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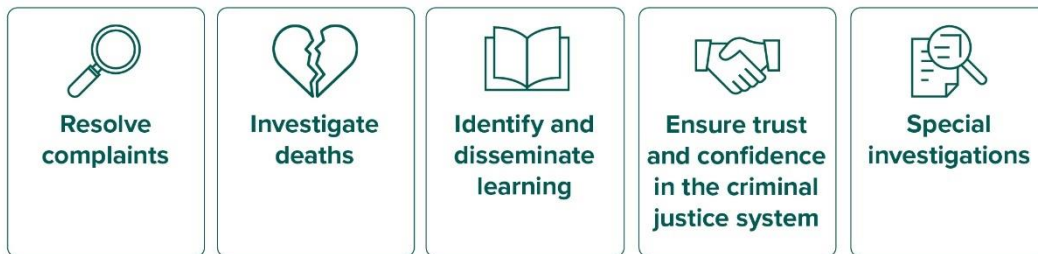
# **Independent investigation into the death of Mr Dominic Burges, a prisoner at HMP Bullingdon, on 10 February 2022**

**A report by the Prisons and Probation Ombudsman**

## OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

## WHAT WE DO



## WHAT WE VALUE



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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 Dominic Burges died in his cell at HMP Bullingdon on 10 February 2022. He was 30 years old. I offer my condolences to his family and friends.

Following post-mortem and toxicology examinations, Mr Burges' cause of death was recorded as unascertained. The pathologist recorded that it was possible that his death was related to the ingestion or inhalation of an unidentified substance, and also identified sudden adult death syndrome (SADS) as a potential cause of death. The jury at the inquest into Mr Burges' death recorded a narrative conclusion, finding that on the available evidence they were unable to say the cause of Mr Burges' death.

In recent years, Bullingdon has struggled to control the supply of drugs into the prison. Previous investigation reports from this office have highlighted that those prisoners who died of apparent drugs toxicity found it easy to obtain drugs. Bullingdon has since introduced measures to limit the supply of drugs, with some success, although it is apparent that more needs to be done and that staff should remain vigilant to the key issues surrounding supply and demand.

Mr Burges had a significant mental health diagnosis, and staff and prisoners described his behaviour as unusual. His time at Bullingdon was spent during the COVID-19 pandemic and, while I appreciate the significant impact this had on staffing and available resources, it is concerning that there is little evidence that he received appropriate support from wing staff. However, I am reassured that the mental health team provided a good standard of care.

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

**Susannah Eagle**  
**Deputy Prisons and Probation Ombudsman**

**November 2023**

# Contents

Summary .....	1
The Investigation Process.....	3
Background Information.....	4
Key Events.....	5
Findings .....	10

# Summary

## Events

1. On 27 October 2021, Mr Dominic Burges was remanded in custody to HMP Bullingdon. It was his first time in prison, although he had been admitted to psychiatric hospitals several times in his adult life. At Bullingdon, Mr Burges was reviewed frequently by a prison psychiatrist and mental health nurse who prescribed antipsychotic medication.
2. On 9 November, Mr Burges told a substance misuse recovery worker that that he had used drugs and alcohol in the community. The recovery worker gave Mr Burges a workbook on drugs awareness to complete in his cell.
3. On 5 January 2022, Mr Burges moved into a single cell. His former cellmate told us that other prisoners found it difficult to share a cell with Mr Burges because of his unusual behaviour. The prison psychiatrist recorded that Mr Burges told him that he had eaten faeces due to hunger. Prison staff described incidents such as Mr Burges wetting the bed, eating food from rubbish bins and screaming out of his cell door at night.
4. On 17 January, the recovery worker reviewed Mr Burges. She told us that Mr Burges' presentation indicated that he had used illicit drugs, although he denied this. Mr Burges told her that he had not completed his workbook and that he no longer wanted to work with the substance misuse team.
5. On 8 February, the prison psychiatrist reviewed Mr Burges. He recorded that Mr Burges' mental state had improved and described his presentation as significantly better than when he first arrived at Bullingdon.
6. At around 4.54am on 10 February, the night patrol officer found Mr Burges lying unresponsive on the floor of his cell. He radioed a medical emergency and, when prison staff opened the cell, they found that Mr Burges had died. The officers administered cardiopulmonary resuscitation (CPR) for a short period before a prison nurse stopped them.

