Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Orme, a prisoner at HMP Bullingdon, on 22 February 2023

A report by the Prisons and Probation Ombudsman

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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

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 Peter Orme died in hospital on 22 February 2023 of bronchopneumonia and heart disease while a prisoner at HMP Bullingdon. He was 79 years old. We offer our condolences to Mr Orme's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Orme received at Bullingdon was partially equivalent to what he could have expected to receive in the community. The clinical reviewer identified a number of areas of good practice. However, she also made several recommendations. While not all were directly related to Mr Orme's death, the Head of Healthcare will wish to address them. The clinical reviewer also identified a lack of clarity around the clinical escalation process (for high NEWS2 scores for example). We made a similar recommendation in another recent case and so repeat the recommendation here.

5. We found no non-clinical issues of concern.

Recommendation

- The Head of Healthcare should:

    - create a clear clinical escalation process (outside of emergency response process) for healthcare staff to consistently follow.

    - ensure that when patients have an accepted baseline for clinical observations or use an alternative scale with in the NEWS2, this is formally recorded, and specific clinical instructions given within a care plan as a directive for healthcare staff to follow.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Orme's clinical care at Bullingdon.

7. The PPO investigator investigated the non-clinical issues relating to Mr Orme's care.

8. The PPO family liaison officer wrote to Mr Orme's next of kin to explain the investigation and to ask if she had any matters she wanted us to consider. She did not have any questions but asked for a copy of the report.

9. Mr Orme's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP Bullingdon

11. Mr Orme was the thirteenth prisoner to die at Bullingdon since February 2021. Of the previous deaths, nine were from natural causes, two were self-inflicted and one was drug related. There has been one self-inflicted death since Mr Orme's death, which is under investigation.

12. In a previous investigation into the death of a prisoner at Bullingdon in February 2023, we recommended that the Head of Healthcare at Bullingdon implement a clearer clinical escalation policy. We are awaiting their response.

Key Events

13. On 17 December 2021, Mr Peter Orme was remanded to HMP Bullingdon charged with sexual offences.

14. Prior to going to prison, Mr Orme had been resident in a care home. He had a history of heart failure, high blood pressure, hiatus hernia, ischaemic heart disease, previous thoracic spine fracture, gout, Type 2 diabetes, mitral regurgitation (when the heart valve does not close properly), chronic fatigue and osteoporosis. He had limited mobility and used a wheelchair.

2022

15. When Mr Orme arrived at Bullingdon, healthcare staff noted his medical conditions and made arrangements for him to be allocated a cell in the prison's inpatients unit. On 6 January 2022, Mr Orme said that he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect.

16. On 18 February 2022, Mr Orme was sentenced to 14 years in prison.

17. On 7 March, healthcare staff suggested that Mr Orme be referred to a falls risk service as they had assessed him as at risk of falls. However, he declined the offer.

18. On 28 March, a long term condition nurse saw Mr Orme and noted that his leg was swollen. He had some blood tests and the results indicated that Mr Orme was malnourished and had renal or inflammatory disease. A GP arranged for Mr Orme to have a urine test. The results showed that Mr Orme had E.coli so healthcare staff prescribed antibiotics which cleared the infection. Mr Orme also told staff that he had stopped taking furosemide (a water tablet). A GP at the prison told him that he needed to take it but agreed to lower the dosage. Mr Orme had periods where he would restart taking furosemide but would then stop as he complained about increased need to urinate particularly during the night. The GP explained that the medication was important to ease his shortness of breath. A paramedic at the prison suggested that Mr Orme should be issued with a urine bottle, rather than having to get out of bed to use the toilet. Mr Orme agreed to this and started taking furosemide again.

19. On 10 June, Mr Orme complained to a GP that he had ongoing shortness of breath. The GP arranged for a chest X-ray and blood tests. The X-ray results indicated that Mr Orme had either an infection or cancer. Under the two week cancer referral, healthcare staff requested an urgent CT scan. However, on 22 June, Mr Orme said he did not wish to attend any hospital appointments. Healthcare staff noted that he had the capacity to make that decision. Between July and November, Mr Orme frequently changed his mind about attending hospital appointments. On several occasions he agreed and then refused to attend his appointments.

20. On 29 August, Mr Orme told healthcare staff that he felt unwell with a cough and sore throat. Healthcare staff assessed him as having a NEWS2 score of four (NEWS2 is a tool to detect acute illness and deterioration, a score of three indicates that an urgent review by a nurse is needed) as he had a low oxygen saturation level, elevated temperature and blood pressure. A GP diagnosed a chest infection and prescribed antibiotics.

21. On 9 November, a healthcare assistant and a nurse at the prison checked Mr Orme's clinical observations and noted he had a NEWS2 score of six (indicating a medium clinical risk). There is no evidence that healthcare staff escalated this to a GP as they should have done.

22. On 13 November, Mr Orme attended hospital for his chest X-ray appointment. The hospital told him that he needed further tests as he had a suspected hiatus hernia. Mr Orme declined any further medical tests in relation to this.

23. On 17 and 22 November, a healthcare assistant noted that Mr Orme's NEWS2 score was high at six as he had elevated blood pressure respiratory rate and oxygen saturation levels and she referred this to a nurse. There is no record that a anyone took any action.

24. On 6 December, Mr Orme fell in his cell. He did not have any injuries. However, healthcare staff monitored his clinical observations and his NEWS2 score was again six. A GP reviewed him and diagnosed a urine infection, prescribed antibiotics and requested a urine test. However, healthcare staff did not schedule a urine test as they should have done.

25. During December, Mr Orme had several periods where healthcare assistants checked his clinical observations and gave a NEWS2 score of between five and six. There is no record that they took any clinical action in response to the high scores.

2023

26. On 6 January 2023, healthcare staff diagnosed Mr Orme with another urine infection and prescribed antibiotics. They did not organise further urine tests until the long term condition nurse requested this on 15 February.

27. On 20 February, the long term condition nurse conducted a diabetic review. She noted that Mr Orme "appeared poorly" with swollen legs and looking pale and she emailed her concerns to the GP at the prison. Later that day, Mr Orme told a nurse that he had breathing difficulties, so she arranged for a GP to see him. However, she did not complete a NEWS2 assessment. The GP saw Mr Orme and completed a review. There was no evidence of respiratory issues, but the GP acknowledged Mr Orme's poor clinical observation results from earlier that day. Mr Orme was adamant that he did not want to go to hospital.

28. On 21 February, healthcare staff arranged for Mr Orme to go to hospital because they noted that he had a low oxygen saturation level, despite giving him supplementary oxygen and he was confused. Mr Orme agreed to go. Two officers escorted him, and he was not restrained.

29. On 22 February, Mr Orme's died in hospital.

Post-mortem report

30. The post-mortem report gave Mr Orme's cause of death as bronchopneumonia, caused by valvular and hypertensive heart disease. Type 2 diabetes mellitus was also listed as a contributory factor.

Inquest

31. The inquest into Mr Orme's death concluded on 3 October 2023, with a verdict of natural causes.

Adrian Usher
Prisons and Probation Ombudsman **December 2023**

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