Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Gilbert Mitchell a prisoner at HMP Lewes on 14 June 2016

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*

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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.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Gilbert Mitchell died on 14 June of pneumonia at Royal Sussex County Hospital while a prisoner at HMP Lewes. He was 89 years old. I offer my condolences to Mr Mitchell's family and friends.

I consider that Mr Mitchell received a good standard of care at Lewes, equivalent to that which he could have expected to receive in the community. Healthcare staff managed his chronic obstructive pulmonary disease well and when they became concerned about his breathing difficulties, they appropriately referred him to the prison's inpatient healthcare unit or to hospital.

However, I am not satisfied that prison managers authorising the use of restraints, properly considered Mr Mitchell's risk to the public, condition and mobility and how they impacted his risk of escape.

I am also not satisfied that the prison appointed a family liaison officer soon enough when it became clear that Mr Mitchell was seriously ill.

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

Richard Pickering
Deputy Prisons and Probation Ombudsman **January 2017**

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Summary

Events

1. In March 2013, Mr Gilbert Mitchell was sentenced to nine years in prison for sexual offences, and was sent to HMP Lewes. Upon arrival in prison, Mr Mitchell suffered from chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases including chronic bronchitis and emphysema). He was a smoker but did not accept assistance from healthcare staff to help him stop smoking.

2. Healthcare staff managed Mr Mitchell's COPD by creating a care plan, providing him with medication and checking him during annual reviews. As Mr Mitchell's health gradually deteriorated, healthcare staff regularly reviewed him, in line with his COPD care plan, to make sure that his basic observations were acceptable.

3. On 5 March 2016, healthcare staff sent Mr Mitchell to hospital because he had a chesty wheeze, an irregular pulse and blood in his urine. Hospital doctors diagnosed a chest infection and prescribed antibiotics, before discharging him on 9 March.

4. In April and May, healthcare staff regularly reviewed Mr Mitchell and took his basic observations. When Mr Mitchell's oxygen saturation level had dropped, healthcare staff used inhalers and oxygen to raise them to normal levels.

5. On the evening of 22 May, a nurse saw Mr Mitchell, as he was struggling to breathe. She measured his oxygen saturation levels at 66%, which did not improve significantly after giving him oxygen, so the nurse sent him to hospital.

6. While in hospital, doctors diagnosed Mr Mitchell with pneumonia, which they treated with intravenous antibiotics and by draining fluid from his chest. Mr Mitchell's health did not improve and, on 3 June, hospital doctors decided to treat him for end of life care. Mr Mitchell died at 1.19am on 14 June.

Findings

7. We are satisfied that healthcare staff managed Mr Mitchell's COPD well and appropriately referred him to secondary care providers when required. We agree with the clinical reviewer that he received a good standard of care, equivalent to that he could expect to have received in the community.

8. However, we are concerned that when Mr Mitchell went to hospital in May prison managers failed to consider how his condition and mobility affected his risk of escape.

9. We are also concerned that the prison did not appoint a family liaison officer until 14 June, despite Mr Mitchell having been considered terminally ill since 3 June.

Recommendations

- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position

on the use of restraints 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 Governor should ensure, in line with Prison Rule 22 and PSI 64/2011, that the next of kin of seriously ill prisoners are informed as soon as possible so that they are able to visit them in hospital without unnecessary delay.

The Investigation Process

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

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

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

13. We informed HM Coroner for Brighton of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.

14. One of the Ombudsman's family liaison officers contacted Mr Mitchell's daughter, to explain the investigation. She did not have any matters that she wanted the investigation to consider.

15. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies and their action plan is annexed to this report.

16. Mr Mitchell's daughter received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.

Background Information

HMP Lewes

17. HMP Lewes is a local prison serving the courts of East and West Sussex and holds up to 692 men. Sussex Partnership NHS Foundation Trust provides primary care services. Healthcare staff are on duty at the prison at all times.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Lewes was in January 2016. Inspectors found that health services were reasonably good but too many hospital appointments were cancelled because of a shortage of staff to escort prisoners. The inpatient unit provided compassionate care for patients with complex health needs but there were insufficient custody staff to deliver a therapeutic regime. Medicines management was reasonably good. Primary care services and management of long-term conditions were reasonably well managed. Clinical records were generally good.

