

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Darren Heather, a prisoner at HMP Bure, on 26 July 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

OGL

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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 Darren Heather died from a heart attack caused by coronary artery disease on 26 July 2022 at HMP Bure. He was 58 years old. I offer my condolences to his family and friends.

The clinical reviewer concluded that the clinical care that Mr Heather received at Bure was equivalent to that which he could have expected to receive in the community.

When Mr Heather was found unresponsive in his cell, poor communication with the ambulance service meant that prison staff unnecessarily tried to resuscitate him. There was also a delay in admitting the ambulance into the prison.

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

March 2023

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Summary

Events

1. On 25 October 2021, Mr Darren Heather was remanded to HMP Norwich. On 23 November, he was sentenced to three years and eight months in prison for sex offences. On 24 March 2022, he was transferred to HMP Bure.
2. On 13 July, a nurse assessed Mr Heather because he said that he had chest pain. Mr Heather's clinical observations were all within the normal range. The nurse carried out an electrocardiogram (ECG) which was inconclusive.
3. On 20 July, a nurse saw Mr Heather to discuss recent blood test results. Mr Heather told the nurse that he had experienced tight chest pain for the last three weeks after walking short distances. Mr Heather's observations were within the normal range. The nurse noted that she would request an ECG and a chest x-ray.

Events of 26 July 2022

4. At 5.33am on 26 July, an operational support grade (OSG) found Mr Heather lying face down on the floor of his cell, fully dressed, not breathing. The OSG radioed a medical emergency code blue (which indicates that a prisoner is unconscious or having difficulty breathing).
5. A custodial manager (CM) and two officers went to Mr Heather's cell. They went into the cell and concluded that Mr Heather had died.
6. An OSG working in the control room telephoned the ambulance service and told the operator that they had a prisoner who had clearly died. The ambulance service operator told the OSG that the officers with Mr Heather must apply a defibrillator and begin cardiopulmonary resuscitation (CPR). At 6.02am, an ambulance arrived at Bure, but the paramedics were unable to gain access to the prison because the gates were locked. The OSG in the control room had to leave her post to unlock the vehicle gate. An officer escorted the ambulance to the wing. At 6.11am, paramedics confirmed that Mr Heather had died.

Findings

7. The clinical reviewer concluded that the clinical care that Mr Heather received at Bure was equivalent to that which he could have expected to receive in the community.
8. More direct communication with the ambulance service might have meant that prison staff did not have to attempt CPR on Mr Heather when he was clearly dead. When an ambulance arrived at Bure, there was a delay before it could enter the vehicle gates.

Recommendations

- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that:
 - relevant information about the condition of the prisoner is provided to the ambulance service, directly from staff on the wing when appropriate; and
 - an appropriate number of night staff have access to vehicle gate keys and there are no unnecessary delays in admitting ambulances into the prison.

The Investigation Process

9. 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.
10. The investigator obtained copies of relevant extracts from Mr Heather's prison and medical records.
11. The investigator interviewed five members of staff by video between 18 November and 29 November.
12. NHS England commissioned a clinical reviewer to review Mr Heather's clinical care at the prison.
13. We informed HM Coroner for Norfolk of the investigation. He gave us the result of the post-mortem examination. We have sent the Coroner a copy of this report.
14. The Ombudsman's family liaison officer wrote to Mr Heather's wife to explain our investigation. Mr Heather's wife said that she was concerned about the response from prison healthcare staff after he told her that that he had been having chest pains. We have addressed her concerns in this report.
15. We shared the initial report with the Prison Service. There were no factual inaccuracies. Their action plan has been appended to this report.
16. We shared the initial report with Mr Heather's wife. There were no factual inaccuracies. Mr Heather's wife asked a number of questions regarding the initial report, the clinical review and the interview transcripts which have been addressed in a letter and a response document completed by the clinical reviewer.

