Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Julian Mardon, a prisoner at HMP Bure, on 7 March 2021

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

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 Julian Mardon died on 7 March 2021 of coronary artery thrombosis at HMP Bure. He was 86 years old. I offer my condolences to Mr Mardon's family and friends.

Mr Mardon had a number of complicated medical conditions, which were controlled by medication and monitored by prison healthcare staff. The clinical reviewer concluded that the care Mr Mardon received at HMP Bure was equivalent to that which he could have expected to receive in the community.

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 **April 2022**

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Summary

Events

1. On 30 September 2016, Mr Julian Mardon was sentenced to 16 years in prison for sexual offences. On 29 June 2018, he transferred to HMP Bure.

2. Mr Mardon had several chronic health conditions, including hyperlipidaemia (too many fat deposits in the blood), atrial fibrillation (irregular heart rate), high blood pressure, leukaemia and skin and penis cancer. He also used a hearing aid.

3. When he arrived at Bure, a nurse conducted an initial health screen. She did not record all of his medical conditions in his medical record. Mr Mardon had a secondary health screen three days later, which did record all his medical conditions. Staff prescribed appropriate medications and created care plans.

4. On 7 March 2021, an officer found Mr Mardon unresponsive in his cell. The officer shouted for assistance and radioed a medical emergency code. She was joined by other officers and they began cardiopulmonary resuscitation (CPR). The control room staff called an ambulance.

5. At 12.08pm, paramedics arrived and continued resuscitation attempts. At 12.35pm, a senior paramedic confirmed that Mr Mardon had died.

6. A post-mortem examination gave Mr Mardon's cause of death as coronary artery thrombosis.

Findings

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

8. The clinical reviewer did, however, identify some areas of concern.

9. He found that during his initial health screen healthcare staff did not accurately record all of Mr Mardon's allergies and existing medical conditions, and that his blood pressure checks were not conducted in line with NICE guidelines.

Recommendations

- The Head of Healthcare should ensure that reception screening records all allergies and existing medical condition in line with NICE guidance NG57.

- The Head of Healthcare should ensure that blood pressure readings are recorded for both sitting and standing in line with NICE Guidance Hypertension in adults: diagnosis and management [NG136].

The Investigation Process

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

11. The investigator obtained copies of relevant extracts from Mr Mardon's prison and medical records.

12. NHS England commissioned a clinical reviewer to review Mr Mardon's clinical care at the prison.

13. We informed HM Coroner for Norfolk of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

14. The PPO family liaison officer contacted Mr Mardon's next of kin, his sister, to explain the investigation and to ask if she had any matters they wanted the investigation to consider. She did not respond to our letter.

15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Bure

16. HMP Bure is a medium security prison near Norwich and can hold approximately 650 men. The accommodation is a mix of new buildings and converted RAF accommodation and service buildings. From 2019, healthcare services were provided by Care UK and from 2021 were provided by Practice Plus Group.

HM Inspectorate of Prisons

17. The most recent inspection of Bure was in March and April 2017. Inspectors found that Bure remained an overwhelmingly safe and respectful prison.

18. Prisoners told the HMIP inspectors that the health services provided were very good. Inspectors noted that there was an appropriate range of primary care services that were provided and waiting times were short. Long-term conditions and complex health needs were overseen by the GP, who liaised with health services staff to ensure a coordinated approach. There were plans for this to be changed to nurse-led long-term condition clinics, to provide a more systematic approach.

19. External hospital appointments were well managed with good support from the prison, which ensured that security measures on escorts were proportionate and based on individual risk.

Independent Monitoring Board

20. 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 period August 2019 to July 2020, the IMB reported that prior to the COVID-19 restrictions, prisoners felt safe, and morale was high with low levels of violence. They noted the impact of COVID-19 with prisoners locked in their cells for up to 23 hours a day and said that it had been difficult both for staff and prisoners.

21. The IMB considered that healthcare staff delivered a service equivalent to that expected in the local community. Due to the COVID-19 restrictions, clinics had been cancelled, but the healthcare team had face-to-face meetings with prisoners and used appropriate personal protective equipment in urgent cases.

Previous deaths at HMP Bure

22. Mr Mardon was the seventh prisoner to die at Bure since March 2019. Of the previous deaths, four were from natural causes and two were self-inflicted deaths.

23. There are no similarities between our findings in the investigation into Mr Mardon's death and our investigation findings in the previous deaths.

Key Events

24. On 30 September 2016, Mr Julian Mardon was sentenced to 16 years in prison for sexual offences. He spent time in several prisons and transferred to HMP Bure on 29 June 2018.

25. Mr Mardon had a complicated medical history, including hyperlipidaemia (too many fat deposits in the blood), atrial fibrillation (irregular heart rate), high blood pressure, leukaemia and skin and penis cancer. He also used a hearing aid.