## Findings

7. Bullingdon has taken significant steps to try to combat the supply of drugs to the prison. While these appear to have had some success, it is concerning that supply continues to be an issue and it is possible that the misuse of drugs contributed to Mr Burges' death.
8. When a member of the substance misuse team suspected that Mr Burges was under the influence of drugs, this was not recorded and reported in line with local policy.
9. Mr Burges had a significant mental health diagnosis and exhibited some very unusual behaviour in prison. He appears to have struggled to adapt to prison life. While we appreciate the pressures that prisons faced during the COVID-19 pandemic, it is concerning that there is little evidence of key work or welfare entries

in his prison records. It is likely that Mr Burges would have benefitted from additional support.

10. The officers who responded to the medical emergency inappropriately administered CPR when rigor mortis was established.

## **Recommendations**

- The Governor should ensure that the key drug issues at HMP Bullingdon are identified, that the local drugs strategy is appropriately reviewed and revised to address them, and that staff are aware of its contents and their responsibilities.
- The Governor and Head of Healthcare should ensure that suspected drug use is recorded and reported in line with local guidelines, with appropriate testing and support provided to prisoners suspected of using illicit substances.
- The Governor should ensure that there is an effective key worker scheme which provides meaningful and ongoing support to prisoners.
- The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is inappropriate in line with European Resuscitation Council Guidelines.

## The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Bullingdon informing them of the investigation and asking anyone with relevant information to contact him. Two prisoners contacted the investigator and were interviewed by telephone in February 2022.
12. The investigator obtained copies of relevant extracts from Mr Burges' prison and medical records.
13. The investigator interviewed six members of staff at Bullingdon in April and a further four members of staff in May.
14. NHS England commissioned a clinical reviewer to review Mr Burges' clinical care at the prison. She joined the investigator for interviews with healthcare staff.
15. We informed HM Coroner for Oxfordshire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
16. The Ombudsman's family liaison officer contacted Mr Burges' mother, to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Burges' mother asked the following questions:
  - What were the circumstances of Mr Burges' death and had there been any change to his behaviour in the time leading up to it?
  - If his death was drug-related, when and how did Mr Burges obtain illicit drugs and what has Bullingdon done to stop drugs from getting into the prison?
  - What assessment, medication and support did Mr Burges receive for his mental ill-health?
  - Why was she informed of her son's death over the telephone rather than in person?
17. We shared the initial report with HM Prison and Probation Service. Following discussion, we have amended this report to reflect the ambiguity surrounding the cause of death.
18. We also shared the initial report with Mr Burges' mother. She asked some further questions that we have addressed in separate correspondence.

## Background Information

### HMP Bullingdon

19. HMP Bullingdon is a local and resettlement prison, serving the courts of Oxfordshire and Berkshire. It holds approximately 1,100 prisoners. Practice Plus Group provides healthcare services and Cotswold Medicare Ltd provides GP services.

### HM Inspectorate of Prisons

20. The most recent inspection of HMP Bullingdon was in October to November 2022. Inspectors reported that prison leaders had focused attention on the main security risks, including the supply of drugs. They found that, although intelligence indicated that drugs were still too prevalent, there was evidence in their prisoner survey that aspects of the prison's drugs strategy were effective. The survey found that 31% of prisoners said it was easy to obtain illicit drugs, down from 52% at the last inspection (in July 2019). Only 4% of prisoners said that they had developed a problem with drugs since arriving at the prison, down from 21% at the previous inspection.
21. Inspectors found that the mental health team provision was timely and reasonable, although there was scope to improve the range of interventions on offer.

### Independent Monitoring Board

22. 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 June 2022, the IMB reported that the quantity of drugs coming into Bullingdon was high. They identified that measures, including a body scanner for all newly arrived prisoners and airport-style scanning for all staff and visitors, had helped reduce the supply of drugs.
23. The IMB also reported that the key work scheme had not been applied at the frequency and consistency expected due to the combination of COVID-19 restrictions and staff shortages. However, they found that the most vulnerable prisoners had generally received key work and the service had begun to expand in the last two months of the reporting year.