Background Information

HMP Bure

17. HMP Bure is a medium security prison near Norwich and can hold approximately 600 men. Healthcare services are provided by Practice Plus Group. Healthcare staff are on duty Monday to Friday between 8.00am and 7.00pm and weekends between 8.00am and 5.30pm.

HM Inspectorate of Prisons

18. The most recent inspection of Bure was in March and April 2017. Inspectors found that Bure remained an overwhelmingly safe and respectful prison.
19. Inspectors carried out a short scrutiny visit of HMP Bure in March 2021, which focused on key issues for prisoners during the COVID-19 pandemic. Inspectors reported that the prison had managed well in protecting its frail and older population from COVID-19. Inspectors found a committed and caring leadership and staff group which had maintained a safe, decent and very respectful prison despite the challenges of the pandemic. Inspectors reported that healthcare providers delivered effective healthcare services and found that around two thirds of prisoners reported that health services were good.

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 to July 2021, the IMB reported that healthcare was fully staffed and that they had delivered a service equal to that expected in the local community during the COVID-19 pandemic.

Previous deaths at HMP Bure

21. Seven prisoners died from natural causes at HMP Bure in the two years before Mr Heather's death. There was also one self-inflicted death in the same period. One prisoner died from natural causes at Bure since Mr Heather's death. There are no significant similarities between our findings in this investigation and those of the other deaths.

Key Events

22. On 25 October 2021, Mr Darren Heather was remanded in custody to HMP Norwich. On 23 November, he was sentenced to three years and eight months in prison for sex offences. On 24 March 2022, Mr Heather was transferred to HMP Bure.
23. At his initial health screen, Mr Heather told a nurse that he had not seen a doctor in the previous few months and that he was healthy. On 29 March, at his secondary health screen, a Healthcare Assistant (HCA) noted that Mr Heather's observations were all normal.
24. On 11 May, the HCA carried out an NHS health check. (An NHS health check is undertaken to offer advice to help prevent the onset of cardiovascular disease for people aged between 40 and 70 years of age.) The HCA noted that Mr Heather's HDL cholesterol (high-density lipoprotein, or good cholesterol, which absorbs cholesterol and carries it back to the liver) was low and that he had a high Qrisk score (a tool for predicting cardiovascular risk) which showed that he was at risk of having a stroke or heart attack in the next ten years. The HCA took blood samples which were within the normal range and noted that Mr Heather was overweight. The HCA booked Mr Heather for a review.
25. On 29 May, another HCA noted that Mr Heather refused to have blood tests because he had an "extreme needle phobia".
26. On 6 June, the nurse noted that she had discussed simple diet changes with Mr Heather and advised him to attend the gym for exercise. The nurse also noted that she advised Mr Heather to attend for his blood tests.
27. On 13 June, Mr Heather told the nurse that he had indigestion. The nurse requested a prescription for omeprazole (for gastric reflux).
28. On 13 July, a nurse assessed Mr Heather because he said that he had chest pain. The nurse noted that Mr Heather "arrived very swiftly, clearing the stairs with ease - no shortness of breath". Mr Heather told the nurse that, for the past two weeks, he had experienced shortness of breath and upper chest pain after five minutes of walking. The nurse noted that his clinical observations were all within the normal range and that Mr Heather looked fit and well. The nurse carried out an electrocardiogram (ECG) which was inconclusive. A prison GP reviewed the ECG but the outcome was not recorded in Mr Heather's medical records because the SystmOne electronic record was not available that day.
29. On 14 July, Mr Heather had fasting blood samples taken which were all normal.
30. On 20 July, a nurse saw Mr Heather to discuss his recent blood test results. Mr Heather told the nurse he had experienced tight chest pain for the last three weeks after walking short distances. He told her that he felt his chest getting tight. The nurse recorded that this settled after five minutes with no chest pain, no obvious wheeze and no cough. Mr Heather's observations were within the normal range but the nurse noted that he was very anxious and wanted a diagnosis and medication that day. The nurse noted that Mr Heather needed further investigations but that there were no obvious red flags. The nurse planned to give Mr Heather vitamin D

because he felt tired and noted that she would request an ECG and a chest x-ray. She did not request the chest x-ray that day and, on 25 July, noted that a nurse practitioner advised her that Mr Heather did not need an ECG as he had already had one that month.