Independent Monitoring Board

19. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure prisoners are treated fairly and decently. In its latest report, for the year to 31 January 2016, the IMB noted that there had been a sharp increase in older prisoners with complex needs. The IMB considered that end of life care was well managed, despite inadequate accommodation.

Previous deaths at HMP Lewes

20. Mr Mitchell was the fourth prisoner to die of natural causes at HMP Lewes since January 2015. There have been two subsequent deaths. There were no similarities between the circumstances of Mr Mitchell's death and previous deaths at the prison.

Key Events

21. On 7 March 2013, Mr Mitchell was sentenced to nine years imprisonment for sexual offences and was sent to HMP Lewes. Mr Mitchell smoked for most of his life and, while in the community, doctors had diagnosed him with chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases including chronic bronchitis and emphysema).

22. During an initial health screen, a nurse noted that Mr Mitchell used fluticasone (to reduce nasal swelling), salbutamol and tiotropium (to manage his COPD). On the same day, a doctor prescribed these medications.

23. On 2 April 2013, a nurse created a COPD care plan to monitor Mr Mitchell's vital signs, administer his medication and allow reviews by prison GPs where necessary. The nurse noted that Mr Mitchell smoked and advised him to stop.

24. Six days later, a nurse created a physical health care plan to address Mr Mitchell's physical health needs. The nurse noted that he had reduced mobility, though he could walk slowly around his cell and to the kitchen.

25. On 12 May 2014, a nurse carried out an annual review of Mr Mitchell's COPD. She advised Mr Mitchell to stop smoking and he said that he would reduce the number of cigarettes that he smoked, though he did not want to quit entirely.

26. As Mr Mitchell's health gradually deteriorated, healthcare staff regularly reviewed him, in line with his COPD care plan, to make sure that his basic observations were acceptable.

27. On 5 March 2016, healthcare staff reviewed Mr Mitchell because he was confused and disorientated. They found that he had a chesty wheeze, an irregular pulse and blood in his urine so the healthcare manager sent him to the Princess Royal Hospital, Haywards Heath. Hospital doctors diagnosed a chest infection and prescribed antibiotics. The hospital discharged Mr Mitchell back to the prison on 9 March.

28. On 12 March, Mr Mitchell moved to the prison's inpatient unit because he suffered with incontinence and officers were concerned that he could not cope with his medication. Mr Mitchell said that he was unhappy to be in the inpatient unit because he could not smoke there. On 22 March, the healthcare manager agreed that Mr Mitchell could move back to a smaller cell on a normal wing, which would make it easier for him to reach the toilet.

29. In April and May, healthcare staff regularly reviewed Mr Mitchell and took his basic observations. When Mr Mitchell's oxygen saturation level had dropped, healthcare staff used inhalers and oxygen to raise them to normal levels.

30. On 20 May, prison officers asked healthcare staff to review Mr Mitchell, as he was struggling for breath. A nurse reviewed Mr Mitchell, who said that he had experienced difficulty breathing for three days. The following day, a doctor prescribed Mr Mitchell prednisolone (a medication used to treat inflammation of blood vessels).

31. On the evening of 22 May, prison officers again asked healthcare staff to review Mr Mitchell, as he was struggling to breathe. A nurse measured his oxygen saturation levels at 66%, which increased to 78% only after giving him oxygen. They called an ambulance so that Mr Mitchell could be admitted to Royal Sussex County Hospital, Brighton for observation. A senior prison manager authorised two officers to accompany Mr Mitchell and restrain him with handcuffs.

32. While in hospital, doctors diagnosed Mr Mitchell with pneumonia, which they treated with intravenous antibiotics and by draining fluid from his chest. Mr Mitchell's health did not improve because the chest drain, which was fitted on 24 May, allowed air to leak into his lungs, which caused subcutaneous emphysema (when air is located under the skin). Due to the deterioration in Mr Mitchell's condition, on 31 May, a senior prison manager authorised officers to remove the restraints.