### Previous deaths at HMP Bullingdon

24. Mr Burges was the twelfth prisoner to die at Bullingdon since February 2020. Two of the previous deaths were a result of drugs toxicity. In both of our investigations into these deaths, we found that it was concerning how easily the men could obtain illicit drugs.

## Key Events

25. Mr Dominic Burges was admitted to psychiatric hospitals under the Mental Health Act over a dozen times as an adult. He was diagnosed with schizophrenia and prescribed various antipsychotic medications during his life. His most recent admission was for two days in August 2021. Mr Burges was homeless for several periods of his life, including immediately before he was sent to prison.
26. On 27 October 2021, Mr Burges was remanded in custody to HMP Bullingdon charged with attempted robbery and failure to surrender. This was his first time in prison.
27. A nurse recorded Mr Burges' medical history, including that he was prescribed antipsychotics but that he said he had not had any medication for seven weeks. Mr Burges said that he had no drug or alcohol issues. The nurse referred him to the mental health team.
28. On 4 November, a mental health nurse assessed Mr Burges. She recorded his diagnosis and history of admissions. Mr Burges told her that he could not sleep, that his mind was distracted and that he needed to be back on medication. The nurse noted that Mr Burges appeared to be experiencing blocked thoughts and that it was evident he had relapsed. She recorded that he should be accepted onto the mental health team's caseload and reviewed by the prison psychiatrist. She also asked for Mr Burges to be prescribed medication to help him sleep, which was completed the following day.
29. On 8 November, a prison psychiatrist reviewed Mr Burges. He recorded that Mr Burges' presentation suggested schizophrenia and that his thoughts appeared slightly disordered. He prescribed risperidone (an antipsychotic).
30. On 9 November, a nurse wrote a mental health care plan for Mr Burges. The plan included that he should be seen weekly by a mental health nurse and as required by the psychiatrist.
31. That day, a recovery worker completed an initial substance misuse assessment. She recorded that Mr Burges said that he had used amphetamines, smoked heroin and cannabis, and drank alcohol daily in the community, although his account appeared confused and inconsistent. The recovery worker recommended that Mr Burges undertake drug and alcohol awareness work. She told us that Mr Burges opted to take a workbook on cannabis awareness.
32. On 11 November, Mr Burges moved to B Wing and began sharing a cell with another prisoner. His cellmate told us that Mr Burges' behaviour was often bizarre and, as a result, he asked to move cells after three days. He said that he once found Mr Burges snorting table salt as if it were a drug, although he did not otherwise know Mr Burges to use drugs in prison.
33. On 15 November, a mental health nurse reviewed Mr Burges. She recorded that a prisoner told her that Mr Burges had woken other prisoners by shouting out of his cell at night, and that Mr Burges laughed about this when she spoke to him about it. (Staff on Mr Burges' previous wing had also recorded that he shouted out of his cell at night and kept others awake.) Mr Burges said that he did not think that his

medication was working. The nurse recorded that she would ask for the prison psychiatrist to review Mr Burges.

