Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Anthony George a prisoner at HMP Moorland on 25 February 2017

A report by the Prisons and Probation Ombudsman
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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 Anthony George died on 25 February 2017 of sepsis, caused by a urinary infection and chest infection, while a prisoner at HMP Moorland. He was 76 years old. I offer my condolences to Mr George's family and friends.

Mr George had a number of health concerns and he had his complex care needs managed well at Moorland. I consider the care Mr George received while at Moorland to be of a high standard, at least equivalent to that he could have expected to have received in the community.

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 **July 2017**

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Summary

Events

1. On 2 April 2015, Mr Anthony George was sentenced to 22 years imprisonment for historic sexual offences. This was reduced to 19 years on appeal. He spent time at other prisons before arriving at HMP Moorland on 18 May 2016.

2. Mr George's reception health screen at Moorland revealed that he had limited mobility and required a walking aid. He also had type 2 diabetes. On 19 May, Mr George was placed on a complex care register after falling in his cell and being incontinent of faeces.

3. Mr George began to fall frequently and experienced rapid weight loss during the summer. He was managed using more frequent complex care reviews; falls risk assessments; and high protein meal supplements. On 15 August, he was found unresponsive in his cell and sent to hospital with a suspected stroke. He was diagnosed with an acute kidney injury and discharged back to Moorland on 3 October, after treatment and rehabilitation. He was granted a fully funded social care plan for his return.

4. On 11 November, Mr George was sent to hospital with a suspected urinary tract infection, and discharged the next day. A week later, he was re-admitted and seen by a renal expert. He was discharged after five days. On 1 December, Mr George was sent to hospital where he was treated for dehydration and acute kidney injury. Two days later, he was placed on an end of life pathway and was not expected to recover. However, he returned to Moorland on 5 January 2017, and tests revealed that although he had enlarged kidneys, there was no obvious malignancy.

5. On 19 January, a prison GP sent Mr George to the hospital for urinanalysis (a routine examination of the urine). Mr George returned to Moorland on 25 January. A letter from the hospital stated that he was reaching the end of his life and staff were briefed to prepare for a death in custody. A 'priorities of care for the dying patient' document was opened.

6. On 18 February, Mr George deteriorated further and was taken to hospital. He remained there until his death was confirmed at 1.20pm on 25 February.

Findings

Clinical care

7. We agree with the clinical reviewer that Mr George received a level of care at HMP Moorland equivalent to that he could have expected in the community. Staff at Moorland managed Mr George's conditions well throughout, and kept excellent medical records. Healthcare staff responded quickly to any deterioration in his condition, and made appropriate and timely referrals to external specialists.

8. Mr George's social needs were attended to appropriately, and he benefited from full time care during his final few months at Moorland. We note that there were

two occasions in November when Mr George's agency carer failed to attend, but staff ensured he was looked after to the best of their ability and this matter was rectified quickly.

Compassionate release

9. An application for release on compassionate grounds was not considered for Mr George until a few days before he died. However, given that Mr George was never diagnosed with a terminal illness, and never received a prognosis of less than three months' life expectancy, we are satisfied that the prison acted properly in only considering compassionate release when they did.

Contact with the family

10. When Mr George became seriously ill the prison made active efforts to contact his wife and son. Both were reluctant to be involved but agreed to limited contact with the prison family liaison officer. The wishes of Mr George's family were respected by the prison and we consider that they acted appropriately and with sensitivity throughout.

The use of restraints

11. Risk assessments were completed for Mr George every time he was escorted to hospital. From December 2016, restraints were not used as he was deemed to be a low risk due to his poor health. We consider that the prison acted appropriately in deciding not to restrain Mr George from this time.

Recommendations

We make no recommendations.

The Investigation Process

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

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

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

15. We informed HM Coroner for South Yorkshire East District of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.

16. The investigator wrote to Mr George's wife and son to explain the investigation and to ask whether they had any matters they wanted the investigation to consider. They did not respond to our letter.

17. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP Moorland

18. HMP Moorland holds up to 1,000 men. Nottinghamshire Healthcare NHS Trust runs healthcare services at the prison, including primary care, mental health and substance misuse services. The prison does not have an inpatient facility or full time nursing cover.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Moorland was conducted in February 2016. Inspectors reported that healthcare staffing levels and the skill mix were appropriate, but high demand and continuing vacancies had placed significant pressure on frontline staff. A dedicated lead for older people had recently been identified, but prisoner needs had not been fully assessed.

