Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr George Gough a prisoner at HMP Stafford on 14 June 2018

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*

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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.

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 George Gough died in hospital on 14 June 2018, from acute gall bladder inflammation, while a prisoner at HMP Stafford. He was 80 years old. I offer my condolences to Mr Gough's family and friends.

Mr Gough arrived at Stafford with several complex medical problems and his condition deteriorated over time. Healthcare staff responded appropriately to his symptoms and referred him promptly to secondary care. I am satisfied that Mr Gough's care was mostly equivalent to that which he could have expected to receive in the community.

However, during the last 18 months of his life, Mr Gough spent significant periods in hospital and at other prisons when Stafford could not meet his need for 24-hour healthcare. As a result of this and other investigations we have conducted into deaths at Stafford in the last year, I question whether the prison should have 24-hour healthcare given the elderly nature of its population.

I am concerned that some entries in Mr Gough's medical record were made retrospectively, weeks after the actual events. Timely record keeping is vital to effective continuity of care.

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

Sue McAllister CB
Prisons and Probation Ombudsman **January 2019**

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Summary

Events

1. Mr George Gough was convicted of sexual offences on 9 May 2016 and sentenced to seven and a half years in prison. On 20 June, after spending a few weeks at HMP Hewell, he was transferred to HMP Stafford.

2. Before he went into prison, Mr Gough had been diagnosed with several chronic health conditions and he had limited mobility. Prison healthcare staff recorded his medical history, continued his medication and put in place care management plans. They also referred him to hospital, as necessary, and facilitated daily social care.

3. He was admitted to hospital several times for various medical problems, including a stroke and fractures following falls. When he required 24-hour care, he was transferred temporarily to other local prisons.

4. In October 2017, Mr Gough was admitted to hospital, where he was diagnosed with cholecystitis (inflammation of the gall bladder). Given the risks associated with surgery at Mr Gough's age and his own views, doctors decided not to remove his gall bladder and inserted a biliary drain.

5. On 22 May 2018, Mr Gough was admitted to hospital after he was found lying on his cell floor, unwell. Doctors treated him for a small bowel obstruction, but he remained very ill. Prison staff then began an application for early release on compassionate grounds. However, Mr Gough's health quickly deteriorated and he died on 14 June.

Findings

6. The investigation found that Mr Gough received a good standard of care for his complex health conditions. Prison doctors and nursing staff monitored him closely and were responsive to his needs, with input from secondary care specialists and external carers. We agree with the clinical reviewer that Mr Gough's clinical care at Stafford was mostly equivalent to that which he could have expected to receive in the community.

7. The clinical reviewer found some apparent gaps in service provision at Stafford, although these did not contribute directly to Mr Gough's death.

8. Mr Gough spent significant amounts of time in hospital and at other prisons when Stafford could not meet his need for 24-hour healthcare.

9. Significant entries about events in April and May 2018 were added to Mr Gough's medical record after his death. We are satisfied that there was no intention to mislead, as the author had highlighted that they were retrospective. However, it is essential that medical notes are recorded promptly after an action or event.

Recommendations

- NHS England commissioners should assure themselves that prisoners at HMP Stafford have access to the Falls Prevention Team and to dementia services.
- The Governor, the Prison Group Director for the West Midlands and NHS England should review the Health Needs Assessment at Stafford to ensure that healthcare provision meets the needs of an increasingly elderly population.
- The Head of Healthcare should ensure that healthcare staff fully adhere to the requirement to record events contemporaneously, in accordance with the required standards of the Nursery and Midwifery Council and the General Medical Council.

The Investigation Process

10. 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.

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

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

13. We informed HM Coroner for South Staffordshire of the investigation, who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

14. The investigator wrote to Mr Gough's son and daughter, his next of kin, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They did not respond.

15. We shared the initial report with HM Prison and Probation Service (HMPPS) and they found no factual inaccuracies. The HMPPS action plan has been annexed to this report.

Background Information

HMP Stafford

16. HMP Stafford is a medium security prison in Staffordshire for adult sex offenders. It can hold around 750 prisoners across seven wings. Care UK provides healthcare services. Nurses are on duty daily between 7.30am and 5.30pm and there is a weekday GP service, with on-call doctors outside these hours.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Stafford was conducted in February 2016. Inspectors found that the range of primary care services was appropriate and access to nurses and GPs was good. However, health provision was not consistently meeting the needs of the ageing population. There was a very high need for hospital appointments and, at times, over a quarter of appointments were cancelled or rescheduled because there were not enough escort staff. Prisoners over 65 and those with mobility problems were not routinely handcuffed for external hospital appointments except when a specific risk had been identified. Governance was reasonable overall, with effective working between providers and the prison.

