

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Graham Bertram, a prisoner at HMP Moorland, on 25 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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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 Graham Bertram died on 25 March 2021 of heart-related conditions at HMP Moorland. He was 73 years old. I offer my condolences to Mr Bertram's family and friends.

Mr Bertram had limited contact with healthcare staff at HMP Moorland. The clinical reviewer found the overall care relating to his long-term conditions was of an acceptable standard and was equivalent to that which he could have expected to receive in the wider community. However, we share the clinical reviewer's concern that Mr Bertram did not have a secondary health screen when he arrived at Moorland, which was a missed opportunity to assess his health and signpost him to relevant healthcare services.

We were concerned that staff did not follow resuscitation guidelines when they tried to resuscitate Mr Bertram. The clinical reviewer concluded that this would not have changed the outcome for him, but might be crucial in future medical emergencies.

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

Elizabeth Moody
Deputy Prisons and Probation Ombudsman

January 2022

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Summary

Events

1. In August 2019, Mr Graham Bertram was remanded to HMP Leicester. In September, he was sentenced to five years in prison.
2. Mr Bertram had ischaemic heart disease and had two heart stents (a device placed in the arteries to keep them open) following a heart attack in 2000.
3. Mr Bertram transferred to HMP Moorland in December 2020. During an initial health screen, a nurse did not record his medical history. Mr Bertram did not have a secondary health screen.
4. While in HMP Moorland, Mr Bertram did not need to see healthcare staff for any medical concerns, apart from receiving his first COVID-19 vaccination at the beginning of February 2021.
5. At 3.47pm on 25 March, an officer found Mr Bertram lying unresponsive on his bed. The officer shouted for another officer to help. When the second officer got to the cell, he radioed an emergency medical code and immediately started cardiopulmonary resuscitation (CPR). Two more officers arrived, but did not assist with CPR.
6. A nurse arrived at the cell promptly and took over chest compressions. A second nurse arrived shortly afterwards with an emergency resuscitation bag and defibrillator. CPR continued until paramedic staff arrived at 4.04pm. Paramedic staff confirmed Mr Bertram's death at 4.24pm.
7. The post-mortem report found that Mr Bertram died from heart-related conditions, including acute myocardial ischaemia, ischaemic heart disease and coronary artery atheroma.

Findings

Clinical care

8. The clinical reviewer found the overall care relating to Mr Bertram's long-term conditions was of an acceptable standard and equivalent to that which he could have expected to receive in the wider community. Although the reception nurse did not take Mr Bertram's medical history, clinics for his long-term conditions were automatically generated in his medical record, so the omission did not impact on his care.
9. The clinical reviewer was, however, concerned that Mr Bertram did not have a secondary health screen, contrary to national guidelines.

Emergency response

10. The first officer on scene confirmed that he knew he should have radioed a medical emergency code, but panicked in the moment.

11. We are concerned that CPR attempts by the officer and the first nurse would have been ineffective as Mr Bertram was sitting with pillows behind his back, and not lying flat. The officer who led the resuscitation attempts (until healthcare staff arrived) had not had any first aid training for at least five years. The three other officers in the cell had up to date first aid training but did not take an active role in resuscitation attempts.

Recommendations

- The Head of Healthcare should ensure that initial and secondary health screens are carried out and recorded for every prisoner who arrives at Moorland, in line with national clinical guidelines.
- The Governor and the Head of Healthcare should ensure that:
 - all staff understand the correct position in which to administer cardiopulmonary resuscitation; and
 - training records are kept up to date and refresher training is delivered at appropriate intervals.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Moorland informing them of the investigation and asking anyone with relevant information to contact her.
13. She obtained copies of relevant extracts from Mr Bertram's prison and medical records.
14. The investigator interviewed two members of staff and a prisoner at HMP Moorland on 18 and 20 May 2021. The interviews were conducted by telephone because of the COVID-19 restrictions in place. NHS England commissioned an independent clinical reviewer to review Mr Bertram's clinical care at the prison.
15. We informed HM Coroner for Yorkshire South East of the investigation. She gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
16. One of the Ombudsman's family liaison officers contacted Mr Bertram's brother, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not have any questions but asked for a copy of the report.
17. We shared our initial report with HM Prison and Probation Service (HMPPS). They pointed out one factual inaccuracy which has been amended in this report. They provided an action plan which is annexed to this report.
18. We sent a copy of our initial report to Mr Bertram's brother. He did not notify us of any factual inaccuracies.