Independent Monitoring Board

20. 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 February 2016, the board reported that they were concerned about the number of external hospital appointments cancelled due to staff shortages. They were also concerned about the number of internal appointments cancelled due to lack of notification and staff shortages.

Previous deaths at HMP Moorland

21. Mr George was the third person to die of natural causes at Moorland since January 2016. There are no significant similarities with the circumstances of previous deaths.

Key Events

22. Mr Anthony George was convicted of historic sexual offences on 26 March 2015. On 2 April he was sentenced to 22 years imprisonment, but this was reduced to 19 years on appeal. Mr George was initially sent to HMP Leeds, and spent time at HMP Rye Hill, before arriving at HMP Moorland on 18 May 2016.

23. When he arrived at Moorland, a nurse reviewed Mr George at a reception health screen. She noted that Mr George used a Zimmer frame due to his limited mobility, and requested a ground floor cell. Mr George also suffered from type 2 diabetes. His weight was recorded as 78kg.

24. On 19 May, a nurse saw Mr George after officers reported he had been incontinent of faeces. Mr George said that he had slipped while going to the toilet, and did not normally suffer with stomach problems or incontinence. She noticed that Mr George's shoes were too big, and requested new ones to reduce his risk of falling. Mr George was relocated to a bigger cell, and allocated a full time buddy to assist him. He was also placed on the complex care register with a plan for fortnightly reviews. On 5 June, a nurse observed that Mr George had no further episodes and reduced this to monthly reviews.

25. On 23 June, a nurse saw Mr George due to his low blood sugar level and poor diet. She planned for Mr George to have urgent blood tests, a GP review and food intake monitoring. She also upgraded Mr George's complex care review to amber to ensure closer monitoring. Later that day, Mr George suffered a significant hypoglycaemic attack, but improved after he was given glucagon (a high energy food source to treat diabetes). She told Mr George's buddy to alert an officer if Mr George became ill during the night. Mr George had a fit in his cell later that night, and was admitted to hospital. He was discharged three days later.

26. On 27 July, Mr George's buddy told a nurse that he was falling on a daily basis, but disclosed no other health concerns. A risk assessment was completed to manage Mr George's falls, and he was referred to the physiotherapist. She planned to monitor Mr George's weight and food intake. She also took a urine sample to check for a urinary tract infection.

27. The next day Mr George's weight was recorded as 63.8kg, and he was given a MUST score of 1. (This is a Malnutrition Universal Screening Tool - to monitor weight loss.) A nurse upgraded his complex care rating to red and planned to review him after the weekend. She also requested a prescription for a short course of fortisips (a nutritionally complete, high energy or high protein supplement for the management of disease-related malnutrition). The following day, Mr George was seen by the physiotherapist who advised him about fall prevention, and ordered him a narrower Zimmer frame to fit in his cell.

28. On 2 August, a nurse saw Mr George in his cell after reports that he had fallen during the night and was incontinent of urine. She planned for him to see a GP to look into getting him a carer, and to continue the complex care reviews on a weekly basis. Four days later, she saw Mr George again and noted his weight was 60.7kg. She booked him an urgent GP appointment.

29. On 9 August, a prison GP reviewed Mr George's health. Mr George told him he had been ill for two months. He noted that Mr George had lost 17kg since arriving at Moorland three months earlier, and was concerned about a potential malignancy. He booked Mr George in for blood tests a few days later, and made a fast track two-week referral to the hospital for a suspected case of gastrointestinal cancer.

30. On the morning of 12 August, Mr George's buddy told an officer that Mr George was unresponsive and had collapsed on his bed. The officer called a code blue emergency and healthcare staff attended. (A code blue indicates that a prisoner is either unconscious or has difficulties breathing.) A nurse recorded that she found Mr George slumped on his bed with increased respiratory and pulse rates, and with reduced movement to the right side of his face. Mr George was taken straight to hospital and located on the stroke ward.

31. On 15 August, Mr George was diagnosed with acute kidney injury. The two-week cancer referral was performed while he was at the hospital, but no malignancy was found. Mr George was transferred to the Mexborough Rehabilitation Unit on 25 August to recover from his treatment. He was discharged back to Moorland on 3 October.