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 30 April 2018, the IMB reported that the healthcare service was generally working well. Waiting times for appointments had reduced and were comparable to, or better than those in the community. If a waiting list became too long, the healthcare manager paid for additional sessions. The Board noted the additional demands on resources for hospital visits and lengthy admissions, as well as social care, because of the prison's ageing population. Although external carers provided care for some prisoners, the Board felt that in the community some of them would have been admitted to a care home for 24-hour support.

Previous deaths at HMP Stafford

19. Mr Gough was the 15th person to die from natural causes at Stafford since January 2016. This is not surprising given that it holds a significant number of older prisoners. In a number of our investigations we have questioned whether Stafford was the right location for prisoners who we considered would have benefitted from 24-hour healthcare.

Key Events

20. On 9 May 2016, Mr George Gough was convicted of sexual offences and sentenced to six and a half years imprisonment. (This was subsequently extended to seven and a half years.) He was sent to HMP Hewell. It was Mr Gough's first time in prison.

21. At his reception health screen, a nurse and a locum prison GP recorded that Mr Gough had multiple health problems, including depression, irregular heartbeat, hernia, swollen legs and reduced mobility. Healthcare staff created care plans and prescribed medication for his conditions.

22. On 20 June 2016, Mr Gough was transferred to HMP Stafford. In addition to his previously recorded medical conditions, a nurse noted that he had right leg cellulitis, bladder problems and hearing aids in both ears. She advised that he should be located on a flat, low floor due to his poor mobility and that he needed a walking frame to get around his cell. He used a wheelchair for longer distances on the wing.

23. Within the first few days of his arrival, healthcare staff referred Mr Gough for an urgent occupational health assessment and to a specialist to assess his hernia. (The occupational therapist later provided disability aids for his cell, such as a shower chair, raised toilet seat and special mattress.) Staff managed him under the prison's suicide and self-harm prevention procedures between 21 and 24 June, due to his frustration about pain management and medication. Mr Gough was also referred to the prison's mental health team, who discharged him in September 2016, as there were no concerns about his mental health at that time.

24. On 22 September, Stafford referred Mr Gough to Staffordshire County Council for a social care support assessment. External carers were then provided three times a day to assist with his personal care. This was subsequently increased to four times a day.

25. Throughout the remainder of 2016 and in 2017, healthcare staff monitored Mr Gough's medical conditions closely, alongside secondary care specialists.

26. In January 2017, Mr Gough spent three weeks in hospital after falling and fracturing his hip. In May 2017, he was admitted to hospital following a stroke.

27. In June 2017, he was admitted to hospital again after falling and fracturing his elbow. He was discharged back to Stafford after two weeks, but a few days later he was transferred to HMP Birmingham for nearly a month for 24-hour healthcare before returning to Stafford.

28. Towards the end of 2017, staff became increasingly concerned about changes in Mr Gough's behaviour - he behaved inappropriately to female nurses, urinated and soiled himself inappropriately, and deliberately put himself on the floor on occasions. A CT scan showed some brain damage. On 17 September, a prison GP examined him and referred him to a consultant in older age psychiatry.

29. In September, prison staff completed an application for early release on compassionate grounds. However, he was considered to be at high risk of

reoffending due to repeated inappropriate behaviour towards female staff throughout his sentence.

30. On 2 October, wing officers found Mr Gough lying on his cell floor. After examining him, healthcare staff sent him to the Accident and Emergency Department of County Hospital, Stafford, where he was admitted as an inpatient. A few days later Mr Gough was transferred to Royal Stoke University Hospital. Doctors diagnosed cholecystitis, an inflammation of the gall bladder often caused by gallstones blocking the main opening. Mr Gough declined to have his gall bladder removed and the doctors were concerned about the high risks of surgery, so they inserted a biliary drain. He also contracted sepsis during his admission. Prison healthcare staff kept in touch with the hospital and a nurse telephoned frequently to discuss potential discharge arrangements and the level of support that would be required.

31. Mr Gough was due to be discharged from hospital on 28 October. However, Stafford was unable to accommodate him immediately without a social care assessment, as his physical and mental health needs had increased significantly since his admission and a nurse considered he would need an extended care package. He was eventually discharged on 16 November. After a further period in hospital from 23 November, Mr Gough was discharged to HMP Dovegate on 5 December (where he remained until 30 January 2018).

32. On 19 December, a forensic psychiatrist assessed Mr Gough and concluded that he almost certainly had vascular dementia and further cognitive decline was inevitable. She considered that if he lived in the community he would probably have been given a place in a nursing home with input from physical and mental health professionals. She noted that Mr Gough's mental capacity was decision specific, would vary with time and required continual assessment.

