

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Graham Broadley, a prisoner at HMP Lewes, on 11 January 2020

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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 Graham Broadley died of bilateral bronchopneumonia on 11 January 2020 at HMP Lewes. He was 76 years old. I offer my condolences to Mr Broadley's family and friends.

The clinical reviewer was satisfied that the care Mr Broadley received at Lewes was broadly satisfactory and equivalent to that which he could have expected to receive in the community.

However, the clinical reviewer found that healthcare staff did not create care plans to manage Mr Broadley's conditions, and that no one had officially verified and certified Mr Broadley's death when he was found unresponsive in his cell.

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

December 2020

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Summary

Events

1. On 27 April 2018, Mr Graham Broadley was sentenced to 14 years in prison for sexual offences and sent to HMP Lewes.
2. Mr Broadley had several chronic health conditions, including diabetes, various heart conditions and osteoarthritis, and had had a previous mini stroke and spinal surgery. He used a wheelchair and hearing aids.
3. When he arrived at Lewes, a nurse conducted an initial health screen. There is, however, no record of a referral to the chronic disease management system, or a care plan or a referral for any secondary health screens. Care plans were not created until Mr Broadley had been at Lewes for 12 months.
4. In May 2019, Mr Broadley was admitted to hospital for two days after reporting chest pain. He was diagnosed with angina and an irregular heart rate and prescribed medication.
5. On 2 January 2020, Mr Broadley complained of chest pain. He was seen by a prison GP who diagnosed angina and prescribed medication.
6. On 9 January, Mr Broadley complained of having difficulty breathing. A prison GP arranged for him to go to hospital. Hospital staff diagnosed “non-specific chest pain” with no follow up action and Mr Broadley returned to the prison in the early hours of 10 January.
7. On 11 January, at 9.05am, an officer found him unresponsive slumped in his wheelchair. The officer shouted for assistance and used his radio. Another officer responded and radioed a medical emergency code. They were joined almost immediately by other officers. The control room staff called an ambulance.
8. Healthcare staff arrived and said that it was not necessary to begin cardiopulmonary resuscitation (CPR) as there were no signs of life. At 9.33am, paramedics arrived and noted that healthcare staff had confirmed that Mr Broadley had died.
9. A post-mortem examination gave Mr Broadley’s cause of death as bronchopneumonia.

Findings

10. The clinical reviewer considered that Mr Broadley’s care was equivalent to that which he could have expected to receive in the community.
11. The clinical reviewer did, however, identify some concerns, although he did not consider that these contributed to Mr Broadley’s death. He found that Mr Broadley did not have a secondary screen when he arrived at Lewes and care plans were not created until twelve months after his arrival. He also found that healthcare staff did not follow the expected verification and certification process after Mr Broadley’s unexpected death.

12. We are also concerned that an officer did not call the correct emergency code when he found Mr Broadley unresponsive in his cell. As a result, the first nurse to arrive did not bring the emergency equipment, and there was a delay of two minutes in calling an ambulance. We are satisfied that this did not affect the outcome for Mr Broadley as he had been dead for some time when he was found.
13. A nurse did not respond to the PPO's requests for an interview.

Recommendations

- The Head of Healthcare should ensure that all prisoners have a secondary screen for a clinical assessment to ensure continuity of healthcare.
- The Head of Healthcare should ensure that healthcare staff create and document care plans for all prisoners with chronic and/or life limiting conditions.
- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that staff promptly use a recognised emergency code to communicate the nature of the emergency.
- The Head of Healthcare should ensure that healthcare staff are aware of the verification and certification of death procedures, in line with the Royal College of Nursing and British Medical Association guidelines and recommendations.
- The Head of Healthcare should ensure that all staff co-operate fully with all requests from the PPO for information or material in line with PSI 58/2010.
- The Governor and Head of Healthcare should ensure that any staff named in this report are given the opportunity to read the report at the draft stage in line with paragraph 1.11 of PSI 58/2010.
- The Head of Healthcare should discuss the Ombudsman's findings with Nurse A.

