Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Robert Jones, a prisoner at HMP Bure, on 22 May 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

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 Robert Jones died in hospital from heart failure on 22 May 2020, while a prisoner at HMP Bure. He was 68 years old. I offer my condolences to Mr Jones' family and friends.

The clinical reviewer concluded that the clinical care Mr Jones received at Bure was of a good standard and equivalent to that which he could have expected to receive in the community. However, while Mr Jones was at HMP Chelmsford in December 2018, a prison GP mistakenly stopped some of Mr Jones' heart medication. Staff at Bure discovered this only shortly before Mr Jones became seriously ill in April 2020.

I am also concerned that staff failed to take account of Mr Jones' poor health and mobility when they authorised the use of restraints when he was taken to hospital on 27 April.

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**

Contents

Summary

Events

1. On 26 October 2018, Mr Robert Jones was sentenced to nine years imprisonment for sexual offences. In December, he spent two weeks at HMP Chelmsford and then moved to HMP Bure.

2. Mr Jones had serious health problems before he went to prison. These included hypertension (high blood pressure), chronic obstructive pulmonary disease (COPD, the term for a group of serious lung diseases), atrial fibrillation (AF, a heart condition which causes it to beat irregularly), asthma and diabetes.

3. On 21 April 2020, a review of Mr Jones' medical history revealed that while he was at Chelmsford in December 2018, a GP had stopped his medication for AF in error. The GP at Bure reinstated Mr Jones' AF medication, but before treatment began, Mr Jones fell ill on 27 April, and he was taken to hospital.

4. Mr Jones remained in hospital until he died on 22 May. A hospital doctor gave Mr Jones' cause of death as heart failure due to biventricular impairment (restriction of the blood supply from the heart to the lungs and the rest of the body). The doctor listed AF and type 2 diabetes as contributory factors.

Findings

5. The clinical reviewer was satisfied that overall, the healthcare Mr Jones received at Bure was of a good standard and equivalent to that he could have expected to receive in the community. She said that the way the prison responded to the discovery of the AF medication mistake was also equivalent to what could have been expected in the community. However, both Chelmsford and Bure need to safeguard against future medication mistakes.

6. When Mr Jones fell ill on 27 April, items were found to be missing in the emergency equipment.

7. The decision to apply restraints to Mr Jones when he was taken to hospital on 27 April, was not proportionate to his level of health and mobility.

Recommendations

- The Head of Healthcare at Chelmsford should ensure that when a prisoner is transferred to another prison, accurate information on their prescribed medications is provided.
- The Heads of Healthcare at both Chelmsford and Bure should ensure that a clinically valid reason is recorded on SystmOne records for discontinuing prescribed medications and that adherence to this requirement is confirmed through annual audit.

- The Head of Healthcare at Bure should ensure that there is a local operating procedure in place to capture the process for checking recently discontinued prescribed medications within the medicines reconciliation process.
- The Head of Healthcare at Bure should review clinical stock checking and maintenance processes to ensure that when attending emergency situations staff have all the necessary equipment.
- The Governor of Bure should ensure that authorising managers of risk assessments indicate on the risk assessment form that they have taken account of the information supplied by healthcare staff.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Bure informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

9. The investigator obtained copies of the relevant extracts from Mr Jones' medical and prison records.

10. NHS England commissioned a clinical reviewer to review Mr Jones' clinical care in prison.

11. We informed HM Coroner for Norfolk of the investigation. The coroner provided us with the cause of death. We have sent the coroner a copy of this report.

12. One of the PPO's family liaison officers contacted Mr Jones' next of kin, his wife, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. In her reply, she said that she had several concerns about to her husband's healthcare treatment. The issues she raised are covered in the clinical review annexed to this report.

13. The initial report was shared with Mr Jones' wife. She did not make any comments.

14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found no factual inaccuracies.

Background Information

HMP Bure

15. HMP Bure is a medium security prison near Norwich, which holds over 600 men convicted of sexual offences.

HM Inspectorate of Prisons

16. The most recent inspection of Bure was in April 2017. Inspectors reported that the healthcare centre was clean and clinical rooms were fit for purpose. Healthcare equipment was checked and maintained regularly and healthcare staff received intermediate-level resuscitation training. Defibrillators were in place on all residential units, and rotas were arranged to ensure that first-aid-trained prison staff were consistently on duty. An appropriate range of primary care services was provided and waiting times were short. Routine GP appointments were available within two days and urgent appointments were facilitated based on clinical need. Long-term conditions and complex health needs were overseen by the GP, who coordinated their approach with healthcare staff.

