

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Raibeart Browne, a prisoner at HMP Gartree, on 25 June 2022

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 Raibeart Browne died in hospital of ischaemic heart disease on 25 June 2022 while a prisoner at HMP Gartree. He was 78 years old. I offer my condolences to his family and friends.

The clinical reviewer concluded that the healthcare that Mr Browne received at Gartree was equivalent to that which he could have expected to receive in the community.

However, she was concerned that following Mr Browne's discharge from hospital in December 2021, prison staff were not made aware that hospital staff had completed forms on his behalf about his treatment and resuscitation wishes in the event of a medical emergency. The Head of Healthcare will need to ensure that there are robust mechanisms in place to communicate and share information with hospitals to ensure continuity of care for prisoners.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman

July 2023

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Summary

Events

1. On 1 January 2013, Mr Raibert Browne was remanded to HMP Exeter, charged with attempted murder and breach of a restraining order. On 27 September, he was sentenced to life imprisonment, with a minimum tariff of seven years. On 19 August 2014, Mr Browne was transferred to HMP Gartree.
2. Mr Browne had several pre-existing medical conditions, including micturition frequency (a condition which causes issues with urinating) and bipolar disorder.
3. On 12 December 2021, Mr Browne had fallen over three times in one day, he appeared confused and was unable to support his own weight. He was admitted to hospital, where he was diagnosed with an erratic heart rate.
4. Mr Browne's condition continued to deteriorate in hospital and his prognosis was poor. He also tested positive for COVID-19. Hospital staff signed an order on Mr Browne's behalf for him not to be resuscitated if his heart or breathing stopped. He also had a form in place which set out his preferences for medical emergency care and treatment.
5. On 31 January 2022, he was discharged from hospital and returned to Gartree. The hospital did not share copies of these forms with prison healthcare staff and prison healthcare staff in turn did not follow this up.
6. At 7.15am on 25 June 2022, a prison officer carried out the morning roll check. He noted that Mr Browne was lying on his bed and appeared to be asleep.
7. At 8.13am, a prisoner tried to speak to Mr Browne, but he did not respond. He asked a prison officer to check on him. The officer entered Mr Browne's cell and noted that his face had a blue tinge and that he felt cold. He checked for signs of life but found none.
8. At 8.17am, the officer radioed a medical emergency code. Staff in the prison control room telephoned for an emergency ambulance immediately.
9. At 8.22am, two healthcare nurses arrived at the cell. One of the nurses noted that Mr Browne had early signs of rigor mortis and decided not to attempt cardiopulmonary resuscitation (CPR).
10. At 8.36am, paramedics arrived at the cell, and at 8.45am, they confirmed that Mr Browne had died.
11. The post-mortem report established that Mr Browne had died from ischaemic heart disease.

Findings

12. The clinical reviewer concluded that the healthcare that Mr Browne received at HMP Gartree was equivalent to that which he could have expected to receive in the community.
13. However, she was concerned that when Mr Browne was discharged from hospital and returned to Gartree on 31 January 2022, he arrived without a copy of his discharge summary. As a result, healthcare staff were unaware that Mr Browne had in place a plan which recorded his preferences for emergency care and treatment and an order not to be resuscitated if his heart or breathing stopped. She was also concerned that there was no evidence to indicate that healthcare staff had followed up Mr Browne's hospital discharge paperwork to ensure continuity of care.

Recommendations

- **The Head of Healthcare should ensure that valid Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) and Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) forms are scanned into prisoners' medical records and shared with the multidisciplinary team involved in their care.**
- **The Head of Healthcare should ensure that:**
 - **all prisoners who return from hospital have appropriate discharge paperwork; and**
 - **healthcare administration follow up any missing paperwork and ensure that it is received promptly.**

The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP Gartree informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
15. The investigator obtained copies of relevant extracts from Mr Browne's prison and medical records.
16. On 25 August 2022, the investigator interviewed three members of staff at the prison.
17. NHS England commissioned a clinical reviewer to review Mr Browne's clinical care at the prison.
18. We informed the Coroner for Rutland and North Leicestershire of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.
20. The Ombudsman's family liaison officer wrote to Mr Browne's next of kin, his son, to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond to her letter.