The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP Lewes informing them of the investigation and asking anyone with relevant information to contact her. One prisoner responded.
15. The investigator visited Lewes on 21 January 2020. She obtained copies of relevant extracts from Mr Broadley's prison and medical records.
16. The investigator interviewed four members of staff and a prisoner at Lewes on 10 March 2020. She interviewed the temporary Head of Healthcare by telephone on 11 March.
17. NHS England commissioned a clinical reviewer to review Mr Broadley's clinical care at the prison.
18. We informed HM Coroner for East Sussex of the investigation. He gave us the results of the post-mortem examination. We have sent him a copy of this report.
19. The investigator contacted Mr Broadley's daughter, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She asked whether Mr Broadley had received his medication at the correct times, and what had happened on 9 January when Mr Broadley became unwell.
20. We have addressed her concerns in this report.
21. Mr Broadley's family received a copy of the initial report. They said that the prison FLOs were amazing. They raised a question that does not impact on the factual accuracy of this report and made some comments which have been addressed through separate correspondence.
22. 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. They also made comments that do not impact on the factual accuracy of this report and has been addressed through separate correspondence. The action plan has been annexed to this report.
23. HMPPS said that two nurses were "named as nurses but they are Healthcare Assistants and do not have the ability to verify death". We note that in her written statement a healthcare assistant signed herself off as "Associate Practitioner, Forensic Health Services Primary Care, HMP Lewes."

Background Information

HMP Lewes

24. HMP Lewes is a local prison serving the courts of East and West Sussex and holds up to 692 men. Sussex Partnership NHS Foundation Trust provides primary care services. HMP Lewes has a healthcare centre with a full time senior medical officer. Healthcare is provided on a 24-hour basis. There is also a 12-bed inpatient unit, an outpatient facility, a pharmacy and a range of clinics.
25. Following an inspection by HM Inspectorate of Prisons in 2016, Lewes was placed on 'special measures' for two years. This means that HM Prisons and Probation Service considered that the prison needed additional, specialist support to improve performance.

HM Inspectorate of Prisons (HMIP)

26. The most recent full inspection of HMP Lewes was conducted in January 2019. Inspectors reported that their findings were "deeply troubling and indicative of systematic failure within the Prison Service". They found that in the three years since their last inspection, very few of their recommendations had been fully implemented, and that few of the action points arising from the special measures action plan had been carried out. They concluded that, far from delivering better outcomes, two years of special measures had coincided with a serious decline in performance.
27. Inspectors found that many prisoners were negative about healthcare provision and that 67% regarded the overall quality as quite bad or very bad. Inspectors reported that healthcare staff were positive about the new clinical leadership but that many teams were understaffed leading to delays.
28. Inspectors reported that the overall management of long-term health conditions was poor, and patients did not have care plans to inform their ongoing care. Management was GP-led and ad hoc. There were no regular specialist nurse-led clinics. Systems for managing older prisoners and patients with palliative care needs were also underdeveloped.
29. HMIP carried out an Independent Review of Progress in December 2019 to review the prison's response to the key recommendations from its earlier inspection. They found that good or reasonably good progress had been made in response to two-thirds of the areas they reviewed and that the prison had a new sense of purpose and direction.
30. They reported that health governance structures had improved, and healthcare staff now received clinical and managerial supervision. Care for prisoners with long-term health conditions had also improved but was undermined by the large number of prisoners who did not attend their appointments, and they concluded that the prison had made insufficient progress in this area.

Independent Monitoring Board

31. 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 year to January 2019, the IMB reported that the delivery of healthcare services had suffered from staff shortages and that poor process and communication had significantly impacted on prisoner care.
32. The Board noted that the healthcare screenings in reception were hampered by poor facilities and levels of secondary screens within the 72-hour target continued to be disappointing.
33. The Board noted that some staff went 'the extra mile' to help prisoners, but that there was an increasing shortage of experienced staff.

Previous deaths at HMP Lewes

34. Mr Broadley was the eighth prisoner to die at Lewes since January 2018. Of the previous deaths, three were from natural causes, two were self-inflicted and two were drug-related deaths.
35. We have previously made a recommendation about the lack of care plans in our investigation into a death at Lewes in January 2019.