34. On 24 November, Mr Burges was sentenced to 12 weeks in prison. Prison staff recorded that he shouted and gesticulated throughout his court appearance and made unusual comments about cannibalism afterwards.
35. On 25 November, the prison psychiatrist and the mental health nurse reviewed Mr Burges. The psychiatrist recorded that Mr Byrne's mental state was at risk of deteriorating and that he would ideally be treated in a psychiatric hospital. He recorded that they would consider a 'gate' admission under the Mental Health Act if Mr Burges was released in December, as expected. He increased Mr Burges' dose of risperidone and prescribed a sleeping tablet.
36. On 3 December, Mr Burges was remanded in custody on additional charges. This meant that he would not be released from prison that month as planned.
37. On 16 December, a mental health nurse reviewed Mr Burges. She recorded that he reported a good mood and no psychotic symptoms, although he appeared "manic" during the review. She also recorded that wing staff told her that Mr Burges needed more support than other prisoners and often struggled to understand simple instructions.
38. On 20 December, the prison psychiatrist and a mental health nurse reviewed Mr Burges. The psychiatrist recorded that there was no evidence at the review that Mr Burges was experiencing psychotic symptoms or hallucinations. He recorded that he did not now think that Mr Burges needed to be transfer to a psychiatric hospital.
39. On 5 January 2022, Mr Burges moved into a single cell. In a statement completed after Mr Burges' death, an officer recorded that Mr Burges' unusual behaviour – including wetting the bed, eating food from rubbish bins and screaming out of the door at night – meant that other prisoners were not comfortable sharing with him. Other staff described similar behaviour in their statements. His former cellmate also told us that Mr Burges "got through a lot of cellmates" because of his bizarre behaviour and gave other examples of behaviour which he understood had led other prisoners to ask to move out of the cell. Mr Burges' cell sharing risk assessment was subsequently upgraded to high. (The cell sharing risk assessment is designed to assess the risk of violence a prisoner poses either to or from a cellmate.)
40. On 8 January, pharmacy staff stopped Mr Burges' antipsychotic medication as he had missed some recent doses. There is no record that anyone spoke to Mr Burges about this to determine why he had not taken his medication. On 12 January, a nurse recorded that the mental health team had not been informed of this and asked for the antipsychotic medication to be re-prescribed.
41. On 14 January, the prison psychiatrist and a mental health nurse reviewed Mr Burges. The psychiatrist recorded that Mr Burges denied the presence of any psychotic features, although he said that he had been eating faeces due to hunger.
42. On 17 January, the recovery worker met Mr Burges for a substance misuse care review. She recorded that he had not completed the in-cell work that he had been

given and that he did not want to participate in one-to-one work. She told us that Mr Burges did not engage in the review, appeared to be very “vacant” and was falling asleep in the room. The recovery worker said that she suspected that Mr Burges had used illicit drugs, although he denied having taken anything. Mr Burges said that he no longer wanted to work with the substance misuse team and signed paperwork to this effect. She therefore discharged him from their caseload.

43. The recovery worker said that she reported her concerns about Mr Burges’ drug use to wing staff and the mental health team. (There is no record of Mr Burges seemingly having been under the influence of drugs in any of his prison or healthcare records.)
44. On 26 January, a mental health nurse reviewed Mr Burges. She recorded that Mr Burges said that “everything was okay” and that he was keen to go to court and be released. She recorded that there was no evidence of blocked thoughts, distraction or delusions.
45. On 4 February, a mental health nurse spoke to Mr Burges, as he had only intermittently collected his medication that week. She recorded that Mr Burges said that he no longer needed the medication and became irritable when she encouraged him to take it. She also recorded that another prisoner told her that Mr Burges had been keeping others awake at night by banging in his cell.
46. On 5 February, Mr Burges left his taps running and flooded his cell. An officer recorded that when challenged, Mr Burges said that the water was “coming through the wall”. The officer said that he thought that Mr Burges’ actions were prompted by his mental ill-health, rather than to be deliberately disruptive or because he was under the influence of drugs.
47. On 8 February, the prison psychiatrist reviewed Mr Burges. He recorded that Mr Burges denied any psychotic or mood symptoms (such as anxiety or depression). He recorded that Mr Burges’ mental state had improved compared to his last review. Mr Burges said that he was now taking his medication. The psychiatrist told us that Mr Burges’ presentation was the best he had seen over the previous months and significantly better than when he first arrived in prison.

## **9-10 February 2022**

48. From 8.00am on 9 February, an officer went to Mr Burges’ cell five times in half an hour. On most visits, she spoke to Mr Burges for a few seconds or less but on one visit, they spoke for around a minute. The officer said that she spoke to Mr Burges about the taps in his cell as his hot tap needed to be fixed. She said that she also persuaded Mr Burges to clean the cell. (CCTV footage shows that Mr Burges removed rubbish from his cell at around 8.30am.)
49. As he did not work or go to education, Mr Burges spent most of the day locked in his cell. At 11.15am, an officer unlocked cells on the landing for prisoners to collect lunch. Mr Burges did not leave his cell during this time.
50. At around 2.00pm, an officer spoke to Mr Burges at his cell door for around 30 seconds. He told us that he did not remember what they spoke about.

