Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Smith, a prisoner at HMP Preston, on 7 July 2015

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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 John Smith died of heart failure in hospital on 7 July while a prisoner at HMP Preston. He was 88 years old. I offer my condolences to Mr Smith's family and friends.

Mr Smith arrived at Preston with several chronic health problems, including severe heart disease, and staff cared for him in the inpatient unit throughout his time in the prison. We are satisfied that the care he received was at least equivalent to that he could have expected to receive in the community. However, the investigation found a need for better arrangements to help elderly and infirm prisoners keep in touch with their families. I am also not satisfied that the use or restraints when Mr Smith was taken to hospital in May was justified by a fully considered risk assessment, but I recognise that restraints were not used after that.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2016**

Contents

Summary

Events

1. On 15 April 2015, Mr John Smith was remanded to HMP Preston, charged with the murder of his wife. He had several existing chronic health problems, including heart disease and dementia. His initial health assessment noted that he was very frail. He found it difficult to walk and mainly used a wheelchair.

2. Mr Smith was admitted to the prison's healthcare inpatient unit, which offers 24-hour care. Healthcare staff created care plans, reviewed him daily and sent him to hospital for assessment and treatment when his condition worsened. In May, tests indicated that he had extensive coronary heart disease. On 1 June, a vascular surgeon noted no improvement in his condition.

3. After worsening heart and kidney failure, Mr Smith was admitted to hospital on 25 June. He remained in hospital until he died of heart failure on 7 July.

Findings

4. We are satisfied that the clinical care Mr Smith received at Preston was equivalent to that he could have expected to receive in the community. There was good communication between prison healthcare staff and the hospital and healthcare staff implemented appropriate care plans to help manage his conditions.

5. The investigation identified a need to improve arrangements for elderly and infirm prisoners, unable to get to the visits hall or get to a telephone to keep in touch with their families. Subsequently, family liaison arrangements were good. When Mr Smith was admitted to hospital in May, we were concerned to note that restraints were used without proper justification. However, restraints were not used for his subsequent hospital visits.

Recommendations

- The Governor should ensure that reasonable adjustments are made to allow elderly and infirm prisoners to keep in contact with their families.

- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

The Investigation Process

6. The investigator issued notices to staff and prisoners at HMP Preston informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

7. The investigator obtained copies of relevant extracts from Mr Smith's prison and medical records.

8. NHS England commissioned a clinical reviewer to review Mr Smith's clinical care at the prison.

9. We informed HM Coroner for Preston and West Lancashire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

10. One of the Ombudsman's family liaison officers contacted Mr Smith's daughter, to explain the investigation and to ask if she had any matters she wanted the investigation to take into account. Mr Smith's daughter said that the lack of contact with her father, while he was in prison, had been upsetting. Visiting arrangements were difficult and sometimes she was unable to see him after she had arrived at the prison. She said that her father could not write or get to the phone, but several times when she had phoned, she had been unable to speak to him. She said the prison had told her that this was due to a shortage of staff.

11. Mr Smith's family received a copy of the initial report. They pointed out some omissions. This report has been amended accordingly.

12. The prison reported no factual inaccuracies. The prison has also submitted an action plan detailing what they have done to address the issues we raised.

Background Information

HM Prison Preston

13. HMP Preston is a local prison holding up to 842 adult men. Lancashire Care Foundation Trust provides healthcare services at the prison. There is an inpatient unit for up to 30 prisoners, which is used as a regional facility, including for end of life care.

HM Inspectorate of Prisons

14. The most recent inspection of Preston was in April 2014. Inspectors reported that healthcare provision was safe and decent, but staffing shortages were causing some delays in prisoners accessing the services. Mental health services were very good. Links to services for prisoners with social care needs needed improvement. The inpatient unit provided good support for patients with complex needs. Chronic disease management and access to mobility aids were good.

Independent Monitoring Board

15. 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 March 2015, the IMB reported that the prison provided a wide range of services and care for prisoners. There were several chronic disease clinics each week but staffing shortages had affected efficiency.