Background Information

HMP Moorland

19. HMP Moorland is a category C resettlement prison which holds up to 1,000 men. The Practice Plus Group (formerly Care UK) provides healthcare services at the prison, including primary care, mental health and substance misuse services.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Moorland was in February 2019. Inspectors found that there had been many improvements since their previous visit in 2016. A strategic approach to health promotion had been developed and bespoke events took place throughout the year. Reception screening identified individuals who needed ongoing help and advice and healthcare referrals were made appropriately. An appropriate range of primary health services and secondary care services was available.

Independent Monitoring Board

21. 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 published in August 2021, the IMB reported that despite COVID-19, and the resulting impact on healthcare provision, they were satisfied that everything possible had been done to maintain essential services and to minimise the risk of infection.

Previous deaths at HMP Moorland

22. Mr Bertram was the seventh prisoner to die at HMP Moorland since March 2019. The previous six deaths were from natural causes, three caused by a heart condition. One of these deaths was due to COVID-19. There are no similarities between our findings in this investigation and the other deaths.

Key Events

23. On 23 August 2019, Mr Graham Bertram was remanded into custody at HMP Leicester charged with voyeurism, assault on a child and drugs offences.
24. Mr Bertram had ischaemic heart disease and had had two heart stents (a tube-shaped device placed in the coronary arteries, to keep them open) following a heart attack in 2000. While in HMP Leicester, medication was prescribed to treat this condition.
25. On 5 September, Mr Bertram was sentenced to five years in prison. He transferred to HMP Doncaster three weeks later, on 27 September, where a hypertension (high blood pressure) management plan was agreed. On 7 January 2020, he had a cardiovascular disease annual review. No issues were identified, and it was agreed that he should continue with his current medication.

HMP Moorland

26. On 2 December 2020, Mr Bertram transferred to HMP Moorland. During an initial health screen, a nurse listed his prescribed medication but did not record his past or current medical history. The nurse did not refer Mr Bertram to any long-term condition clinics, despite his history of heart conditions and treatment.
27. On 3 February 2021, Mr Bertram received his first vaccination against COVID-19. He had no other contact with healthcare staff in the nearly four months he was at Moorland.

25 March

28. At 2.26pm on 25 March, an officer completed a welfare check on Mr Bertram who was in his cell. The officer said that Mr Bertram was in good spirits and recorded in his prison record that he “raised no concerns about his physical or emotional wellbeing”. Mr Bertram’s cellmate worked on the wing’s food servery, which meant that he was out of the cell for much of the day.
29. At about 3.47pm, the officer went to Mr Bertram’s cell door to ask him to collect his dinner from the servery. When Mr Bertram did not answer, he went into the cell and found him on his bed. Mr Bertram was sitting back on pillows at a 45-degree angle, apparently asleep. The officer spoke to him again but got no response, and then noticed that he looked unusually pale. The officer shouted for another officer to come and help. He did not use his radio to call a code blue (an emergency medical code that indicates a prisoner has breathing difficulties or is not breathing).
30. The other officer was only a few doors down on the landing so arrived at the cell within seconds. At 3.48pm, he went into the cell, radioed a code blue and immediately started cardiopulmonary resuscitation (CPR). Two officers arrived shortly afterwards, and one switched on her body-worn camera to record the emergency response.
31. A nurse arrived at the cell at 3.49pm and took over chest compressions. About one minute later, another nurse arrived with other healthcare staff and the emergency resuscitation bag, including a defibrillator. The defibrillator was

attached to Mr Bertram but no shockable rhythm was found. CPR continued until paramedic staff arrived at 4.04pm. Paramedic staff confirmed Mr Bertram's death at 4.24pm.

Contact with Mr Bertram's family

32. At 5.10pm the same day, the prison's family liaison officer contacted Mr Bertram's brother, his next of kin, to break the news of Mr Bertram's death.
33. The prison contributed to funeral costs in line with national instructions and arranged Mr Bertram's cremation at his brother's request.