33. On 3 June, hospital doctors decided that Mr Mitchell's deterioration meant that his emphysema could not be treated so they began to treat him for end of life care. Mr Mitchell's condition continued to deteriorate and he died at 1.19am on 14 June.

Contact with Mr Mitchell's family

34. On 14 June, the prison appointed a prison officer as Mr Mitchell's family liaison officer.

35. Mr Mitchell listed his wife as his nominated next of kin, but the family liaison officer could not reach her at her home address on the morning of his death. The family liaison officer tried to contact Mr Mitchell's wife several times but could not reach her in the days following his death.

36. On 17 June, the family liaison officer found contact details for Mr Mitchell's daughter and telephoned her to inform her that Mr Mitchell had died. The family liaison officer offered her condolences and support. His daughter explained that Mr Mitchell's wife lived with her, which was why they could not contact her at her home address.

37. Mr Mitchell's funeral was held on 24 June. The prison arranged and paid for the funeral, in line with national policy.

Cause of death

38. The coroner determined that the cause of Mr Mitchell's death was hospital acquired pneumonia. This was caused by a spontaneous right pneumothorax (an abnormal collection of air that causes the lung to part from the chest wall) with persistent air leak from lung with surgical emphysema treated with intercostal chest drainage (a tube to drain air from the chest) and chronic obstructive pulmonary disease.

Findings

Clinical care

39. Mr Mitchell often suffered from poor health as a result of his COPD. As Mr Mitchell's lung disease progressed, he suffered from breathing difficulties and chest infections. Healthcare staff treated his COPD appropriately and, where required, made arrangements for his admission to hospital for treatment. They also offered him help to stop smoking though Mr Mitchell declined these offers. We agree with the clinical reviewer that Mr Mitchell received appropriate care, equivalent to that which he could have expected to receive in the community.

Restraints, security and escorts

40. 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.

41. In the risk assessment for Mr Mitchell's emergency admission to hospital in May, a nurse noted that Mr Mitchell had difficulty breathing though she did not raise any medical objections to the use of restraints. A prison manager recorded that Mr Mitchell presented a low risk to the public and a low risk of escape. On the basis of this information, a senior prison manager authorised officers to restrain Mr Mitchell with handcuffs. We do not consider this decision appropriate given the assessment of Mr Mitchell's risk and his physical condition.

42. Moreover, prior to his admission, Mr Mitchell suffered from reduced mobility and the clinical reviewer concluded that his breathing difficulties would have caused further impairment. Therefore, we are not satisfied that there was sufficient healthcare input into the risk assessment that allowed managers to make an informed decision about his health and how that impacted his risk of escape, as required by the 2007 High Court judgment.

43. On 31 May, the prison reviewed Mr Mitchell's security arrangements. The Head of Healthcare noted that Mr Mitchell suffered from impaired mobility, had a deflated lung and had a chest drain inserted. As a result, a senior prison manager authorised officers to remove the handcuffs and reduce the number of escorting officers to one. Officers did not reapply the restraints.

44. We are not satisfied that the prison reviewed the level of restraints quickly enough, since the hospital fitted the chest drain on 24 May yet the restraints were not removed until a week later. 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 on the use of restraints 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.

Contact with Mr Mitchell's family

45. Prison Rule 22 requires that when a prisoner becomes seriously ill, the Governor should "at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed". In addition, Prison Service Instruction (PSI) 64/2011, about safer custody, states that where prisoners suffer a rapid deterioration in their physical health, prisons must have in place procedures for supporting the prisoner and engaging with their next of kin.

46. We are concerned that the prison did not appoint a family liaison officer until the day of Mr Mitchell's death, despite hospital doctors having fitted him with the chest drain on 24 May and having begun treating him for end of life care on 3 June. While Mr Mitchell's family were able to visit him in hospital before he died, delays in informing a family when a prisoner is seriously ill can mean that they miss the opportunity to see the prisoner before they die. We make the following recommendation:

The Governor should ensure, in line with Prison Rule 22 and PSI 64/2011, that the next of kin of seriously ill prisoners are informed as soon as possible so that they are able to visit them in hospital without unnecessary delay.

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