

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Wayne Cannon, a prisoner at HMP Bullingdon, on 15 July 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.

If my office is to best assist HM Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Wayne Cannon died in hospital of a hypoxic brain injury following a cardiac arrest, while a prisoner at HMP Bullingdon. He was 51 years old. I offer my condolences to Mr Cannon's family and friends.

The clinical reviewer concluded that the care Mr Cannon received at Bullingdon was equivalent to what 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.

**Adrian Usher**  
**Prisons and Probation Ombudsman**

**October 2023**

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# Summary

## Events

1. On 26 May 2022, Mr Wayne Cannon was recalled to prison for breaching his licence conditions and was sent to HMP Bullingdon.
2. Mr Cannon had a history of substance misuse and heart problems. Substance misuse staff provided good support for him. Healthcare staff completed appropriate referrals to cardiology specialists to monitor his heart problems.
3. On 8 July 2022, Mr Cannon collapsed in the communal shower area. When a supervising officer realised that something was wrong with Mr Cannon, he responded promptly and appropriately. He immediately called a medical emergency code. Prison and healthcare staff arrived quickly and started cardiopulmonary resuscitation (CPR). Paramedics attended and continued with resuscitation attempts. Mr Cannon was taken to hospital by emergency ambulance.
4. Mr Cannon's condition deteriorated in hospital, and he died on 15 July.

## Findings

5. The clinical reviewer concluded that the care Mr Cannon received at Bullingdon was equivalent to what he could have expected to receive in the community.
6. When Mr Cannon collapsed, prison and healthcare staff's response was appropriate and good.
7. There was a delay in the ambulance reaching Mr Cannon and leaving the prison when he was taken to hospital. Although this did not affect the outcome for Mr Cannon, such delays could make a critical difference in other medical emergencies.

## Recommendation

- **The Governor should review the local security procedures for emergency response staff and vehicles to ensure they do not create avoidable delays in the emergency response.**

## The Investigation Process

8. HMPPS notified us of Mr Cannon's death on 15 July 2022. The investigator issued notices to staff and prisoners at HMP Bullingdon informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
9. The investigator obtained copies of relevant extracts from Mr Cannon's prison and medical records. She also viewed the body-worn video camera (BWVC) footage from staff who had attended the emergency response when Mr Cannon collapsed.
10. NHS England commissioned a clinical reviewer to review Mr Cannon's clinical care at the prison. She conducted joint interviews with the investigator.
11. The investigator interviewed four members of staff and two prisoners on 28 and 29 September using Microsoft Teams and the telephone.
12. We informed HM Coroner for Oxfordshire of the investigation. The Coroner gave us the cause of death. We have sent the Coroner a copy of this report.
13. The Ombudsman's family liaison officer contacted Mr Cannon's sister to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.
14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

## **Background Information**

### **HMP Bullingdon**

15. 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**

16. The most recent inspection of HMP Bullingdon was in November 2022. Inspectors reported that the prison was reasonably safe and respectful, which was consistent with their previous inspection findings from 2019. Health services were well-led. Arrangements to respond to health emergencies were effective, with first responders trained to immediate life support level.
17. Inspectors noted that prisoners with long term conditions were generally well supported, and hospital appointments and escorts were well managed.

### **Independent Monitoring Board**

18. 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 2022, the IMB reported that the prison was returning to a pre COVID-19 regime which had resulted in a very restrictive regime to help maintain social distancing for prisoners and staff. Staff retention issues had impacted on effectiveness for all areas of prison life. The IMB noted that healthcare provision was generally good and improving.

### **Previous deaths at HMP Bullingdon**

19. Mr Cannon was the fifteenth prisoner to die at Bullingdon since July 2019. Of the previous deaths, nine were from natural causes, two were self-inflicted and three were drug related. There have been four further deaths since Mr Cannon's death, one self-inflicted death and three deaths from natural causes. There are no significant similarities between our findings in the investigation into Mr Cannon's death and the findings of the previous deaths.

## Key Events

20. On 17 June 2019, Mr Wayne Cannon was sentenced to six years in prison for robbery. This was not his first time in prison. Mr Cannon was released from HMP Spring Hill on 13 May 2022, but, on 25 May, he was arrested for breaching the terms of his licence and recalled to HMP Bullingdon.
21. On arrival at Bullingdon, Mr Cannon had a medical reception screen which noted his medical history. He said that he had recently had chest pain and been diagnosed with hypertension and COPD. He said that for the time he was released he had been smoking heroin daily. A substance misuse practitioner noted there were no immediate concerns regarding withdrawal symptoms.
22. The next day, Mr Cannon tested positive for heroin and crack cocaine use. A substance misuse practitioner arranged for Mr Cannon to be prescribed methadone and to be monitored for withdrawal. Substance misuse practitioners noted that there were no issues with his withdrawal.
23. At his secondary reception screen, a GP at the prison completed a more in-depth assessment and investigation of Mr Cannon's healthcare issues. He made referrals to the John Radcliffe Hospital Heart Centre for follow up cardiology appointments.
24. Mr Cannon attended his cardiology appointment on 22 June, and specialists told him that tests results had indicated that at some point, he had suffered a heart attack, which needed further investigation. No changes were needed to his medication.

