

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Kenneth Mockford, a prisoner at HMP Bure, on 14 April 2023

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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Summary

1. 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.
2. If my office is to best assist His Majesty's 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.
3. Mr Kenneth Mockford died in hospital from a bleed on the brain on 14 April 2023, while a prisoner at HMP Bure. He was 80 years old. We offer our condolences to Mr Mockford's family and friends.
4. The clinical reviewer concluded that the care Mr Mockford received at Bure was equivalent to that which he could have expected to receive in the community. She made no recommendations.
5. We found no non-clinical issues of concern. We make no recommendations.

The Investigation Process

6. HMPPS notified us of Mr Mockford's death on 14 April 2023.
7. NHS England commissioned an independent clinical reviewer to review Mr Mockford's clinical care at Bure.
8. The PPO investigator investigated the non-clinical issues relating to Mr Mockford's care.
9. The PPO family liaison officer wrote to Mr Mockford's wife to explain the investigation and to ask if she had any matters she wanted us to consider. She said that Mr Mockford's arm and hand were black and painful when she last saw him, and she wanted to know if this was connected to his death. We have addressed this in the report.
10. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies.
11. We sent a copy of our initial report to Mr Mockford's wife. She did not notify us of any factual inaccuracies.

Previous deaths at HMP Bure

12. Mr Mockford was the thirteenth prisoner to die at Bure since April 2020. Two of the previous deaths were self-inflicted and the rest were from natural causes.

Key Events

13. In 2014, Mr Kenneth Mockford was sentenced to 16 years and six months in prison for historic sex offences.
14. Mr Mockford was moved to HMP Bure on 6 September 2018. He had several health issues, including chronic obstructive pulmonary disease (COPD, a lung condition causing breathing difficulties), ischaemic heart disease (a weakness of the heart from a previous heart attack), atrial fibrillation (causes an irregular heartbeat), hypertension (high blood pressure), chronic kidney disease and osteoarthritis. He was on various medication for these conditions.
15. On 21 September 2022, Mr Mockford had his annual electrocardiogram test. (ECG - a check on the heart). There were no further details in his medical record.
16. On 26 December, Mr Mockford complained of breathlessness and chest pain. Healthcare staff examined him, and he was taken to hospital. He remained there until 3 January 2023. He was treated with antibiotics.
17. On 13 February, Mr Mockford had his annual atrial fibrillation review. There were no concerns about his heart rate, but his blood pressure was raised. Staff noted that they would monitor it.
18. At a blood pressure check on 1 March, Mr Mockford was breathless. He told the member of staff that this was normal due to his COPD. His blood pressure was still high, and he was advised to monitor it himself three times a day over the next three days.
19. On 9 March, Mr Mockford asked to see a nurse due to a bruise on his arm. The nurse noted a swelling on his right shoulder with bruising down his arm. She advised him to rest and arranged for him to be seen again the next day.
20. On 10 March, a nurse practitioner examined Mr Mockford. He said that he had woken the previous day with a sore shoulder. He said that he had not knocked it against anything. The nurse practitioner recorded a blood clot. She prescribed pain medication and gave Mr Mockford a medical device to support his arm. On 13 March, he went to hospital for an X-ray, which showed a muscle injury but no fracture. He was told to continue to use the support device.
21. On 15 March, a nurse saw Mr Mockford as a blood clot had appeared on his upper arm and shoulder. He said that it had appeared the previous day, and he felt unwell. The nurse bandaged his arm and arranged for blood tests. On 16 March, Mr Mockford saw a physiotherapist because of the shoulder pain and bruising to his arm, hand and chest. He said that he had no recollection of sustaining an injury. On 17 March, he went to hospital. X-rays showed no fracture but that he might have damage to the muscles and tendons of his shoulder. He was advised to see the physiotherapist in prison.

Events of 13 April

22. At 2.08pm on 13 April, an officer saw that Mr Mockford was having difficulty walking to his wheelchair. He was unsteady, and as she helped him, he became increasingly confused. She was concerned and used her radio to call a code blue emergency (used when a prisoner is unconscious or having difficulty breathing). This prompted the control room to call an ambulance. Staff responded to the emergency call, and a nurse noted that Mr Mockford was breathing but that his speech was incomprehensible. Staff moved Mr Mockford to the floor, with a pillow and a blanket for comfort, but he started to vomit. Ambulance paramedics arrived at 3.43pm and took over Mr Mockford's care. They transferred him to hospital. Staff did not apply restraints.
23. Mr Mockford was admitted to hospital. His health deteriorated and he died at 3.45am on 14 April.

Cause of death

24. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem was held. The doctor gave Mr Mockford's cause of death as acute intraparenchymal haemorrhage (bleed on the brain). Atrial fibrillation, hypertension, ischaemic heart disease and smoking were listed as contributory factors.

Good practice

25. When Mr Mockford was taken to hospital on 13 April, the prison assessed that restraints should not be applied given Mr Mockford's advanced age and poor health. This was good practice.

Adrian Usher
Prisons and Probation Ombudsman

December 2023

Inquest

The inquest, held on 14 December 2023, concluded that Mr Mockford died from natural causes.

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