51. At around 4.15pm, an officer unlocked Mr Burges' cell and he collected his evening meal. He returned to his cell almost immediately. At around 4.50pm, an officer locked Mr Burges' cell door for the night.
52. An officer was the night patrol officer on 9-10 February. At around 9.35pm, he completed a count of prisoners. He told us that Mr Burges was lying on his bed and looked towards the door when he opened the cell observation panel.
53. At 4.54am on 10 February, the night patrol officer returned to Mr Burges' cell for the morning count of prisoners. He told us that he could see Mr Burges lying on the floor in the "prone position" (flat on his stomach). He said that Mr Burges did not respond when he kicked the door to try to rouse him. The officer radioed a medical emergency code blue, indicating a life-threatening situation. The control room operator telephoned for an ambulance. He said that he considered opening the cell immediately, but as he did not know Mr Burges and did not therefore know whether he had a history of violence against staff, he did not know whether it was safe to do so without additional staff being present.
54. At 4.57am, seven staff, including a Custodial Manager (CM) who was the night manager, and another officer arrived at the cell. The night patrol officer opened the cell immediately on their arrival. The response staff identified that Mr Burges was cold, stiff and had no pulse. The second officer told us that the staff thought that Mr Burges had died but because there was some doubt, he began cardiopulmonary resuscitation.
55. At 5.00am, a nurse arrived at the cell. She identified that rigor mortis was present and instructed the staff to stop the resuscitation efforts. At 5.26am, paramedics arrived and confirmed that Mr Burges had died.
56. After Mr Burges died, prison staff submitted intelligence to identify that they had found smoking paraphernalia (meaning vaping capsules) in his cell. Prison staff also submitted intelligence that Mr Burges had been selling his medication. (There is no evidence that prison staff knew prior to his death that Mr Burges had sold medication.)

## **Contact with Mr Burges' Family**

57. Mr Burges did not identify a next of kin when he arrived at Bullingdon. Prison staff obtained contact details for his mother from Thames Valley Police. At 10.35am on 10 February, a prison family liaison officer telephoned Mr Burges' mother and informed her of his death. (Family liaison officers would normally break the news of a death in person but were instructed to do so by telephone during the COVID-19 pandemic.)

## **Support for prisoners and staff**

58. After Mr Burges' death, an operational 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.

## **Post-mortem report**

59. Toxicology examinations of Mr Burges' blood and urine identified therapeutic levels of risperidone (which Mr Burges was prescribed). No other medications, illicit drugs or alcohol were identified, including psychoactive substances. The post-mortem examination identified no evidence of natural disease to account for Mr Burges' death.
60. The pathologist recorded that the cause of death was unascertained. However, she noted that the circumstances of Mr Burges' death meant it was possible that the death "may be related to the ingestion or inhalation of an unknown poison" which laboratory investigations could not identify. The pathologist also identified sudden adult death syndrome (SADS) as a potential cause of death.

## **Inquest**

61. The inquest into Mr Burges' death concluded on 9 October 2023. The jury recorded a narrative conclusion, stating that on the available evidence they were unable to say the cause of Mr Burges' death.