Events of 25 and 26 July 2022

31. At about 8.15pm on 25 July, an Operational Support Grade (OSG) carried out the evening roll count and saw Mr Heather lying in bed, with the cover over him, watching television.
32. At 5.33am on 26 July, the OSG carried out the morning roll count. He saw Mr Heather lying face down on the floor of his cell, fully dressed, not breathing. The OSG radioed a medical emergency code blue. A second OSG who was working in the control room, telephoned for an ambulance immediately.
33. A Custodial Manager (CM), and two officers were close to the wing and immediately went to Mr Heather's cell. The OSG unlocked the cell door as the officers came onto the wing. Mr Heather's feet were against the door and the officers had to push the door to open it. An officer said that when they pushed the door, Mr Heather felt stiff.
34. The officers rolled Mr Heather onto his back. An officer said that when they turned him onto his back, Mr Heather's hand stayed where it was and didn't move. He said that he thought that this was rigor mortis and that Mr Heather was dead.
35. The officer saw that Mr Heather was not breathing, he was blue around the lips, his face was pale, and he was cold. He also thought that Mr Heather was dead.
36. The OSG said that as soon as he saw Mr Heather, he knew that he was dead. He said that Mr Heather was "stone cold", that he was purple/blue in the face and his eyes and mouth were open. He said that Mr Heather wasn't stiff but very heavy.
37. The CM thought that Mr Heather was dead. She said that he was cool to touch, he was blue around the mouth and his jaw and hands appeared quite rigid. The CM said that when she touched Mr Heather's hand, she felt a bit of warmth in it and found it to be flexible so decided that rigor mortis had not yet set in. She said that she had therefore instructed staff to start CPR.
38. The officers relayed their findings to the OSG working in the control room, who told the ambulance service operator that they had a prisoner whom they thought was dead. The OSG said that Mr Heather was "very cold and very gone". The ambulance service operator told the OSG that the officers with Mr Heather must apply a defibrillator and follow its instructions. She passed this instruction to the CM. The OSG told the ambulance service operator that Mr Heather was "very, very much dead".
39. An officer attached a defibrillator which on several occasions advised not to shock and to start cardiopulmonary resuscitation (CPR). The officers and the OSG therefore started CPR.
40. At 6.02am, an ambulance arrived at Bure. The paramedics were unable to gain access to the prison because the gates were locked. The OSG left the control

room, which is above the main gate, and went to the key cabinet where she drew the two gate keys. She went to the vehicle gate which she unlocked to allow access to the ambulance. An officer escorted the ambulance to the wing.

41. At 6.11am, paramedics confirmed that Mr Heather had died.

Contact with Mr Heather's family

42. On 26 July, Bure appointed a CM as the family liaison officer (FLO). The FLO and the Head of Safer Prisons visited Mr Heather's father and informed him of the death. Later that day, the FLO and the Head of Safer Prisons visited Mr Heather's wife and told her of the death. Mr Heather's funeral took place on 25 August. The prison contributed to its cost in line with national instructions.

Support for prisoners and staff

43. After Mr Heather's death, the Head of Security, 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.
44. The Governor posted notices informing other prisoners of Mr Heather's death and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Heather's death.

Post-mortem report

45. A post-mortem examination established that Mr Heather died from acute cardiac failure, caused by acute myocardial infarction (a heart attack) as a result of coronary artery atherosclerosis (coronary artery disease). Mr Heather also had ischaemic heart disease (heart disease) and left ventricular hypertrophy (a thickening of the wall of the heart's main pumping chamber) which contributed to but did not cause his death.