32. While at Mexborough, Mr George was granted a fully funded care plan which was implemented on his return to Moorland. This involved a carer being employed full time during the night to attend to him every couple of hours, or as requested by prison officers. Mr George was monitored and reviewed regularly during October and early November. His weight continued to fall, but otherwise his condition remained stable. On 17 October, a prison GP reviewed Mr George and observed that he was eating well, had no nausea, and was feeling well. For two nights in November the carer did not attend, so Mr George was attended to by officers and healthcare staff.

33. On 11 November, a prison GP examined Mr George and noted that he had blood in his catheter bag. The next day, Mr George was sent to hospital with a suspected hematuria (blood in the urine, often caused by a urinary tract infection). Mr George had investigations at the hospital but was discharged the next day.

34. On 17 November, a nurse saw Mr George in his cell. She performed sepsis screening and observed that Mr George met two of the criteria. Mr George was sent to the hospital with a suspected urinary tract infection, and was treated for urosepsis (a bacterial infection in the urinary system which can infect the bloodstream) and hypoglaecemia (a drop in blood glucose). Mr George was referred to a renal physician while at the hospital, but was discharged back to Moorland on 22 November.

35. On 1 December, a nurse examined Mr George in his cell. She suspected urosepsis and Mr George was sent back to the hospital for a full examination. Mr George was kept in hospital and treated for severe dehydration and acute kidney injury. On 3 December, a nurse noted that Mr George was not expected to return to Moorland, and that hospital staff had initiated an end of life pathway for him. Mr George's condition improved however, and a CT scan revealed that he had enlarged kidneys but no obvious malignancy. He returned to Moorland on 5 January 2017.

36. A Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order means that in the event of cardiac or respiratory arrest no attempt at resuscitation will be made. All other appropriate treatment and care will continue to be provided. Mr George completed a DNACPR form at the hospital and this was given to prison staff on his return, along with his discharge letter. Mr George was kept under regular review at Moorland and monitored regularly using a National Early Warning Score (NEWS) tool to recognise any change in his condition.

37. On 19 January, a prison GP examined Mr George and observed that his urine was cloudy, he was dehydrated and generally unwell. The GP referred Mr George immediately to the Medical Assessment Unit at the hospital for urinanalysis (a routine examination of the urine for cells, tiny structures, bacteria, and chemicals that suggest various illnesses). Mr George returned to Moorland on 25 January, with a letter from the hospital stating that he was reaching the end of his life. Staff were briefed to prepare for a death in custody, and a 'priorities of care for the dying patient' document was opened.

38. At 2.00am on 18 February, Mr George's agency carer alerted staff to a significant deterioration in Mr George's condition. A GP was providing emergency cover and called Oscar 1 (the Orderly Officer, in charge of running the prison) to say he was not going to admit Mr George to hospital because he was likely to die soon. The agency carer was not satisfied and spoke to her manager, who advised that an ambulance be called. Mr George was taken to hospital.

39. On 21 February, a prison GP called the acute care consultant at the hospital. The consultant said there was little point in continuing to admit Mr George to hospital since he was close to the end of his life. He added that Mr George had a DNACPR order in place and that there was no terminal illness, just general frailty. The GP explained the difficulty in dealing with terminal care in the prison, given they did not have 24-hour healthcare cover. They agreed to defer any discharge decision until they had input from the palliative care team. The GP also recorded that he would talk to prison management about whether Mr George could be released on compassionate grounds.

40. On 22 February, a manager began the process of applying for release on compassionate grounds for Mr George. She emailed the forms to a prison GP and a supervisor at the Offender Management Unit, requesting a reply as soon as possible. The supervisor returned the completed forms a little over an hour later.

41. Healthcare staff remained in regular contact with the hospital but Mr George was never discharged. Mr George died in hospital at 1.20pm on 25 February.

Contact with Mr George's family

42. When Mr George went to hospital in December, there was a fear he might die imminently, so the prison appointed an officer as his family liaison officer on 2 December.