Key Events

36. On 27 April 2018, Mr Graham Broadley was sentenced to 14 years in prison for sexual offences. He was sent to HMP Lewes.
37. Mr Broadley entered prison with a number of chronic conditions, including diabetes, cardiovascular disease, angina, hypertension, adenosis polyposis (growths in the large intestine), hypothyroidism and osteoarthritis, and had previously had a mini stroke and spinal surgery. He used a wheelchair and hearing aids.
38. Mr Broadley had an initial health screen when he arrived at Lewes. A nurse prescribed his medication and offered him advice about stopping smoking (which he declined). The nurse conducted health and general wellness checks and took his observations. There is no record that the nurse referred him for chronic disease management, created a care plan or referred him for any secondary health screens.
39. Mr Broadley had regular tests to monitor his diabetes and thyroid function. Healthcare staff reviewed and adjusted his medications as required.
40. On 11 May, Mr Broadley complained about lower urinary tract problems and knee pain. A prison GP examined him and checked his blood pressure which was low. The GP noted that Mr Broadley was a low risk of prostate cancer and he prescribed medication to ease his urinary problems. No other blood pressure checks were completed until 11 months later.
41. On 3 January 2019, Mr Broadley told a prison GP that he had had a chesty cough for two weeks. The GP suspected that Mr Broadley had chronic obstructive pulmonary disease (COPD), but his chest X-ray result was normal. The GP prescribed ibuprofen to ease Mr Broadley's arthritic pain.
42. On 1 May, wing staff were concerned about Mr Broadley's wellbeing and asked a nurse to examine him. The nurse was concerned that Mr Broadley's oxygen saturation level was low and he was sent to hospital for review. He was admitted to hospital where he was diagnosed with atrial fibrillation (an irregular heart rate) and angina (chest pain caused by reduced blood flow to the heart) and was discharged back to the prison after two days. A prison GP reviewed Mr Broadley and prescribed appropriate medication.
43. On 2 January 2020, Mr Broadley told a prison GP, that he had chest pains. The prison GP examined Mr Broadley and noted that he had exertional angina (angina as a result of physical exertion) with no other symptoms. He prescribed medication for his heart-related chest pain.
44. On 9 January, wing staff were concerned about Mr Broadley's wellbeing and asked healthcare staff to examine him. A healthcare assistant noted that he had chest pains and she made an urgent GP referral. A prison GP reviewed Mr Broadley and noted that his blood test results indicated that he might have had a heart attack. He was sent to hospital by emergency ambulance for review.
45. In A&E he had a chest X-ray which was reported as normal and an ECG (a test of the heart's rhythm and electrical activity) which was also normal. He had no complaints of cough or shortness of breath. The hospital diagnosed non-specific

chest pain with no follow up action and he was discharged, arriving back at Lewes at 2.55am.