Support for prisoners and staff

34. On 26 March, the day after Mr Bertram's death, the Head of Reducing Reoffending debriefed staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
35. The prison posted notices informing other prisoners of Mr Bertram's death, and offering support. Staff also offered support to Mr Bertram's cellmate and reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Bertram's death.

Post-mortem report

36. The post-mortem report found that Mr Bertram died from acute myocardial ischaemia (where a heart muscle is not getting enough blood to work as it should), which was caused by ischaemic heart disease and coronary artery atheroma (the narrowing of the heart arteries with a build-up of fatty deposits on the walls of the arteries around the heart, limiting blood and oxygen flow). Mr Bertram also had high blood pressure that contributed to, but did not cause his death.

Findings

Clinical care

37. Having reviewed Mr Bertram's clinical care, the clinical reviewer concluded that the clinical management of his long-term conditions was of an acceptable standard and was equivalent to that which he could have expected to receive in the community.
38. Although Moorland's initial health screen did not record any information about Mr Bertram's long-term conditions, the clinical reviewer confirmed that the record had been set up to automatically generate annual reviews for his cardiovascular disease and blood pressure, so this omission would not have affected his care. Nevertheless, the clinical reviewer considered that the reception screen should have been completed in full.
39. Mr Bertram did not have a secondary health screen at Moorland, contrary to national clinical guidelines. The clinical reviewer considered that this was a further missed opportunity to explore and document his medical history and signpost to other services, if appropriate. We agree and make the following recommendation:

The Head of Healthcare should ensure that initial and secondary health screens are carried out and recorded for every prisoner who arrives at Moorland, in line with national clinical guidelines.

Emergency response

40. When the officer opened Mr Bertram's cell door and found him on his bed, he did not call a medical emergency code blue. The officer told the investigator that Mr Bertram was the first death in custody he had experienced. He confirmed that he knows when a code blue should be called, but said that he froze and called another officer rather than using an emergency radio call. We are satisfied that the officer understood his responsibilities, so do not make a recommendation.
41. The body-worn camera (BWC) footage shows neither the officer nor nurse removed the pillows from behind Mr Bertram's back before starting CPR. The clinical reviewer said that during CPR a person should be on a hard, flat surface. If a patient is not flat, chest compressions (used to mimic the heart pumping blood around the body) are ineffective.
42. The officer and the nurse attempted CPR without removing the pillows for two minutes, before another nurse arrived and removed the pillows. The clinical reviewer considered that removing the pillows sooner would not have changed the outcome for Mr Bertram, but that such a delay could be critical in a future medical emergency.
43. The officer who led the resuscitation attempts until healthcare staff arrived told the investigator at interview that he had not had any first aid training for at least five years. The three other officers in the cell had an up to date 'Emergency First Aid' qualification but did not take an active role in resuscitation attempts. The BWC footage showed that the officer went to great efforts to revive Mr Bertram.

While we commend his efforts, his attempts at resuscitation were unfortunately ineffective because he did not lay Mr Bertram on a hard, flat surface. If the officer's first aid training had been up to date, it is likely that he would not have made this mistake.

44. Prison Service Instruction (PSI) 29/2015, *First Aid*, says that there should be at least one member of staff trained in 'First Aid at Work' and sufficient numbers of staff trained in 'Emergency First Aid at Work' to provide emergency first aid to staff and prisoners at all times. It also says that if the first aider does not retrain or requalify before the expiry date, they are no longer considered competent to act as a first aider in the workplace. The officers who were on scene before healthcare staff arrived did not have the required First Aid at Work qualification.
45. A safer custody officer said that the prison was "planning [first aid] courses from June and staff will be picked up in due course". However, she told the investigator that they did not have a record of the most recent first aid training course completed by the officer who led the resuscitation attempts. We consider that the prison should keep staff's first aid training records up to date to inform refresher training programmes and so that the Governor can ensure sufficient trained staff are on duty. We make the following recommendations:

The Governor and the Head of Healthcare should ensure that:

- **all staff understand the correct position in which to administer cardiopulmonary resuscitation; and**
- **training records are kept up to date and refresher training is delivered at appropriate intervals.**

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