Previous deaths at HMP Preston

16. Mr Smith was the fifth prisoner to die of natural causes at HMP Preston since July 2014. There were no significant similarities with the circumstances of the other deaths.

Key Events

17. On 15 April 2015, Mr John Smith was remanded to HMP Preston, charged with murdering his wife. He was nearly 88 at the time. Mr Smith had several health problems, including heart disease, an abdominal aortic aneurysm (a swelling of the main artery that leads from the heart), leg ulcers, double incontinence, type two diabetes and chronic kidney disease. He used a wheelchair but, with help, he could walk with a walking frame. He needed help with eating and drinking. Mr Smith had spent the previous five days in hospital, with a suspected blood clot on his lungs. Hospital records showed that he had low blood pressure, heart damage and possible dementia.

18. A nurse carried out an initial health screen to assess Mr Smith's immediate and ongoing health needs. Mr Smith refused to answer her questions, so she reviewed the hospital discharge letter. She noted he was very frail and admitted him to the prison's healthcare inpatient unit. A prison doctor examined Mr Smith and prescribed eight different medications to treat heart problems, prevent strokes, water retention, breathing difficulties, and excess stomach acid.

19. Nurses reviewed Mr Smith each day. They created several care plans, to monitor his risk of pressure sores, further heart failure and diabetes. He also had an older person's care plan. Nurses frequently monitored his blood pressure, pulse, temperature, weight, and food and fluid intake. On 20 April, a psychiatrist concluded that Mr Smith was probably suffering from dementia and a related psychotic illness. He planned to review him at his next clinic.

20. On 11 May, Mr Smith complained of chest pain, and used a GTN spray for relief. A nurse took his clinical observations, which were all within normal range. A doctor decided to send Mr Smith to hospital for an electrocardiogram (ECG – a test of the electrical activity of the heart). Officers restrained Mr Smith with an escort chain. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.) Mr Smith stayed in hospital overnight for monitoring, and returned to prison the next day.

21. A doctor from the older persons' mental health team assessed Mr Smith on 21 May and confirmed that he had dementia and psychosis.

22. At a hospital appointment on 1 June, a vascular surgeon reported that Mr Smith's condition had not changed. Officers did not use restraints for this appointment or subsequently. After this, Mr Smith's health worsened and he became bedridden. On 12 June, blood results indicated a reduced kidney function and a doctor sent him to hospital as an emergency. The hospital treated him with intravenous antibiotics for a chest infection that had caused kidney failure, and inserted a catheter. Doctors noted he needed further investigations of his liver. The escort officers recorded that Mr Smith was confused in hospital.

23. Mr Smith returned to the prison on 17 June and his condition continued to deteriorate. He was not eating or drinking much, had low blood pressure (90/50) and low oxygen levels (94%), which were signs of worsening heart and kidney failure. On 23 June, Mr Smith's daughter went to visit her father but the lift was out of order and he was too unwell to use the stairs to go to the visits hall. A member of the chaplaincy arranged for his daughter to visit him in the inpatient

unit on 29 June. However, on 25 June, a nurse sent Mr Smith back to hospital as an emergency.

24. A member of chaplaincy booked a taxi to take Mr Smith's daughter and her sister to visit him, and met them at the hospital that evening. Mr Smith's daughters then visited him throughout his time in hospital. Hospital doctors informed them of his care, and prison nurses met them to explain what treatment he had received in prison. The member of chaplaincy arranged for a priest to give Mr Smith the Last Rites on 28 June.

25. Mr Smith remained in hospital and received pain relief. Healthcare staff telephoned hospital staff frequently for updates on his condition. The hospital said that he was severely dehydrated, and they intended to place him on end of life care, as the only treatment they could give him was rehydration. On 29 June, the hospital inserted a feeding tube to aid his nutrition. Mr Smith decided that he did not want to be resuscitated if his heart or breathing stopped. On 7 July, the hospital began end of life care. Mr Smith died that evening. One of his daughters and the member of chaplaincy were with him when he died.

