Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Robert Constable, a prisoner at HMP Bure, on 6 May 2021

**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*

# 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 Constable died in Norfolk and Norwich University Hospital on 6 May 2021 of sepsis while a prisoner at HMP Bure. Mr Constable was 87 years old. We offer our condolences to Mr Constable's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Constable received at HMP Bure was equivalent to that which he could have expected to receive in the community. She made no recommendations.

5. We are concerned that the decision to restrain Mr Constable when he was taken to hospital on 2 May 2021 was unsound given his advanced age and poor mobility.

**Recommendation**

- The Governor should ensure that all staff undertaking and reviewing risk assessments for prisoners admitted to hospital understand the legal position on the use of restraints, and that assessments fully take into account the prisoner's health and are based on the actual risk he presents at the time.


# The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Constable's clinical care at HMP Bure.

7. The PPO investigator has investigated non-clinical issues, including Mr Constable'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 Constable's next of kin, his son and daughter, to explain the investigation. They did not have any specific questions for us to consider.

### Previous deaths at HMP Bure

9. Mr Constable was the 11th prisoner to die at Bure since May 2019. Of the previous deaths, eight were from natural causes and two were self-inflicted.

10. There are no similarities between our findings in the investigation into Mr Constable's death and our investigation findings for the previous deaths.

# Key Events

11. On 29 January 2016, Mr Robert Constable was sentenced to seven years in prison for sexual offences. On 10 June, he transferred to HMP Bure.

12. Mr Constable was previously diagnosed with asthma, glaucoma, an enlarged prostate and in January 2021, he had a pulmonary embolism (blockage in the artery of his lungs).

13. On 9 March, a nurse saw Mr Constable because he was experiencing shortness of breath. She checked his oxygen saturation which was low. Mr Constable was taken to hospital as an emergency.

14. On 10 March, a nurse contacted Norwich Hospital for an update on Mr Constable's condition. The hospital told her that Mr Constable was being treated for anaemia. They did not know the cause of the anaemia so arranged for Mr Constable to undergo further tests and examinations.

15. On 17 March, the hospital told Mr Constable that it was likely he had bowel cancer. His prognosis was not clear so the hospital continued to investigate the extent of his illness and the treatment options available to him. Mr Constable was discharged from hospital and went back to Bure.

16. On 2 May, Mr Constable complained of abdominal pain and said that he had not opened his bowels in a few days. He was also experiencing shortness of breath. A nurse examined him and sent him to hospital for further assessment. Mr Constable was escorted by two officers and restrained using a single handcuff.

17. On 3 May, Mr Constable underwent emergency surgery due to a bowel obstruction. The restraints were removed for his operation and he was not restrained again. Following his operation, Mr Constable was admitted to the hospital's Intensive Care Unit.

18. On 4 May, the hospital told the prison that Mr Constable's health was rapidly declining, and that the bowel obstruction was likely to be cancerous. The prison started an application for early release on compassionate grounds on Mr Constable's behalf. Mr Constable died before the application could be completed.

19. At 1.21am on 6 May, it was confirmed that Mr Constable had died in hospital.

### Cause of Death

20. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Constable's cause of death as sepsis caused by perforated colonic carcinoma (colon cancer which has grown through the wall of the bowel).

## Non-Clinical Findings

### Restraints, security and escorts

21. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility.

22. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when he has a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change. These requirements are reflected in Prison Service Instruction (PSI) 33/2015 on external prisoner movements.

23. The medical section of the risk assessment for Mr Constable's last journey to hospital on 2 May 2021, recorded that he could not walk unaided and that he was 'frail and lacked mobility'.

24. The security assessment noted that Mr Constable was 87 years old, a category D prisoner and assessed as being a low risk of harm to the public and staff, and a high risk of harm to children. A prison manager decided that Mr Constable should be restrained using a single handcuff and be accompanied by two escorting officers for the journey to hospital.

25. We recognise that many factors must be taken into account in determining the level of restraints. However, we question whether the use of a single handcuff to restrain Mr Constable was proportionate given that his offences were historic, he was assessed as a low risk of harm to adults and staff, his ill health, age, frailty and lack of mobility. We cannot see the justification for using a single handcuff and we question whether the use of any restraints was proportionate when he was already escorted by two officers. We therefore consider that the authorising manager's decision to use restraints was unsound. We recommend:

    **The Governor should ensure that all staff undertaking and reviewing risk assessments for prisoners admitted to hospital understand the legal position on the use of restraints, and that assessments fully take into account the prisoner's health and are based on the actual risk he presents at the time.**

26. The prison appropriately removed Mr Constable's restraints for his operation on 3 May and he was not restrained again.

**Lisa Burrell** **December 2021**
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