Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Seddon a prisoner at HMP Stafford on 22 December 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 Michael Seddon died on 22 December 2017 of pneumonia and lung disease at hospital while a prisoner at HMP Stafford. He was 64 years old. I offer my condolences to Mr Seddon's family and friends.

I am satisfied that Mr Seddon received a good standard of care while at Stafford, and that the prison investigated a safeguarding incident related to Mr Seddon's care appropriately and implemented actions from the investigation.

I am, however, concerned that Mr Seddon would have been more appropriately located in a prison with 24-hour healthcare when his health deteriorated. I am disappointed that a previous recommendation I made to HMPPS about the referral pathway for prisoners with deteriorating health has not been addressed and I make two recommendations.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **August 2018**

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Summary

Events

1. Mr Seddon arrived at HMP Stafford in February 2015. He was a serving a life sentence for sexual offences. In 2010 he had been diagnosed with Chronic Obstructive Pulmonary Disease (COPD). By July 2016, his disease was considered to have reached stage 4 (end stage). Mr Seddon's mobility was severely impaired due to his illness.

2. Mr Seddon was fully aware of his condition and received regular emotional and practical support from nursing staff at the prison. Stafford does not have inpatient healthcare services and Mr Seddon's health needs were managed on his wing. He shared a cell with prisoner carers who helped support him. When his health needs increased, external carers also came in during the morning and evening.

3. In 2016, Mr Seddon had seven hospital admissions when his condition deteriorated. In July and August 2016, he was very unwell in hospital and a family liaison officer was appointed and attempted to contact his family. Although she was unable to establish contact with Mr Seddon's listed next of kin, she maintained contact with Mr Seddon during his illness.

4. On 1 May 2017, Mr Seddon had a fall in his cell, which resulted in him fracturing a hip and suffering a heart attack. A safeguarding review was held after the incident because it took a long time for an ambulance to be called. Recommendations from the review have been implemented in the prison. Mr Seddon returned to prison from hospital on 29 June.

5. Mr Seddon's health got progressively worse during July and August and he was admitted to hospital several times. He developed pressure sores and leg ulcers due to poor mobility.

6. An application was made for a transfer to HMP Birmingham for palliative care but was rejected because Mr Seddon's health needs did not meet Birmingham's criteria at the time. A residential care home space was secured for him on 5 December, and the funding agreed on 21 December. On 17 December, Mr Seddon was admitted to hospital and died on 22 December.

Findings

7. Mr Seddon arrived at Stafford with a diagnosis of COPD. We agree with the clinical reviewer that Mr Seddon received a good standard of care at Stafford but consider that Mr Seddon would have been more appropriately located in a prison with 24-hr nursing care. We are disappointed that this investigation repeats previous concerns we had about the arrangements for transfer from Stafford to Birmingham for increased nursing care and repeat a recommendation we made in a previous report.

8. Although there was a serious safeguarding concern around how Mr Seddon was looked after when he fell from his bed on 1 May, we are satisfied that the prison addressed this concern appropriately.

Recommendations

- NHS England and should ensure that healthcare provider palliative care policies include clearly defined clinical pathways of care for terminally ill prisoners which meet their assessed needs.
- HM Prison and Probation Service should ensure that accommodation is available in which appropriate care can be provided and the needs of the individual can be met.

The Investigation Process

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

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

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

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

13. At the time of writing this report, no next of kin had been established for Mr Seddon.

14. The investigation has assessed the main issues involved in Mr Seddon's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.

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

Background Information

HM Prison

16. HMP Stafford is a medium security prison for adult sex offenders. It holds more than 700 prisoners across seven wings. Care UK has provided healthcare services since April 2016. There are no inpatient facilities. Nurses are on duty daily between 7.30am and 5.30pm and there is a weekday GP service, with on-call GPs outside these hours.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Stafford was conducted in February 2016. Inspectors considered that the range of primary care services was reasonable, with good access to nurses and GPs available. They found that wing-based nurses provided consistent care, treatment and review.

Independent Monitoring Board

18. 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 April 2017, the IMB reported that healthcare had improved substantially since its last report, with a reduction in waiting lists for internal services, and fewer cancelled escorts for external appointments. The IMB acknowledged the exceptional care shown by staff and prisoner carers towards very frail and terminally ill prisoners.

Previous deaths at HMP Stafford

19. Mr Seddon was the eleventh prisoner to die at HMP Stafford since January 2016. This is not remarkable, given the prison's role. We have previously raised the issue about the appropriate location of terminally ill prisoners and repeat the recommendation in this report.

Findings

The diagnosis of Mr Seddon's terminal illness and informing him of his condition

20. On 29 June 2000, Mr Seddon was sentenced to life imprisonment for sexual offences. He had been at HMP Stafford since February 2015. In 2010, he was diagnosed with COPD (chronic obstructive pulmonary disease) and in July 2016 he was considered to have reached end stage (stage 4) COPD.

Mr Seddon's clinical care

21. During 2016, Mr Seddon had seven admissions to hospital due to deterioration of his COPD. During hospital admissions in July and August, he was very unwell and hospital staff asked for his next of kin to be informed. Mr Seddon recovered and returned to prison but continued to smoke, which prevented the use of oxygen therapy.

22. In July 2016, a first discussion about a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order took place. Mr Seddon did not want such an order put in place and maintained this view until October 2017, when he decided he did not want anyone to resuscitate him if his heart or breathing stopped. He signed an order to that effect when in hospital.

23. In January 2017, a Macmillan Nurse, a specialist palliative care nurse, first contacted Mr Seddon and subsequently met with him at least monthly. Mr Seddon had been given a 12-month prognosis of survival and he felt frustrated that he was in prison. She offered emotional support and practical advice during their meetings.

