue to live and work in such uncomfortable and potentially unsafe conditions. In his expectations, Her Majesty's Chief Inspector of Prisons sets out that prisoner accommodation should meet the basic standards of decency, hygiene and health, with due regard being paid to heating and ventilation. In an email on 11 November 2020, the Head of Safer Prisons said that the prison has now agreed works to improve the ventilation. However, while improvement works have been agreed, the work is still outstanding. We therefore make the following recommendations:

The Governor should ensure that all prison cells at Bure are a comfortable temperature and in line with HMIP expectations.

The Governor should ensure that notices are posted to remind prisoners to stay hydrated when the temperature in the cells is high.

COVID-19 and Personal Protective Equipment (PPE)

65. In March and April, Public Health England (PHE) issued advice on preventing and controlling outbreaks of COVID-19 in prisons. HMPPS issued further instructions over the following weeks, including guidance on the appropriate use of PPE.

66. On 23 June, a notice to staff was issued to staff at Bure, including instructions on the use of PPE. The notice said:

> "If the incident is life threatening the first on scene will respond immediately acting to preserve life regardless of potential symptoms or the

presence of PPE. The first on scene will then be relieved by staff in appropriate PPE at the earliest opportunity."

67. On 26 July, PPE grab bags (containing surgical masks, aprons, sanitiser and gloves) were introduced on all residential wings at Bure for staff to use when dealing with incidents that could require them to break social distancing guidelines. The Head of Safer Prisons told the investigator that a specific officer was allocated the duty of bringing the PPE grab bag to the scene of an incident every day. He said that Officer B was allocated the alarm bell response duty on 1 August.

68. However, Officer B said in an email on 24 September, that prison staff did not have access to appropriate PPE during the emergency response when Mr Madden was found unresponsive. She said that, as it was an emergency, they did not have time to locate masks.

69. When healthcare staff arrived, Officer B helped move Mr Madden off the toilet, and later out of the cell to allow better access to treat Mr Madden. He confirmed at interview that he did not wear appropriate PPE, only latex gloves.

70. Nurse A arrived at Mr Madden's cell without appropriate PPE. Face masks and other equipment are kept in healthcare emergency bags. She said at interview that she asked officers on the wing if she could have a mask, but they did not have any. She decided to continue so she could provide lifesaving treatment. Once another nurse arrived with the emergency bag, Nurse A could access the required PPE.

71. The cause of Mr Madden's collapse was unknown at the time and for reasons of health and safety staff should have had access to appropriate PPE. We commend the staff for entering Mr Madden's cell and trying to resuscitate him without PPE, but they should not have had to do so. We make the following recommendation:

    The Governor and Head of Healthcare at HMP Bure should ensure that all staff follow the procedures for PPE use in medical emergencies.

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