26. Healthcare staff completed an initial health screen. A nurse did not note all of Mr Mardon's medical conditions in his medical record. Three days later, Mr Mardon had his secondary health screen. Healthcare staff recorded all of his medical conditions and prescribed appropriate medications and created care plans for cardiovascular screening, high blood pressure, atrial fibrillation and COVID-19 shielding. Prison GPs regularly monitored his hyperlipidaemia and leukaemia through regular blood tests. After a cancer follow up appointment, urology specialists discharged Mr Mardon to the care of his GP in August 2019.

27. On 5 October, Mr Mardon told a nurse that he had a tender spot on his scalp, and he was worried that his skin cancer had returned. Nurses referred him to a hospital dermatologist. The dermatologist made an urgent referral to the local skin cancer service under the NHS pathway, which requires patients with suspected cancer to be seen by a specialist within two weeks. Specialists saw Mr Mardon and completed a biopsy, and Mr Mardon was diagnosed with skin cancer. This was completely removed in March 2020 and checks were scheduled for six months later.

28. On 1 June, healthcare staff advised Mr Mardon to shield as he was clinically vulnerable and at very high risk of severe illness and death from COVID-19. Mr Mardon declined to shield and signed a disclaimer to that effect.

29. On 12 February 2021, Mr Mardon received his first dose of the COVID-19 vaccine.

Events of Sunday 7 March

30. On 7 March, Officer A said that he had spoken to Mr Mardon shortly before prisoners were locked up in their cells between 10.00am and 10.30am. Nothing untoward was noted.

31. At approximately 11.40am, Officer B was unlocking the cell doors for lunch. In her written statement she said that she noted that, unusually, Mr Mardon was not waiting by his cell door. When she pushed his door open, she found him lying on the floor. His skin was pale, and he was cool to the touch. She checked his pulse and found none. She immediately shouted for staff assistance and radioed a code blue (an emergency medical code indicating that a prisoner is unconscious or is having breathing difficulties). Officer A and Officer C arrived at the cell. Officer B told the officers that she thought Mr Mardon was dead. Officer C went into the cell and immediately began CPR; Officer A assisted. The staff attached a defibrillator to Mr Mardon. Two shocks were administered, and staff continued with resuscitation. Officer B was led away from the cell.

32. Two nurses arrived and helped with resuscitation attempts. More healthcare staff arrived minutes later with other medical equipment. Oxygen was administered via a bag valve mask and suction was used to maintain a clear airway. All staff who assisted with the resuscitation attempt were wearing personal protective equipment (PPE).

33. At 12.08pm, the ambulance arrived at the prison and paramedics continued resuscitation attempts. At 12.35pm, a senior paramedic confirmed that Mr Mardon had died.

Contact with Mr Mardon's family

34. Mr Mardon's sister, his next of kin, lives in Spain. The prison appointed an offender manager to act as the family liaison officer (FLO). He telephoned Mr Mardon's sister to inform her of his death. He remained in contact with Mr Mardon's sister to offer support.

35. The prison offered a contribution to Mr Mardon's funeral in line with national instructions.

Support for prisoners and staff

36. After Mr Mardon's death a prison 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.

37. The prison posted notices informing other prisoners of Mr Mardon'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 Mardon's death.

Post-mortem report

38. The pathologist gave Mr Mardon's cause of death as coronary artery thrombosis (a blood clot in one of the main arteries in the heart) caused by coronary artery atheroma (age related narrowing of the arteries).

Findings

Clinical care

39. The clinical reviewer concluded that the care Mr Mardon received at HMP Bure was of a good standard and was equivalent to that which he could have expected to receive in the community. The clinical reviewer noted that Mr Mardon had complex conditions which required ongoing management and monitoring and that staff managed this well.

40. The clinical reviewer did, however, identify two concerns.

Reception screening

41. Prison Service Order (PSO) 3050, Continuity of Care, says that for a prisoner's first reception into custody, an initial assessment of the healthcare needs of all newly received prisoners by the healthcare team should be undertaken within 24 hours. Additionally, the National Institute for Health and Care Excellence (NICE) guidance says that the purpose of this assessment is to identity any existing problems and to plan any subsequent care, recognising the importance of continuity in the success of clinical interventions and treatment.

42. Mr Mardon's initial healthcare assessment failed to identify all his previous medical conditions. The clinical reviewer considered that a more robust process was needed for the initial screen. The secondary screen was completed a few days later and did fully document his medical conditions and medications. We recommend:

The Head of Healthcare should ensure that reception screening records all allergies and existing medical conditions in line with NICE guidance NG57

Hypertension monitoring

43. National Institute for Health and Clinical Excellence (NICE) guidelines says that for patients over 80 years their blood pressure should be checked when sitting and standing and recorded as part of the management of the condition. The clinical reviewer found that although Mr Mardon attended hypertension clinics and it was noted that he had good control, there is no evidence that the two readings were taken in accordance with the NICE guidelines. We recommend:

The Head of Healthcare should ensure that blood pressure readings are recorded for both sitting and standing in line with NICE Guidance Hypertension in adults: diagnosis and management [NG136].

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