# Findings

## Drugs supply at HMP Bullingdon

62. While the cause of Mr Burges' death is unascertained, the pathologist noted that the circumstances of his death meant that it is possible that it might be related to the ingestion of an unidentified substance. (The pathologist also identified other potential causes of death, and the jury at Mr Burges' inquest found that they were unable to say what the cause of death was based on the available evidence.) We note that prison staff found smoking paraphernalia in Mr Burges' cell and the second officer to arrive told us that there were multiple vaping capsules on the floor. (We understand that these were not tested for drugs.)
63. In May 2020 and July 2020, we opened investigations into the deaths of two prisoners at Bullingdon from apparent drugs toxicity. In both investigations, we found that it was concerning how easily the prisoners could obtain illicit substances. We note that both HM Inspectorate of Prisons (HMIP) and the Independent Monitoring Board (IMB) have reported concerns about drug use and supply at Bullingdon, including that drugs were too prevalent. During our investigation into Mr Burges' death, one officer described a culture of prisoners putting paper soaked in drugs under the doors of more vulnerable prisoners' cell doors to test their reaction to it. (If Mr Burges obtained drugs, we do not know when or how he did so.)
64. In an action plan in response to our report following the death in July 2020, Bullingdon noted that it was due to revise its Drug Strategy. It identified measures intended to reduce the supply of drugs, including the introduction of 'Rapiscan' machines to scan incoming mail, a body scanner for all prisoners entering through Reception, and enhanced airport-style security for all staff and visitors coming into the prison.
65. In its annual report for the year to June 2022, the IMB reported that these measures had helped to reduce the supply of drugs, although the quantity of drugs coming into the prison was still high. In July 2022, Bullingdon issued its revised Drugs Strategy, which included the implementation of those measures identified above. In their inspection of October to November 2022, HMIP reported that the number of prisoners who said that it was easy to obtain drugs had fallen significantly, although it was still nearly a third of prisoners.
66. It is apparent that Bullingdon has taken significant steps to try to reduce the supply of drugs. While these may have had some success, it is concerning that supply continues to be an issue and that a prisoner such as Mr Burges – around whom there is little intelligence of involvement with drugs in prison – was likely able to obtain illicit substances. It is important that Bullingdon continues its efforts to prevent the supply of, and demand for, illicit substances and keeps its drugs strategy under regular review to ensure it is tackling the key issues. We make the following recommendation:

**The Governor should ensure that the key drug issues at HMP Bullingdon are identified, that the local drugs strategy is appropriately reviewed and revised to address them, and that staff are aware of its contents and their responsibilities.**

## Support provided to Mr Burges

### *Suspicion of drug use*

67. Mr Burges' prison records do not identify any intelligence about his involvement in the supply or use of drugs at Bullingdon. They contain no record of staff having concerns that he was under the influence of drugs. However, the recovery worker told us that she suspected that Mr Burges was under the influence of drugs when she reviewed him on 17 January 2022. She said that she reported her concerns to wing staff and the mental health team, although we note that there is no record of this incident in Mr Burges' prison or healthcare records.
68. Bullingdon's Drug Strategy states that any prisoner whom staff have reason to believe has misused drugs should be referred for a drugs test. It also states that staff should proactively use the security intelligence reporting system to help gather information on all substance misuse concerns. Following the recovery worker's suspicions, Mr Burges was not tested for drugs and no security intelligence report was submitted. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that suspected drug use is recorded and reported in line with local guidelines, with appropriate testing and support provided to prisoners suspected of using illicit substances.**

### *Key work*

69. Under the Offender Management in Custody model, each prison officer is the named key worker for five or six prisoners and should be allocated an average of 45 minutes per week to spend on key work duties with each prisoner, including having regular meaningful conversations with each prisoner. In March 2020, HM Prison and Probation Service (HMPPS) suspended key work due to the COVID-19 pandemic. On 12 May 2020, key work was reintroduced but delivered in a more limited way in line with an Exceptional Delivery Model, where priority prisoners received key work.
70. A custodial manager with responsibility for residential support during Mr Burges' time at Bullingdon told us that the priority prisoners who received key work during this time included those being monitored under suicide and self-harm prevention procedures (known as ACCT), prisoners held in the segregation unit and those who were identified as needing additional support.
71. Following Mr Burges' death, prison staff completed statements that detailed his unusual behaviour, including eating food from rubbish bins and shouting out of his cell door at night. His former cellmate told us that Mr Burges' behaviour meant that he had several different cellmates. We note that he eventually moved into a single cell and was marked as high risk on his cell sharing risk assessment, seemingly because of this behaviour. Little of this unusual behaviour was recorded in Mr Burges' wing records, and there are no key work or other welfare related entries throughout his time at the prison.
72. Given Mr Burges' mental health diagnosis and unusual behaviour which staff and prisoners described, it is likely that he would have benefitted from additional support

through the key work scheme and greater consideration should have been given to identifying him as a priority prisoner to receive these benefits. This might also have allowed staff to identify any substance misuse issues that Mr Burges had.