17. Prisoners were positive about the quality of the healthcare services. The vast majority of medications were supplied to prisoners to hold in their possession and there were appropriate risk assessments in place for this. Inspectors also found that there was effective learning from serious medical incidents.

18. At the time of the inspection, the healthcare was provided by Virgin Care. The provider was changed to Care UK in April 2019 and there has been no inspection since that time.

Independent Monitoring Board

19. 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 31 July 2019, the IMB said that healthcare staffing levels had significantly improved. The report also noted that regular checks were made by the pharmacy technician regarding compliance with medication.

Previous deaths at HMP Bure

20. Mr Jones was the third prisoner to die at Bure since May 2018. Of the previous deaths, one was from natural causes and one was self-inflicted. There are no similarities between these deaths and that of Mr Jones.

Key Events

21. On 26 October 2018, Mr Robert Jones was sentenced to nine years imprisonment for sexual offences and was sent to HMP High Down. On 3 December, he was sent to HMP Chelmsford. This was a temporary transit stop on the way to HMP Bure. He was sent on to Bure on 17 December.

22. Mr Jones had serious health problems before he went to prison. These included hypertension (high blood pressure), chronic obstructive pulmonary disease (COPD, the term for a group of serious lung diseases), atrial fibrillation (AF, a heart condition which causes it to beat irregularly), asthma, and diabetes, which had caused serious nerve damage and lower limb pain. Mr Jones had declining mobility and was issued with a walking stick after a social care assessment on 11 July 2019.

23. Despite his ill health, Mr Jones' condition remained relatively stable for most of his time at Bure. In February 2019, he was referred to a hospital for investigation of some digestive issues he was experiencing. The diagnosis was that he had a minor hiatus hernia (a common condition in older people, in which a part of the stomach slides into the chest). He had no significant issues until April 2020.

24. On 27 March 2020, Mr Jones was put into protective shielding as he was identified as being vulnerable to the COVID-19 virus. This meant very little time out of his cell, but there were twice daily welfare checks on him. During this period Mr Jones' normal breathlessness from his heart and lung conditions, began to deteriorate. On 20 April, a nurse asked the GP to review Mr Jones' medication and she also noted that he had AF.

25. On reviewing his medical history on 21 April, a prison GP discovered Mr Jones' AF medication had been stopped at Chelmsford when he was there in December 2018. There was no reason noted in the clinical records for this. The GP asked for the AF medication to be resumed, but Mr Jones fell ill before the treatment could begin.

26. On the morning of 27 April, prisoners in nearby cells heard a noise in Mr Jones' cell and pressed their emergency cell bells. An officer responded to the calls and found Mr Jones collapsed on the floor of his cell struggling to breathe. She made a code blue call on her radio (a medical emergency code used when a prisoner is unconscious or having breathing difficulties that alerts healthcare staff and prompts the control room to call an ambulance).

27. Mr Jones had banged his head and was bleeding, but said he had no pain. He was unsure what had happened to him. The officer was quickly joined by other officers and then shortly afterwards by healthcare staff. Mr Jones was given oxygen and was continuously monitored until an ambulance arrived and took him to hospital.

28. By 2 May, hospital doctors had determined that Mr Jones' heart failure was too advanced for corrective treatment and he was put on a palliative pathway (care with the focus on optimising the quality of life and reducing suffering).

29. Because of his advanced ill health, Bure did not have the necessary healthcare provision for Mr Jones to be able to return there. Although Mr Jones tested negative for COVID-19, special measures relating to the virus meant that it was not possible to transfer him to a hospice. However, on 21 May, a space became

available for him on L wing at HMP Norwich (a wing which offers 24-hour nursing and social care packages for prisoners with chronic health conditions).

30. By this time, Mr Jones was seriously ill and he was not transferred to Norwich. He died in hospital on 22 May.

Contact with Mr Jones' family

31. Mr Jones' wife was informed when he was taken to hospital on 27 April. The next day a prison family liaison officer was appointed. They had regular contact with Mr Jones' wife for the remainder of her husband's time at hospital.

32. The prison contributed to the costs of Mr Jones' funeral in line with national prison policy.

Support for prisoners and staff

33. After Mr Jones' death, the duty governor debriefed the staff who had been with him at the hospital. They said they did not wish to be sent home. They were also spoken to by a Custodial Manager, the Head of Safer Prisons and Equalities and informed of the support from the Care Team.