43. Mr George's nominated next of kin was his son. The officer made a number of attempts to contact Mr George's son, without success. During the evening of 3 December, she spoke to Mr George's wife. Mr George's wife explained that his

son had moved away, but agreed that she should be told when he died. She subsequently told the officer that Mr George's son wanted nothing to do with him. On 16 December, Mr George's son telephoned the officer and expressed his concern about the number of calls from the prison about his father which he had not answered. He reiterated that his family did not want any involvement, but agreed to limited contact with her in order to keep him updated and to inform him when his father died.

44. On 22 February 2017, the officer contacted Mr George's son to inform him that his father was expected to die soon. Mr George's son agreed for his details to be passed on to the hospital for contact purposes only, but he maintained that the family's position had not changed regarding contact.

45. On 25 February, at 2.22pm, the officer called Mr George's son to tell him of Mr George's death. Mr George's son asked whether she would meet him in person to discuss matters. The officer and a governor met Mr George's son and wife at their home the following day. Mr George's son confirmed the family's wish not to be involved in any of the funeral arrangements, but requested a copy of the death certificate, which was sent directly to the family by the Coroner.

46. Mr George's funeral was held on 13 March and the prison contributed towards the cost of the funeral in line with national policy.

Support for prisoners and staff

47. After Mr George's death, a governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

48. The prison posted notices informing other prisoners of Mr George's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr George's death.

Post-mortem report

49. The Coroner found that Mr George died from sepsis caused by pyelonephritis (an inflammation of the kidney tissue, calyces, and renal pelvis commonly caused by bacterial infection that has spread up the urinary tract) and a chest infection. The Coroner stated that type 2 diabetes was a contributory factor, but was not a direct cause of Mr George's death.

Findings

Clinical care

50. The clinical reviewer concluded that Mr George received an equivalent level of care at HMP Moorland to that which he could have expected to receive in the community. We agree with the clinical reviewer that healthcare staff managed Mr George's condition well through their use of the complex care register, and that his medical notes and records were maintained to a high standard. This ensured he received good care throughout his time at Moorland, and was treated quickly as and when his condition deteriorated.

51. We also agree with the clinical reviewer that healthcare staff acted appropriately and responded quickly to any deterioration in Mr George's condition. Mr George was referred to external specialists on a number of occasions to be assessed, and this was done efficiently and without delay.

52. We also accept that Mr George's social care needs were addressed appropriately during his time at Moorland. The local authority granted Mr George a fully funded care plan on his return to Moorland in October 2016, which involved a carer being employed full time during the night to attend to Mr George every couple of hours, or as needed. There were two occasions in November when the agency carer did not turn up, but staff took over this responsibility and the matter was rectified quickly. We make no recommendation.

Compassionate release

53. Release on compassionate grounds is a means by which prisoners who are seriously ill, and usually with a life expectancy of less than three months, can be permanently released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. The criteria for early release for determinate sentenced prisoners are set out in Prison Service Order (PSO) 6000, *Parole Release and Recall*. These criteria include: the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of Her Majesty's Prison and Probation Service (HMPPS).

54. An application for release on compassionate grounds was only started for Mr George on 22 February, and not completed in time because he died just three days later. It was clear for some time that Mr George was approaching the end of his life, and regular referrals were made to check for terminal conditions. However, no clear medical opinion was obtained to indicate a prognosis of less than three months life expectancy until this was discussed between a prison GP and the acute care consultant at the hospital on 21 February. The application was then initiated without delay, with the initial paperwork completed in very quick time.

55. We find that the prison acted appropriately, and make no recommendation.

Contact with the family

56. Prison Rule 22 requires governors and directors to inform a prisoner's spouse or next of kin when that prisoner "becomes seriously ill". When Mr George became seriously ill in December 2016, an officer made every attempt to contact his son, who was his nominated next of kin, before making contact with his wife.

57. Both family members were reluctant to have any involvement with Mr George, but agreed to limited contact with the officer. The wishes of Mr George's family were respected by the officer and the prison, and limited contact was maintained.

58. We consider that the prison acted appropriately and with sensitivity to the wishes of the family.

The use of restraints

59. When prisoners have to travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk, taking into account factors such as the prisoner's health and mobility.

60. Risk assessments were completed for Mr George prior to each of his escorts to hospital during his time at Moorland. From December 2016 restraints were not used on Mr George, as he was deemed to be a low risk due to his poor health.

61. We consider that the prison acted appropriately in deciding not to restrain Mr George.

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