73. In May 2022, HMPPS exited the national COVID-19 framework and began to wind down the restrictions in place. This meant that key work should subsequently have been completed in line with pre-pandemic expectations. We note that the IMB reported that key work did not operate at expected levels during the pandemic but had begun to improve towards the end of their reporting year. It is important that all prisoners, especially those who might be considered vulnerable such as Mr Burges, receive consistent and meaningful key work, not least to help identify any underlying issues they might have. We make the following recommendation:

**The Governor should ensure that there is an effective key worker scheme which provides meaningful and ongoing support to prisoners.**

## Clinical care

74. Mr Burges had a long history of mental ill-health, including several hospital admissions under the Mental Health Act before he was sent to prison. The clinical reviewer found that his initial health screens were completed in line with expected standards and that there was good communication between the mental health team and other healthcare disciplines. The clinical reviewer also found that the mental health team provided good continuity of care.
75. The clinical reviewer did not identify any areas of concern in relation to Mr Burges' mental health care at Bullingdon and concluded that the care he received was of a good standard and equivalent to that which he could have expected to receive in the community.

## Allegation from prisoner

76. A prisoner who lived in a cell opposite Mr Burges told us that, on the day before he died, Mr Burges rang his cell bell several times, banged on his cell door and "sounded like he was struggling". The prisoner said that "a female officer" told Mr Burges to stop and said, "Don't just talk about it, fucking do it". The prisoner said that staff did not try to help Mr Burges and told him to stop pressing his cell bell. He said that on one occasion, it took staff around 40 minutes to answer Mr Burges' cell bell.
77. Bullingdon does not have a system to record when cell bells are pressed and answered. However, when a prisoner presses their cell bell, a light goes on outside their cell which can be seen on CCTV footage. We watched footage from 8.00am on 9 February 2022 and Mr Burges' cell bell light did not appear to go on at all during the day.
78. The named female officer worked on Mr Burges' wing on the morning of 9 February. During the morning period, another officer spent some time with Mr Burges and told us that she spoke to him about a maintenance issue with his taps and persuaded him to clean his cell. (CCTV footage shows that Mr Burges cleared rubbish from his cell shortly after his conversation with the officer.) The only other female officer to

go to the cell in the morning went very briefly at 9.45am to unlock the cell door. The female officer did not appear to speak to Mr Burges. (We do not know who this officer is.)

79. Prisoners in the cell two doors down from Mr Burges pressed their cell bell many times during the day, particularly in the late afternoon and early evening. One of the occupants had climbed onto the landing netting (that prevents prisoners from jumping off the landing) earlier in the day. One of the later cell bells was not answered for around 20 minutes and, on some occasions, staff simply reset the bell or looked briefly into the cell without speaking to the occupants. We cannot be certain, but it is possible that the prisoner who spoke to us confused events at this cell with Mr Burges' cell. While we are satisfied that the events at this cell did not have an impact on the care received by Mr Burges, some of the events are concerning and the Governor will want to be aware and consider appropriate action.
80. While it is not possible to know exactly what happened, we are satisfied that there is no corroborative evidence to support the prisoner's allegation that an officer was abusive to Mr Burges or that staff did not respond appropriately to his cell bell.

## **Emergency response**

81. In September 2016, Professor Sir Bruce Keogh, 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 2015 which state, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile".
82. The staff who opened Mr Burges' cell on the night of 9-10 February 2022 described him as cold, stiff and with no pulse. An officer told us that the staff thought that Mr Burges had died but, as they had some doubt, he began cardiopulmonary resuscitation (CPR).
83. We recognise that the officers administered CPR for only a short period and that it was appropriately stopped by a nurse on her arrival, who identified rigor mortis. We also understand the commendable wish to attempt and continue resuscitation until death has been formally recognised. However, staff should understand that they are not required to carry out resuscitation in these circumstances. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is inappropriate in line with European Resuscitation Council Guidelines.**

**Prisons &  
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