### Events on 8 July 2022

25. Sometime after 3.30pm on 8 July, Mr Cannon went into the shower room on his wing. He collapsed and was found by two prisoners. One of them said that Mr Cannon was making a gurgling noise and appeared to have swallowed his tongue. He placed him in the recovery position and shouted for help. A Supervising Officer (SO) was the first member of staff to arrive.
26. In his written statement, the SO said that Mr Saunders called him to attend the shower room. He saw a prisoner trying to assist Mr Cannon, who was slumped on the floor. He noted that when he checked Mr Cannon, he was unresponsive, but breathing. He radioed a medical emergency code blue (indicating a prisoner is unconscious or is having breathing difficulties).
27. Staff responded quickly. The first healthcare member to arrive was the paramedic based at Bullingdon. He noted that Mr Cannon was in peri-arrest and then cardiac arrest. Prison and healthcare staff began resuscitation attempts using the defibrillator.
28. The control room log noted that the ambulance was called immediately at 4.22pm. The first ambulance arrived at the prison at 4:53pm, with three others arriving in the following half an hour. The first ambulance paramedic arrived at the cell within six minutes. The exact arrival times at the cell for the other ambulance paramedics were not recorded. The ambulance paramedic log noted there was a delay in getting to Mr Cannon due to security procedures. The ambulance record notes that

the ambulance left Bullingdon at 5.42pm and arrived at the John Radcliffe Hospital at 6.34pm. Mr Cannon was accompanied by two escort officers and was not restrained.

29. The paramedic noted there was another delay leaving the prison, again due to the security procedures. The control room log did not record the departure times of the emergency vehicles.
30. Mr Cannon's condition deteriorated, and he died in hospital on 15 July.

### **Contact with Mr Cannon's family**

31. On 8 July, the prison appointed a family liaison officer (FLO) when Mr Cannon collapsed. She rang Mr Cannon's mother and told her that he was unwell and was going to hospital. Mr Cannon's mother asked her to liaise with Mr Cannon's sister. The FLO spoke to Mr Cannon's sister and provided regular updates and arranged for his family to attend the hospital.
32. The FLO rang Mr Cannon's next of kin to tell them he had died and maintained contact with Mr Cannon's family, offering support and information.
33. The prison contributed towards Mr Cannon's funeral in line with national guidance.

### **Support for prisoners and staff**

34. After Mr Cannon's 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. A member of the healthcare team said they had not felt supported.
35. The prison posted notices informing other prisoners of Mr Cannon'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 Cannon's death.

### **Cause of death**

36. The Coroner accepted the cause of death provided by the hospital doctor who treated Mr Cannon and no post-mortem examination was carried out. The hospital doctor gave Mr Cannon's cause of death as hypoxic brain injury, caused by cardiac arrest and myocardial infarction (heart attack) and dilated cardiomyopathy (a disease of the heart muscle).

# Findings

## Clinical care

37. The clinical reviewer concluded that the care that Mr Cannon received at Bullingdon equivalent to what he could have expected to receive in the community.
38. When Mr Cannon collapsed, prison and healthcare staff responses was appropriate and the care they provided to Mr Cannon was good.

## Ambulance access during the emergency response

39. Prison Service Instruction (PSI) 03/2013, contains mandatory instructions that prison staff should prevent unnecessary delay in escorting ambulances and paramedics to the patient. Bullingdon has local guidance for medical emergencies which is in line with national instructions (the issue date is 2012). The local guidance says that emergency response staff can retain their work issue mobile phones, but personal phones must be placed in a locker. In 2019, a Memorandum of Understanding between HMPPS and South Central Ambulance Service NHS Foundation Trust was agreed and noted that emergency vehicles and staff will not normally be subject to a full search and emergency response staff can retain their work issue mobile phones. The Memorandum of Understanding noted that personal phones must be handed in before entering the prison. The prison confirmed that the guidance also covered smart watches (which are internet enabled).
40. Our investigation into Mr Cannon's death found that four emergency vehicles attended. The first paramedic was admitted quickly. However, when more emergency crews arrived, they were asked to remove personal equipment such as smart watches which were then stored at the gate in lockers. There are differing accounts as to which ambulance paramedic had to place items in the locker (as four emergency vehicles had attended) and how long it took the other paramedics to reach Mr Cannon as this information is not noted in the control room or vehicle log. Times range from six minutes to 12 minutes.
41. It is less clear how long it took the ambulance to leave Bullingdon, but we do know that the ambulance crew would have been required to collect their belongings again at the gate. This would have naturally delayed the ambulance leaving the prison. However, paramedics in the ambulance taking Mr Cannon to hospital noted in the ambulance log that they were delayed getting to Mr Cannon and leaving with him due to "prison security policies". The prison paramedic confirmed that he was aware of the delay.
42. The Practice Plus Group Healthcare 72 Hour Report, produced after Mr Cannon's death, noted a 12 minute delay caused by officers asking the paramedics to remove "smart watches etc". The report recommended that the Head of Healthcare should share this learning with the prison by 31 August 2022, to clarify exemptions to prohibited items. The investigator was told that due to staff absences, this had not happened.
43. On balance, the delay did not have an adverse impact on Mr Cannon receiving the appropriate clinical care, however any delay could make a critical difference in

future medical emergencies. To minimise delays, we make the following recommendation:

**The Governor should review the local security procedures for emergency response staff and vehicles to ensure they do not create avoidable delays in the emergency response.**

## **Head of Healthcare to note:**

### **Staff support**

44. Prison Service Instruction (PSI) 64/2011 requires that where staff are affected by events leading to a death they should be identified and offered support. This means that all the staff involved in the resuscitation attempt should have been offered support. As a member of the healthcare team did not feel fully supported, we bring this to the Head of Healthcare's attention.

### **Inquest**

45. The inquest held on 16 November 2023, concluded that Mr Cannon died from natural causes.

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