Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Joseph Louis, a prisoner at HMP Wormwood Scrubs, on 26 April 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

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 Joseph Louis died on 26 April 2023, at HMP Wormwood Scrubs. He was 84 years old. The cause of Mr Louis' death was heart failure caused by heart disease and other cardiovascular conditions. He also had underlying diabetes, high blood pressure and a respiratory disorder. We offer our condolences to Mr Louis' family and friends.

4. The PPO family liaison officer wrote to Mr Louis' next of kin to explain the investigation and to ask if there were any matters they wanted us to consider. They did not reply.

5. NHS England commissioned an independent clinical reviewer to review Mr Louis' clinical care at HMP Wormwood Scrubs. She found that Mr Louis was a challenging patient, whose long-term medical conditions were managed well and he was monitored daily. However, she concluded that the clinical care Mr Louis received was only partially equivalent to that which he could have expected to receive in the community, as his deteriorating condition was not recognised in the hours before his death and concerning clinical observations had not been escalated at other times.

6. The clinical reviewer made recommendations not related to Mr Louis' death that the Head of Healthcare will wish to address, as well as the following which are related to his death:

    - The Head of Healthcare to assure herself that the healthcare staff who undertake the role of Nurse in Charge on H3 have the sufficient skills and competencies to recognise a clinically deteriorating patient.

    - The Barnet, Enfield and Haringey Mental Health Trust Service Manager should ensure that the RMN and all H3 staff are invited and have the opportunity to engage in a reflective session utilising the Practice Plus Group reflective presentation already completed. This session should include any additional learning required around the use of appropriate emergency codes.

    - The Head of Healthcare to provide reflective and supportive supervision to the RMN who provided care to Mr Louis overnight on the 26 April 2023, and specifically to address the record keeping issues identified. To ensure that the RMN is supported to improve the standard of his record keeping in accordance with the NMC Code for good record keeping.

    - The Head of Healthcare to ensure that all patients who have life limiting conditions have an advanced care plan in place in accordance with the

National Institute for Health and Care Excellence (NICE) guideline [NG142] for 'end of life care for adults: service delivery' (2019) and the NHSE 'universal principles for advanced care planning' (2022). This care plan will include advanced decision made regarding any refusal of treatment including a refusal of transferring to hospital against medical advice.

7. The PPO investigators investigated the non-clinical issues relating to Mr Louis' care. We found no non-clinical issues of concern. We make no recommendations.

8. We shared our initial report with HMPPS and the prison's healthcare providers, Practice Plus Group (PPG) and Barnet, Enfield and Haringey (BEH) Mental Health Trust. They found no factual inaccuracies. They provided an action plan which is annexed to this report.

9. The inquest, held on 9 April 2024, concluded that Mr Louis died from natural causes.

Adrian Usher
Prisons and Probation Ombudsman **December 2024**

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