Contact with Mr Smith's family

26. On 9 July, the member of chaplaincy and the Governor of Preston visited Mr Smith's family at their home to offer condolences and support. They arranged for his family to visit the prison's inpatient unit on 2 August. Mr Smith had arranged and paid for his funeral before he died.

Support for prisoners and staff

27. The prison posted notices informing staff and other prisoners of Mr Smith's death, and offering support.

Post-mortem report

28. A post-mortem examination showed that Mr Smith died of heart failure, and diseased arteries.

Findings

Clinical care

29. The clinical reviewer concluded that the care Mr Smith received at Preston was at least equivalent to that he could have expected to receive in the community. She noted that the care plans implemented when he first came to prison were evidence of good clinical care, in line with national guidelines, and that he had at least daily reviews with a prison GP. Referrals to hospital were prompt, and record keeping was thorough, including recording information about Mr Smith while he was in hospital.

Contact with Mr Smith's family

30. Mr Smith was very frail and apparently suffering from dementia. He could not write or use the telephone. His daughter said she could not speak to him when she called the prison daily, and was told that this was because the prison was short-staffed. The prison told the investigator that Mr Smith had the opportunity to write or use the telephone when he first arrived, but accepted that, when his condition declined, there were no arrangements to help him keep in contact with his family.

31. Mr Smith's daughter attempted to visit Mr Smith from when he first went to prison, but because of an online booking error, the first time she was able to was on 15 May. On 23 June, when Mr Smith's daughter went to the prison to visit her father, she was unable to see him as the lift was broken and Mr Smith could not use the stairs. The Head of Healthcare told the investigator that visits to the inpatient unit would usually need to be pre-planned and agreed with the duty governor, or the Governor. The Head of Healthcare said that the prison was implementing a local policy to help address these issues.

32. After 23 June, there was good contact between Mr Smith's daughter and the member of chaplaincy, who helped her to visit Mr Smith and ensured both his daughters were able to spend time with their father before he died. However, there was no evidence that staff helped Mr Smith to keep in contact his family when he became too ill to write or use the telephone and Mr Smith's daughter reports having trouble making contact with Mr Smith, throughout his time in prison.

33. Prisoners have a statutory entitlement to visits under Prison Rules and the Rules also say that prisons should pay special attention to maintaining relationships between a prisoner and his family when this is in their best interests. These apply equally to aged and infirm prisoners. Prison Service Instruction (PSI) 49/2011, 'Prisoner Communication Services', states that all prisoners should be able to communicate with family and friends, that prisons should actively encourage prisoners to maintain outside contact and that prisoners should normally have access to phones for at least two hours each day. The PSI requires Governors to ensure that prisoners with disabilities are able to make telephone calls.

34. We are pleased to note that the prison subsequently made arrangements for Mr Smith's daughter to visit him in the inpatient unit, although he went to hospital

shortly afterwards. With the growing number of elderly prisoners, particularly in places such as the inpatient unit at Preston, prisons need to ensure that the particular needs of elderly prisoners are not overlooked and they are actively helped to keep in contact with their families. We make the following recommendation:

The Governor should ensure that reasonable adjustments are made to allow elderly and infirm prisoners to keep in contact with their families.

Restraints

35. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

36. When Mr Smith went to hospital on 11 May, there was little input into the medical information section. There was a circled indication that there was no medical objection to the use of restraints and it noted that Mr Smith had chest pains and his observations were stable. There was nothing about his age or very restricted mobility, which severely limited his ability to escape, or his other medical conditions. A prison manager authorised the use of an escort chain, which remained in place until he returned to the prison the next day. One of the escorting officers noted in the escort record that it had been made clear to them he had poor mobility and would need a wheelchair but that there was no information about this on the risk assessment. No one reviewed the risk once Mr Smith got to hospital.

37. We recognise that subsequent risk assessments indicated that Mr Smith was frail and had poor mobility and restraints were not used. However, the risk assessment in May did not take this into account. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141