

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jonathan Macro, a prisoner at HMP Bure, on 12 March 2021

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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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 Jonathan Macro died in Norfolk and Norwich University Hospital on 12 March 2021 of cancer while a prisoner at HMP Bure. He was 58 years old. We offer our condolences to Mr Macro's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Macro received at HMP Bure was of a good standard and equivalent to that which he could have expected to receive in the community. She made one recommendation about ensuring that staff were aware of the location of the Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders, which we have reworded below.
5. We found no non-clinical issues of concern.

Recommendation

- The Governor and the Head of Healthcare should ensure that the presence of a DNACPR order is clearly communicated to all staff involved in the prisoner's care and that the DNACPR document is held in a designated and readily accessible place.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Macro's clinical care at HMP Bure.
7. The PPO investigator has investigated non-clinical issues, including Mr Macro's 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 Macro's next of kin, his sister, to explain the investigation. She did not have any issues for us to consider and asked for a copy of this report.
9. Mr Macro's family received a copy of the initial report. They did not make any comments.
10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Previous deaths at HMP Bure

11. Mr Macro was the ninth prisoner to die at Bure since March 2019. Of the previous deaths, two were self-inflicted deaths and six were from natural causes. Since Mr Macro's death, there have been two natural causes deaths which are currently under investigation.
12. There are no similarities between our findings in the investigation into Mr Macro's death and our investigation findings for the previous deaths.

Key Events

13. Mr Jonathan Macro was serving a 10 year sentence for sexual offences and had been at HMP Bure since 18 November 2016.
14. On 24 September 2020, Mr Macro told a nurse that he had problems swallowing. The nurse referred him to a prison GP for review. The prison GP saw Mr Macro on 28 September and made a referral for a chest x-ray and a two week wait hospital referral (which requires anyone suspected of cancer be referred to clinic specialists under the NHS pathway within two weeks).
15. In preparation for his hospital appointment on 8 October, Mr Macro had a COVID-19 test, which was negative. He isolated in his cell.
16. On 12 October, Mr Macro had an endoscopy at Norfolk and Norwich University Hospital. The results showed that there was a growth. CT scan results indicated that he had cancer.
17. On 30 October, a prison GP reviewed the results of the CT scan and discussed this, and the treatment options available with Mr Macro. Hospital specialists had estimated that without treatment, Mr Macro had six months to live and decided that he should start chemotherapy.
18. Mr Macro was identified as being at high risk of developing complications if he became infected with COVID-19 due to his diagnosis of cancer and was advised to shield for 12 weeks. On 16 November, he isolated in his single cell and began chemotherapy on 20 November. He had regular hospital check-ups which showed that his cancer remained unchanged.

2021

19. On 10 February 2021, Mr Macro received his first COVID-19 vaccination.
20. On 15 February, a prison GP saw Mr Macro because he complained of having black stools and abdominal pain for the past three days. The GP suspected that Mr Macro had an upper gastrointestinal bleed and sent him to hospital. Hospital specialists recommended that prison healthcare staff monitor his haemoglobin levels, as falling levels could indicate an active bleed which would need further investigation. Mr Macro returned to prison the next day.
21. On 26 February, Mr Macro was told that the cancer was active and that he had weeks to live. Healthcare staff began enquiries into a suitable location for Mr Macro's end of life care.
22. On 1 March, Mr Macro told healthcare staff that he did not want anyone to resuscitate him if his heart or breathing stopped and signed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order to that effect. The form was stored in a safe in the control room. Prison managers said that the Orderly Officers (Operational Band 5 Custodial Managers) were aware that the information was stored in the safe, and that the form could be retrieved and sent with a prison escort officer when a prisoner was taken to hospital. The prison managers explained that a list of those prisoners on DNACPR orders was on the control room wall and on the prison's daily briefing sheet. However, on 2 March,

staff were unable to locate Mr Macro's DNACPR when he needed to go to hospital after he had a fall in his cell.

23. Mr Macro was admitted to hospital. Hospital specialists told him that his health was deteriorating, he would not have any more chemotherapy and that he was being cared for under the end of life pathway. Prison healthcare staff remained in regular contact with the hospital about Mr Macro's progress.
24. Release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months can be permanently released from custody before their sentence has expired. On 4 March, the prison submitted an application for early release on compassionate grounds on Mr Macro's behalf. Mr Macro died before a final decision was made.
25. Mr Macro continued to receive palliative care in hospital and on 12 March, a hospital doctor confirmed that Mr Macro had died.

Cause of death

26. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Macro's cause of death as metastatic adenocarcinoma (gastro-oesophageal junction, which is a rare type of cancer of the tube that connects the mouth and stomach).

Lisa Burrell

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October 2021

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