46. On 10 January, Mr Broadley collected his repeat medications and no concerns were noted.

Events of 11 January 2020

47. An Operational Support Grade (OSG) provided the night duty cover on Mr Broadley's unit on the night of 10/11 January. He told the investigator that he did not notice anything untoward when completing his two hourly checks. He said that during his handover to day shift staff, there was nothing to report.
48. An officer was also on night duty. She said that at 4.50am, she was completing a check with the OSG and saw Mr Broadley asleep in his chair and did not notice anything untoward.
49. On the morning of 11 January, an officer began unlocking the cell doors on Mr Broadley's unit. At approximately 9.05am, he opened Mr Broadley's observation panel and saw him slumped over his wheelchair onto his bed. The officer entered the cell and called to Mr Broadley but he did not respond. He said that Mr Broadley was blue and very discoloured. The officer told the investigator that he radioed a medical emergency code blue (indicating breathing difficulties). The incident log noted that he had called a "potential code blue". He also shouted to a prisoner to raise the alarm. He said that nurses arrived very quickly. The officer was ushered away from the cell because he was very distressed.
50. Nurse A was on the unit and immediately went to Mr Broadley's cell. She said in a written statement that the cell door was open and as she entered, Mr Broadley was slumped in his wheelchair with his head facing downwards. She asked staff to call an ambulance and checked for a pulse, but there was none. She asked officers to move Mr Broadley onto the landing.
51. A healthcare assistant attended and she brought the emergency bag and defibrillator. She said that when she started to apply the defibrillator pads she saw that rigor mortis had already set in and nothing further could be done. (Rigor mortis normally sets in around two to six hours after death.)
52. Nurse A said that once Mr Broadley was on the landing she saw that he was stiff, his face was blue/purple and it was evident rigor mortis had set in. She said that she and the healthcare assistant agreed that no resuscitation attempt was necessary as there were no signs of life. Nurse A said that she asked that Mr Broadley's body be covered with a sheet to preserve his dignity.
53. Nurse A did not respond to the investigator's requests to attend an interview.
54. An officer said that he entered the cell and heard Nurse A shout for a defibrillator and call for an ambulance. He radioed the communication room for an ambulance, then helped other prison staff move Mr Broadley out of the cell onto the landing. He said that the nurses had said it was too late for resuscitation.
55. The ambulance log noted that the telephone request for an ambulance was received at 9.19am, paramedics had arrived at 9.33am, and that staff had informed

them on arrival that Mr Broadley “has been confirmed life extinct”. Paramedics noted that Mr Broadley was “obviously deceased with rigor mortis and hypostasis”. The log also noted that “HCP (healthcare professionals) were on scene” and the OTP (operational team leader) advised the ambulance crew that it was not necessary to complete a ROLE (Recognition of Life Extinct) form as ambulance staff had not been responsible for confirming the death.

56. A duty manager completed a debrief report and noted that the nursing staff made the decision not to begin resuscitation as Mr Broadley was dead. He said that when pressed about who pronounced death, both healthcare staff said that they were unwilling to do that. The duty manager said that he was told that a GP was asked to visit the cell, but there is no evidence of this.

Contact with Mr Broadley’s family

57. On 11 January, the prison appointed an administrator as the family liaison officer (FLO) and a supervising officer as the deputy family liaison officer. They visited Mr Broadley’s daughter to break the news of Mr Broadley’s death and to offer their condolences and support.
58. Mr Broadley’s funeral was held on 4 February. The prison paid for the costs of the funeral in line with national guidance.

Support for prisoners and staff

59. After Mr Broadley’s death, the duty manager debriefed the 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.
60. In his debrief report, the duty manager noted that three prison officers who had attended the scene might need extra support from the care team. During the investigation interview, one officer told the investigator that he needed additional support. The investigator informed the Governor and his line manager who arranged for additional support to be provided.
61. The prison posted notices informing other prisoners of Mr Broadley’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 Broadley’s death.

Post-mortem

62. A post-mortem examination gave Mr Broadley’s cause of death as bilateral bronchopneumonia, caused by Type 2 diabetes and cardiac failure.

Findings

Clinical care

63. The clinical reviewer noted that Mr Broadley died of bronchopneumonia. He had been seen by a GP and consultant doctors in A&E in the days before his death but had not shown any respiratory symptoms or signs on examination, and a chest X-ray two days before his death was reported as normal.
64. The clinical reviewer concluded that the care that Mr Broadley received at Lewes was of a reasonable standard and equivalent to that which he could have expected to receive in the community.
65. The clinical reviewer did, however, identify some concerns, although he said these did not affect Mr Broadley's death.

Secondary reception screen

66. Prison Service Order (PSO) 3050, Continuity of Healthcare for Prisoners, gives guidance on the clinical management of prisoners. It contains a mandatory instruction that:

“In the week following first reception, every prisoner must be offered a general health assessment. This assessment is equivalent to a primary care assessment when registering with a new practice in the community...”

67. The secondary screen is an opportunity for care planning and a more in-depth assessment and investigation of healthcare issues. The clinical reviewer noted that Mr Broadley did not have a secondary screen. We recommend:

The Head of Healthcare should ensure that all prisoners have a secondary screen for a clinical assessment to ensure continuity of healthcare.