Background Information

HMP Gartree

21. HMP Gartree is a medium security prison located outside Market Harborough in Leicestershire. It has capacity to hold 708 men and is predominantly for prisoners serving life or other indeterminate sentences.
22. HMP Gartree has 24-hour healthcare services provided by Bridgewater Community Healthcare NHS Foundation Trust (Bridgewater) and Greater Manchester Mental Health NHS Foundation Trust (GMMH).

HM Inspectorate of Prisons (HMIP)

23. The most recent full inspection of HMP Gartree was in January 2019. Inspectors were pleased to note that the healthcare department was clean, treatment rooms generally met clinical requirements and equipment was checked and calibrated regularly. An infection prevention and control audit in November 2018 identified some issues, almost all of which had been addressed.
24. Inspectors also found that nursing staff ran regular health clinics and there was evidence of effective nurse-led interventions, including triage and wound care. In addition, prisoners with long-term conditions were now much better managed following the introduction of a community matron.

Independent Monitoring Board

25. 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 November 2021, the IMB considered that while the standard of in-cell care was good, other general health provision was less so. In particular, the IMB was concerned that attendance by visiting clinicians had dropped and was therefore less effective.
26. The IMB was also concerned that although approval had been given to refurbish an area within the healthcare department to provide gated cells for prisoners who require constant observation, the work had not yet been started. However, they considered that the healthcare service at the prison had benefited from good leadership and good coordination across all health and social care functions.

Previous deaths at HMP Gartree

27. Mr Browne was the twelfth prisoner to die at Gartree since June 2020. Of the previous deaths, nine were from natural causes and two were self-inflicted. There has been one further death since Mr Browne's death, also from natural causes. There are no similarities between our findings in the investigation into Mr Browne's death and our investigation findings for the previous deaths.

Key Events

28. On 1 January 2013, Mr Raibert Browne was remanded to HMP Exeter, charged with attempted murder and breaching a restraining order. On 27 September, he was sentenced to life imprisonment, with a minimum tariff of seven years. He returned to Exeter.
29. Mr Browne had a number of pre-existing medical conditions, including micturition frequency (a condition which causes issues urinating) and bipolar disorder.
30. On 19 August 2014, Mr Browne was transferred to HMP Gartree. A nurse carried out his initial health screen and referred him to the prison's mental health inreach team. The following day, a nurse from the mental health team saw Mr Browne. He denied having any mental health issues and was jovial and relaxed. The nurse told him he could refer himself to the mental health team whenever he needed to. Aside from routine reviews, Mr Browne had little significant contact with the healthcare team over the years that followed.

2021

31. On 12 December 2021, a nurse reviewed Mr Browne after he had fallen over three times in one day. She noted that he appeared confused and unable to support his own weight. She suspected that he might have developed a urinary infection and was at risk of developing sepsis. He was taken to hospital by emergency ambulance for further review.
32. In hospital, Mr Browne was diagnosed with an erratic heart rate and was admitted to hospital as an inpatient. Hospital staff also noted that he appeared confused.
33. Mr Browne's condition continued to deteriorate in hospital, and his prognosis was poor. Mr Browne tested positive for COVID-19. Hospital staff signed on Mr Browne's behalf an order not to resuscitate him if his heart and breathing stopped. They also signed a Recommended Summary Plan for Emergency Care and Treatment (ReSPECT, an advanced care plan that summarises a prisoner's preferences about medical emergency care and treatment). The hospital scanned a copy of the documents into Mr Browne's electronic medical record on 10 January. However, the hospital did not share paper copies of the forms with prison healthcare staff directly and healthcare staff did not follow up the missing paperwork with the hospital.

2022

34. Mr Browne's condition improved and on 31 January, he was discharged from hospital and returned to Gartree. A nurse carried out a reception health screen. She noted Mr Browne's prescribed medications and created care plans to manage his care. However, Mr Browne arrived at the prison without a hospital discharge summary (which should set out the treatment received in hospital, treatment plans, complications and changes to prescribed medications). There is no evidence that healthcare staff followed this up with the hospital. Prison healthcare staff continued to review him regularly.