34. The prison posted notices to staff and prisoners informing them of Mr Jones' death, and offering support.

Cause of death

35. There was no post-mortem examination as the coroner accepted the cause of death provided by the hospital doctor, who said Mr Jones died from heart failure due to biventricular impairment (restriction of the blood supply from the heart to the lungs and the rest of the body). The doctor also listed AF and type 2 diabetes as contributory factors.

Findings

Clinical care

36. The clinical reviewer found that the care Mr Jones received at Bure was of a good standard and equivalent to that which he could have expected to receive in the community.

37. The major issue identified in Mr Jones' care, was the stopping of his AF medication at Chelmsford which was not picked up on his admission to Bure.

38. The clinical reviewer said that the action taken on discovery of the mistake, was appropriate and equivalent to what would have been expected outside prison. The clinical reviewer acknowledged that there was a different care provider at Bure at the time of Mr Jones' admission, and that improvements had been made since then. However, she identified some areas for action.

The error with Mr Jones AF medication

39. There was no cause given in the medical records for ceasing the AF medication at Chelmsford in December 2018. The Pharmacy Manager at Chelmsford told the investigator it was most likely just a mistake by a prison GP, who was the GP responsible for the change. It would be prudent for Chelmsford to have safeguards against such mistakes.

40. The mistake should have been picked up at Mr Jones' reception screening at Bure. Because it was not, his AF condition went largely unnoticed and was not reviewed at Bure until 21 April 2020. We cannot say whether this affected the outcome for Mr Jones.

41. It was evident from the interviews with healthcare staff at Bure that there had been a great deal of progress since the arrival of the new care provider in April 2019. However, some of the current good practice needs to be formalised to build on the progress made, and to safeguard against future mistakes.

42. We recommend:

The Head of Healthcare at Chelmsford should ensure that when a prisoner is transferred to another prison, accurate information on their prescribed medications is provided.

The Heads of Healthcare at both Chelmsford and Bure should ensure that a clinically valid reason is recorded on SystmOne records for discontinuing prescribed medications and that adherence to this requirement is confirmed through annual audit.

The Head of Healthcare at Bure should ensure that there is a local operating procedure in place to capture the process for checking recently discontinued prescribed medications within the medicines reconciliation process.

Emergency response equipment

43. On 27 April, when Mr Jones collapsed and a code blue was called, the prison's emergency healthcare equipment did not contain any gauze, and there were insufficient sticky pads to enable an ECG (electrocardiogram: a check of the rhythm and electrical activity of the heart) to be conducted before paramedics arrived. Neither of these issues affected the outcome for Mr Jones, but stocking issues should not be discovered in an emergency. We recommend:

The Head of Healthcare at Bure should review clinical stock checking and maintenance processes to ensure that when attending emergency situations staff have all the necessary equipment.

The use of restraints

44. 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.

45. 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 suffering from 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.

46. Prison Service Instruction 33/2015, External Prisoner Movements, says normal practice is for male Category B and Escape-List prisoners to be double cuffed while on escort. All other prisoners will be single cuffed unless the individual risk assessment indicates that double cuffing is required and is proportionate. It goes on to say that restraints should not normally be used where the prisoner's mobility is severely limited (for example, due to advanced age or disability) unless there are grounds for believing that an escape attempt may be made with external assistance.

47. A risk assessment form was completed on 27 April in preparation for Mr Jones' transfer to hospital. In the section filled in by healthcare staff, a nurse indicated that Mr Jones was frail or lacking in mobility. In the section asking for further comments to assist the senior manager in their risk assessment, she wrote, "Currently patient unable to walk independently".

48. The Deputy Governor was the senior manager completing the risk assessment. She authorised the use of restraints "to mitigate the risk to the public and of escape". She did not refer to Mr Jones' health or mobility. She said an escort chain (a chain which is handcuffed at one end to the prisoner and at the other to a prison officer) should be used, to allow for social distancing as a precautionary measure against COVID-19.

49. Mr Jones did not remain restrained for long. The bedwatch logs indicate that at 7.00pm on 27 April, the Deputy Governor authorised the removal of restraints. The following day, an officer recorded in the bedwatch log that he had a phone conversation with the prison to discuss a review of the risk assessment and recorded that Mr Jones "has next to no mobility". Restraints were not reapplied for the remaining time Mr Jones was in hospital.

50. Although Bure correctly reassessed the situation and removed Mr Jones' restraints after a few hours, it remains a concern that staff authorised the use of restraints on a 68-year-old Category C prisoner, who healthcare said had very little mobility and was accompanied by two officers. We recommend:

The Governor of Bure should ensure that authorising managers of risk assessments indicate on the risk assessment form that they have taken account of the information supplied by healthcare staff.

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