Care plans

68. PSO 3050 also emphasises the importance of continuity in the success of clinical interventions and treatment. There should have been a plan for Mr Broadley's care with good, clear, holistic care plans, which were well communicated within the healthcare team. Healthcare staff did not arrange chronic disease management reviews and care plans until he had been at Lewes for twelve months.
69. The clinical reviewer also noted that in November 2019, a prison GP recorded that Mr Broadley had an abnormal blood test result and said this should be discussed with Mr Broadley. However, there is no record that this happened. A record of discussions about his blood tests and his blood pressure could have enabled staff to better assess any improvements or deterioration in his condition. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff create and document care plans for all prisoners with chronic and/or life limiting conditions.

Emergency response

70. PSI 03/2013 on medical emergency response codes requires governors to have a medical emergency response code protocol (normally red for bleeding and burns, and blue for breathing difficulties and collapses) to ensure that prison healthcare staff respond with the correct equipment and that the prison's control room calls an ambulance immediately in a life-threatening medical emergency. The PSI explicitly states that control room staff should automatically call an ambulance whenever an emergency code is called.
71. When an officer found Mr Broadley unresponsive and radioed a medical emergency, he did not call a code blue but instead radioed a "potential code blue". In their written statements, Nurse A and the healthcare assistant described hearing "a potential code blue" and Nurse A arrived at the cell without the emergency equipment. The officer told the investigator that he was aware of the appropriate radio call signs but became distressed. Two minutes later, another officer correctly radioed a code blue. The Ambulance Service confirmed that an ambulance was called at 9.19am.
72. Although we recognise that a death is distressing for staff, the failure to call a recognised emergency code initially led to a delay in calling an ambulance and in healthcare staff bringing the right equipment. This did not affect the outcome for Mr Broadley, as he had been dead for some time when he was found, but a delay of this kind could be critical in other emergencies. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that staff promptly use a recognised emergency code to communicate the nature of the emergency.

Verifying and certifying death

73. Confirmation and verification of death is defined as deciding whether a person has actually died. Certification of death requires a registered medical practitioner.
74. The Royal College of Nursing advises that "within prisons, registered nurses do not currently verify death". The British Medical Association (BMA) recommends that a GP with whom the patient was registered is best placed to examine and confirm death. The BMA says that "if an unexpected death occurs out of hours, it is helpful if a duty GP does attend as this may prevent the potentially unnecessary attendance of the emergency services".
75. We have been unable to confirm who verified Mr Broadley's death. Nurse A recorded in her medical notes that "CPR would be of no medical benefit" and asked staff to cover Mr Broadley's body with a sheet. She noted the paramedics (contrary to their report) and herself as the informants. Healthcare staff also told a manager during the hot debrief that a GP had been contacted. However, there is no written record of when or who was contacted and who certified Mr Broadley's death. We therefore recommend:

The Head of Healthcare should ensure that healthcare staff are aware of the verification and certifying death procedures in line with the Royal College of Nursing and British Medical Association guidelines and recommendations.

76. PSI 58/2010, *Prisons and Probation Ombudsman*, requires that the PPO is given “unfettered access” to the documents it requires to carry out an investigation and that “all staff must co-operate fully with all requests from the PPO for information, material or access to establishments and prisoners”. We consider that a failure to do so should be regarded as a potential disciplinary offence.
77. We are, therefore, concerned that, despite several requests, Nurse A failed to attend her interview or contact the investigator. We recommend:

The Head of Healthcare should ensure that all staff co-operate fully with all requests from the PPO for information or material in line with PSI 58/2010.

Sharing of PPO reports

78. We consider that it is important for staff who were involved in the emergency response to see the findings of and learn lessons from our investigation. We make the following recommendations:

The Governor and Head of Healthcare should ensure that any staff named in this report are given the opportunity to read the report at the draft stage in line with paragraph 1.11 of PSI 58/2010.

The Head of Healthcare should discuss the Ombudsman’s findings with Nurse A.

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