35. A nurse saw Mr Browne on 17 February. He told her that he had had diarrhoea for the previous two days. She also noted that he had swelling and pitting to his lower legs caused by fluid retention. She advised him to rest and keep his legs elevated and referred him to a prison GP.
36. A nurse reviewed Mr Browne again on 14 March. He told her that although he felt well, he had noticed a deterioration in his condition since he had contracted COVID-19 in hospital. She advised him it would take time to recover fully and to maintain a gentle level of exercise. A few days later, a prison GP saw Mr Browne. He carried out full blood tests and prescribed him furosemide (a diuretic) to lessen the swelling to his legs.
37. On 28 April, a nurse saw Mr Browne after he complained of pain in his lower legs. He told her that he had no shortness of breath or chest pain but was unable to sleep. She referred him to a prison GP for review and advised him to continue taking furosemide and to keep his legs elevated.
38. At 7.15am on 25 June, Officer A completed a morning roll check and noted that Mr Browne was on his bed and appeared to be asleep.
39. At 8.13am, a prisoner tried to speak to Mr Browne, but he did not respond. The prisoner asked Officer B to check on him. He went into Mr Browne's cell and noted that his face had a blue tinge and that he felt cold. He checked for signs of life but found none. At 8.17am, he radioed a code blue. Staff in the prison control room telephoned for an emergency ambulance immediately.
40. At 8.22am, two nurses arrived at the cell. One nurse noted that Mr Browne felt cold, there was evidence of blood pooling (caused when the blood is unable to be pumped back to the heart) and that he had early signs of rigor mortis in his left arm. She did not attempt CPR.
41. At 8.36am, paramedics arrived at the cell and, at 8.45am, they confirmed that Mr Browne had died.

Contact with Mr Browne's family

42. On 25 June 2022, the prison appointed a family liaison officer (FLO).
43. The FLO noted that Mr Browne's son, who lived on the Isle of Wight, was listed as his next of kin. Due to the distance from Gartree, the Head of Safety at Gartree telephoned HMP Isle of Wight and asked for one of their family liaison officers to visit Mr Browne's son to inform him of his father's death.
44. However, as there were no family liaison officers available, Isle of Wight staff arranged for the local police to inform the family of Mr Browne's death. The police visited Mr Browne's son that day to break the news.
45. The following day, the FLO telephoned Mr Browne's son to offer her support. She remained in contact with him and continued to offer her support.
46. The prison contributed to the cost of Mr Browne's funeral in line with national instructions.

Support for prisoners and staff

47. After Mr Browne's death, a prison manager debriefed the staff who were involved, giving them the opportunity to discuss any issues arising and to offer support. The staff care team also offered support.
48. The prison posted notices informing other prisoners of Mr Browne's death and offered support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by his death.

Post-mortem report

49. The post-mortem report established that Mr Browne had died from ischaemic heart disease.

Inquest into Mr Browne's death

50. The inquest into Mr Browne's death was held on 26 January 2023 and a verdict of natural causes was recorded.
51. The coroner concluded Mr Browne's death was due to ischaemic heart disease.

Findings

Clinical care

52. The clinical reviewer concluded that the care Mr Browne received at HMP Gartree was equivalent to that which he could have expected to receive in the community.
53. However, she identified some areas of concern. She noted that following Mr Browne's admission to hospital on 12 December 2021, hospital staff had completed a ReSPECT form and an order not to resuscitate him if his heart or breathing stopped.
54. Although the completed forms were scanned into Mr Browne's medical records, the hard copy of the forms did not accompany him when he was discharged from hospital to Gartree as they should have been. As a result, healthcare staff were unaware that Mr Browne had in place an active ReSPECT form and order not to be resuscitated. In addition, healthcare staff failed to review Mr Browne's medical record to ensure that they were fully updated about his care needs and preferences.
55. While a nurse's decision not to start CPR was a correct one (as there was evidence of rigor mortis), it is unclear whether the healthcare staff who attended the emergency response were aware that Mr Browne had in place an order not to be resuscitated. We recommend:

The Head of Healthcare should ensure that valid DNACPR and ReSPECT forms are scanned into prisoners' medical records and shared with the multidisciplinary team involved in their care.

56. On 31 January 2022, Mr Browne was discharged to Gartree without a hospital discharge summary. There was no evidence in Mr Browne's medical records that the healthcare team at Gartree followed up the outcome of Mr Browne's hospital admission. This would have better informed healthcare staff about the follow-up treatment Mr Browne needed to ensure the continuity of his care. We recommend:

The Head of Healthcare should ensure that:

- **all prisoners who return from hospital have appropriate discharge paperwork; and**
- **healthcare administration follow up any missing paperwork and ensure that it is received promptly.**

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