33. Healthcare staff at Stafford continued to monitor and address Mr Gough's health needs and external carers assisted with social care. Care plans and a safeguarding action plan were in place.

34. On the morning of 22 May 2018, Mr Gough was found lying on the floor of his cell. Paramedics attended, but they did not take him to hospital. He remained unwell and, later that day, a prison GP sent him to the Accident and Emergency Department at County Hospital. He was admitted as an inpatient and was later transferred to Royal Stoke University Hospital. No restraints were used for the journey, or during Mr Gough's stay in hospital.

35. Hospital doctors found that Mr Gough had a small bowel obstruction. Healthcare nurses frequently telephoned the hospital for updates and to plan for his discharge from hospital. They also visited him.

36. Mr Gough's condition worsened and he was placed on palliative and end of life care. On 11 May, the prison began another application for early release. However, before this was finalised Mr Gough died, at 10.45pm on 14 May.

Contact with Mr Gough's family

37. On 16 March 2018, the prison assigned an officer and supervising officer as family liaison officers. Over the next few months, they updated Mr Gough's

family on his condition, arranged for healthcare staff to speak to them directly and facilitated visits in rooms with better access and facilities than the prison's visits hall.

38. After Mr Gough's death, a prison manager immediately notified his daughter. The prison's family liaison officers provided additional support in the following weeks. In line with national guidance, the prison contributed to the costs of Mr Gough's funeral, which was held on 16 July.

Support for prisoners and staff

39. A prison manager went to the hospital to debrief the escort officers and to offer support. The staff care team also offered support.

40. The prison posted notices informing staff and other prisoners of Mr Gough's death, and offering support. A nurse informed key healthcare staff and Mr Gough's social worker. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm, in case they had been adversely affected by his death.

Post-mortem report

41. The report of the post-mortem examination concluded that the cause of Mr Gough's death was:

    1a: Cholecystitis with peritoneal inflammation and small and large bowel dilatation.

    1b: Gallstones.

42. The pathologist commented that Mr Gough's death was due to sepsis secondary to acute cholecystitis caused by gallstones and his fall on 22 May, that had led to his admission to hospital, had not caused or contributed to his death.

Findings

Clinical care

43. The review of Mr Gough's clinical care found that prison GPs and nurses assessed him frequently and provided appropriate medication, as well as access to secondary care when required. They also arranged a comprehensive social care package and mobility aids. During admissions to hospital, a prison nurse made great efforts to ensure that Mr Gough's needs would be adequately addressed following his discharge. The clinical reviewer noted however that, if Mr Gough had been in the community, he would probably have been cared for in a nursing home with 24-hour support.

44. We agree with the clinical reviewer that Mr Gough's care at Stafford was mostly equivalent to that which he could have expected to receive in the community.

45. The clinical reviewer found some weaknesses in the handling of issues unrelated to Mr Gough's cause of death, particularly in relation to some deficiencies in continuity of care when Mr Gough transferred between prisons. He made recommendations in his review that we have not repeated in this report, but which the Head of Healthcare will wish to address.

46. The clinical reviewer also found what appeared to be gaps in service provision at Stafford in relation to falls prevention and dementia services. Although this did not contribute directly to Mr Gough's death we make the following recommendation:

    NHS England commissioners should assure themselves that prisoners at HMP Stafford have access to the Falls Prevention Team and to dementia services.

47. More generally, we question whether Stafford was the right location for Mr Gough. He was an elderly man with reduced mobility and multiple health problems, including dementia. He required significant help with personal care and when he fell it took two to four people to lift him. In the last 18 months of his life he had frequent falls, some resulting in fractures, and spent significant periods in hospital and at other prisons where he was able to receive 24-hour healthcare. These frequent moves were not ideal for a confused and unwell man.

48. This is one of a number of investigations we have carried out in the last year into the deaths of elderly and chronically unwell prisoners at Stafford which have led us to question whether Stafford should have 24-hour healthcare given the nature of its population. We, therefore, make the following recommendation:

    The Governor, the Prison Group Director for the West Midlands and NHS England should review the Health Needs Assessment at Stafford to ensure that healthcare provision meets the needs of an increasingly elderly population.

Record keeping

49. On 15 June, the day after Mr Gough's death, a nurse recorded information in his medical record relating to events in April and May 2018. She highlighted that

they were retrospective entries and explained that she had made them after collating emails relating to Mr Gough’s case. We are satisfied that no impropriety was intended, but it is important that staff update records promptly after an action or event. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff fully adhere to the requirement to record events contemporaneously, in accordance with the required standards of the Nursery and Midwifery Council and the General Medical Council.

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