Inquest into Mr Heather's death

46. The inquest into Mr Heather's death was held on 11 July 2023 and a verdict of natural causes was recorded.

Findings

Clinical care

47. The clinical reviewer found that the clinical care that Mr Heather received at HMP Bure was of a satisfactory standard and equivalent to that which he could have expected to receive in the community.
48. The clinical reviewer considered the symptoms described by Mr Heather in July 2022, including chest pain and shortness of breath. She identified that these may have been warning signs of a cardiac cause but found that the healthcare team at Bure requested and carried out appropriate investigations, including blood tests, an ECG and a chest x-ray.

Emergency response

Resuscitation

49. In September 2016, the National Medical Director at NHS England, wrote to Heads of Healthcare for prisons introducing new guidance to support staff on when not to perform cardiopulmonary resuscitation. This guidance was designed to address the issue of inappropriate resuscitation following a sudden death in a prison and was in line with the European Resuscitation Council Guidelines which state, “Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile”.
50. Following Mr Heather’s death, the Patient Safety Team of the East of England Ambulance NHS Trust wrote to the prison concerned that the ambulance service operator was unable to speak directly to the prison staff who were with Mr Heather. Prison Service Instruction (PSI) 03/2013 on medical emergency response codes instructs that the member of staff using the medical emergency code must also provide relevant information about the condition of the prisoner to control room staff, so that they can pass it onto the ambulance service for use in the triage process.
51. The OSG promptly telephoned the ambulance service on receipt of the medical emergency code. She said that she told the operator that Mr Heather appeared to be dead, as she had been informed by staff on the wing and described their findings. The operator instructed the prison staff to attach a defibrillator and start CPR.
52. The OSG said that there is one radio channel used during a night shift but that there is also a radio in the control room to use on a separate channel. She said that she used the radio to talk privately and directly with a CM who was with Mr Heather to relay the instructions from the ambulance service operator. During a medical emergency, it would be best practice for prison staff at the scene to be able to speak directly to ambulance staff by telephone. This would enable ambulance service staff to receive direct and accurate information. We are concerned that CPR was not appropriate in these circumstances and direct communication might have led to a better-quality discussion and a different outcome.

Ambulance access at night

53. PSI 03/2013 instructs that prisons must prevent any unnecessary delay in escorting ambulances and paramedics to the patient and that local protocols must include procedures for admitting ambulances during the night state.
54. The Patient Safety Team of the East of England Ambulance NHS trust wrote to Bure with concerns that no prison staff were available to let the ambulance into the prison when it arrived. When ambulance paramedics arrived at the prison, they were unable to enter the prison as there were no prison staff at the gate.
55. The CM told the investigator that during night state, the vehicle gate is double locked. The officers working with the CM had a key that takes the double lock off the vehicle gate ready for the day shift. The CM said that, at the time of the emergency, the officers had taken the double lock off the gates as they had just carried out their morning rounds. However, the officers with the CM did not have access to draw the key that opens the vehicle gates. The OSG did have access to draw the key and had to leave the control room to draw the gate keys from the key cabinet to allow the ambulance into the prison. This caused a delay of a few minutes.
56. The OSG told the investigator that there was only one OSG working in the control room during a night shift. She said that she should not leave the control room. However, on this occasion, there were no other prison staff available with the authority to draw the two gate keys to allow the ambulance into the prison. The OSG explained that the CM also had the authority to draw the gate keys but she was with Mr Heather when the ambulance arrived at the prison.
57. We appreciate that there are very few prison staff working in the prison during a night shift. This resulted in a delay of several minutes when the ambulance was waiting for the gates to be opened. We are satisfied that this made no difference to the outcome for Mr Heather but in other circumstances, such a delay could make a difference. 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:

- **relevant information about the condition of the prisoner is provided to the ambulance service, directly from staff on the wing when appropriate; and**
- **an appropriate number of night staff have access to vehicle gate keys and there are no unnecessary delays in admitting ambulances into the prison.**

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

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

T | 020 7633 4100