24. On 13 February, Mr Seddon was admitted to hospital for three days due to shortness of breath. He was also diagnosed as having had a minor heart attack.

25. On 17 March, a pharmacist met with Mr Seddon and went through his list of medications so that he understood what each of them was for. She explained that his medication was working to ease his COPD and prevent heart attacks. A nursing Sister created a medical passport for Mr Seddon on 23 March, to help when he needed to access out of hours services.

<u>Safeguarding incident</u>

26. On 1 May 2017, at 5.45am, Mr Seddon's cellmate used the cell bell to call for help as Mr Seddon had fallen out of bed and could not get up. The wing night officer responded and asked the night manager to attend. They both offered Mr Seddon help to get off the floor and back into bed or his chair, but he refused. He also declined the offer of a doctor being called. After 15 minutes, the night manager agreed to leave Mr Seddon on the floor and asked his cellmate to use the cell bell if he got worse. At the 7am changeover of staff, Mr Seddon was discussed and the night and day managers agreed to ask healthcare to attend when they came on duty. Mr Seddon's cell was unlocked at 7.50am and, when a nurse arrived at the cell, an ambulance was called immediately. Mr Seddon had suffered a heart attack and fractured his hip bone.

27. Nursing staff expressed concern that Mr Seddon had been left on his cell floor for so long. On 7 June 2017, the Head of Healthcare and a Prison Operational Manager held a safeguarding review of this incident in the presence of the staff involved. A number of recommendations were agreed, including issuing guidance to staff on when an ambulance should be called and a reminder to staff on the procedure to adopt if a person falls out of bed. The Safer Custody Manager told the investigator that all the recommendations from the safeguarding review have now been implemented and provided evidence of this. We are satisfied that the prison has acted on the recommendations from the review.

Remainder of care

28. Mr Seddon remained in hospital until 29 June 2017. When he returned to Stafford he was able to get in and out of bed independently and to use the toilet. Carers were arranged to come in during the morning and the evening to assist.

29. Mr Seddon's health got progressively worse during July and August. He had many hospital admissions, and the prisoner carers who shared his cell were rotated because of the demands on them of sharing a cell with him. On 18 August, a referral was made to HMP Birmingham for a transfer for palliative care.

30. Mr Seddon developed pressure sores on his elbows, spine and lower left leg due to poor mobility, malnutrition and steroid therapy. He was admitted to hospital on 28 September and stayed until 16 October due to deterioration of his COPD and sepsis caused by his leg ulcer.

31. On 26 October, a nurse prescriber received notification that Mr Seddon would not be offered a space at Birmingham because he did not require 24-hour nursing care. She expressed frustration that Mr Seddon's condition could deteriorate very quickly and that Stafford Prison could not provide the nursing care he needed when that happened.

32. On 28 November, Mr Seddon had a fall in his cell but asked his cellmate not to raise the alarm until the morning. He went to hospital for an x-ray and had significant grazing and bruising.

33. On 5 December, a residential home place was secured for Mr Seddon and prison staff went to visit the setting. Funding was agreed for the placement on 21 December.

34. On 17 December, Mr Seddon was admitted to hospital and began intravenous pain relief on 20 December. The Parole Board was informed that Mr Seddon had been admitted to hospital. He died on 22 December.

35. We agree with the clinical reviewer that Mr Seddon's care was equivalent to that he could have expected to receive in the community.

Mr Seddon's location

36. Mr Seddon remained on D wing throughout his illness. He received support from prisoner carers with whom he shared a cell. External carers assisted Mr Seddon in his cell when his health needs increased. His cell was adapted to facilitate his care and he was given an alarm wristband to call for help.

37. Mr Seddon was not accepted for a place at HMP Birmingham for palliative care. Staff at Stafford were frustrated by this decision because when his condition deteriorated they were unable to provide the 24-hour nursing care that he needed. After a place was declined there was no discussion on how his situation would be monitored and what could be done if his condition declined.

38. We have raised a similar issue about transfer arrangements between Stafford and Birmingham in a recent report and are disappointed to see that our previous recommendation, although accepted, has not been addressed. We make the following recommendations:

    NHS England and should ensure that healthcare provider palliative care policies include clearly defined clinical pathways of care for terminally ill prisoners which meet their assessed needs.

    HM Prison and Probation Service should ensure that accommodation is available in which appropriate care can be provided and the needs of the individual can be met.

Restraints, security and escorts

39. 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.

40. From 14 February 2017, Mr Seddon did not have restraints applied when taken to hospital due to his poor mobility and health problems. We are satisfied that the prison acted appropriately in not restraining Mr Seddon.

Liaison with Mr Seddon's family

41. On 14 June 2016, the family liaison officer introduced herself to Mr Seddon. She asked for his next of kin details and attempted to contact his ex-wife and his daughter, who lives in Singapore. Neither responded to her contact. The prison police liaison officer was unable to provide any alternative contact details, so Mr Seddon's family was not informed of his death. We are satisfied that the prison did all that it could to contact Mr Seddon's family.

42. The funeral took place on 16 January 2018 and, in line with national policy, the prison contributed to the costs. Mr Seddon was a Quaker, and there were members of the Quaker community present at his funeral.

Compassionate release

43. Prisoners can be released from custody before their sentence has expired, on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.

44. A compassionate release application was submitted for Mr Seddon in July 2016. This was not approved due to the absence of any release address and, hence, of any risk management plan.

45. On 2 August 2017, a Parole Board oral hearing took place and a decision on Mr Seddon's release was deferred because a residential placement had not been agreed. In early December, Mr Seddon was offered a space at a residential nursing home and prison staff visited the home. Mr Seddon was readmitted to hospital on 17 December and died before the Parole Board had made a decision on his release. We are satisfied that the prison explored possible release opportunities for Mr Seddon appropriately.

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