Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Kenneth Jones a prisoner at HMP&YOI Guys Marsh on 1 June 2017

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.

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 Kenneth Jones died on 1June 2017 of heart failure at HMP Guys Marsh. He was 78 years old. We offer our condolences to Mr Jones' family and friends.

Mr Jones had severe cardiac issues and suspected cancer. From May 2015, Mr Jones refused almost all appointments and it was difficult to diagnose or treat his conditions. Prison healthcare staff established that he had capacity to make these decisions and did their best to persuade him to engage with specialists.

We are satisfied that despite the challenges he presented, the care Mr Jones received was equivalent to that which he could have expected to receive 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.

Elizabeth Moody
Acting Prisons and Probation Ombudsman **December 2017**

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Summary

Events

1. On 21 July 1988, Mr Kenneth Jones was sentenced to life imprisonment for murder and was sent to HMP Full Sutton**.** He was transferred to HMP Guys Marsh on 9 February 2012. Mr Jones had a history of heart issues and mental health problems, and periodically refused to engage with prison healthcare and hospital staff. He had cardiac stents inserted in August 2014 but frequently refused appointments and medication for his medical conditions.

2. On 30 April 2015, after his admission to Accident and Emergency (A&E) for abdominal pain, doctors diagnosed Mr Jones with cardiomegaly (enlarged heart), worsening heart failure and fast atrial fibrillation (irregular heart beat). The prison's mental health team asked a GP to complete a capacity assessment because Mr Jones had refused to be admitted to hospital for full investigations. Healthcare staff assessed him between May and August and concluded that he had capacity to make decisions about his medical care and treatment.

3. On 20 May, a prison GP saw Mr Jones as he raised a number of complaints. The GP noted he also had a very hoarse voice. She referred him to an ENT (ear, nose and throat) specialist and, during a hospital admission on 30 May for atrial fibrillation, Mr Jones saw the ENT specialist. The specialist suspected a malignancy in his throat area. Mr Jones could not tolerate a procedure to investigate further and from this point onwards he refused to attend the majority of his appointments.

4. Mr Jones' condition deteriorated but he remained challenging and uncompromising despite staff's best efforts to engage with him and encourage appointment attendance.

5. On 1 June 2017, at approximately 2.15pm, a prison GP saw Mr Jones on the wing and noted that his condition had deteriorated sufficiently to merit non-urgent admission to hospital that day. Half an hour later, an officer found Mr Jones unresponsive in his cell. The officer's radio could not connect to the network so he used the wing phone to call healthcare for assistance. Nurses and other healthcare staff attended the scene immediately and escalated the ambulance request to 'urgent'. They attempted resuscitation but were not successful. On arrival, paramedics declared at 3.15pm that Mr Jones had died.

Findings

6. The clinical reviewer found that the care Mr Jones received was equivalent to that which he could have expected to receive in the community. Despite his challenging presentation, staff remained alert to his capacity to make decisions about his medical care. The prison took reasonable steps to inform Mr Jones' family of his death.

7. An officer was unable to call an emergency code over the radio because he was in a prison ‘dead spot’, which meant that the radio could not connect to the network and so had to call healthcare for assistance over the phone.

Recommendation

- **The Governor should review the effectiveness of the radio network to ensure that staff can communicate appropriately in an emergency.**

The Investigation Process

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

9. The investigator obtained copies of relevant extracts from Mr Jones' prison and medical records.

10. NHS England commissioned a clinical reviewer to review Mr Jones' clinical care at the prison.

11. We informed HM Coroner for Bournemouth and Poole Eastern District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

12. The investigator contacted Mr Jones' brother to explain the investigation and to ask if he had any had any matters he wanted the investigation to consider. He did not raise any concerns.

13. Mr Jones' family were informed the initial report was available, but did not wish to receive a copy or make any comment.

14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Guys Marsh

15. Guys Marsh is a medium security prison that at the time of Mr Jones' death held up to 579 men. Dorset University Healthcare Foundation Trust provides primary and secondary mental healthcare and has commissioned another agency, EDP, to provide integrated substance misuse services. Healthcare is open at weekdays and weekends from 8.30am to 6.00pm and there a duty doctor is available Saturday mornings.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Guys Marsh was in December 2016. Inspectors found that overall, they were very disappointed with what they found and that Guys Marsh had not improved greatly since their last visit. As before, however, they found healthcare to be largely good although they noted some problems with the supervision of the pharmacy hatch which created opportunities for diversion and violence.

Independent Monitoring Board

17. 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 November 2016, the IMB noted that a lack of staff had seriously inhibited the prison's ability to work properly. The board reiterated previous concerns about the availability of drugs and the knock on effects such as debt and psychosocial impacts.

Previous deaths at HMP Guys Marsh

18. Mr Jones is the third natural cause death at Guys Marsh since the beginning of 2015. There are no similarities with those cases.

Key Events

19. On 21 July 1988, Mr Kenneth Jones was sentenced to life imprisonment for murder and was sent to HMP Full Sutton**.** He spent time in several establishments and was transferred to HMP Guys Marsh on 9 February 2012. Mr Jones had a history of heart issues and mental health problems. He regularly refused to engage with prison healthcare staff and hospitals. Mr Jones had cardiac stents inserted in August 2014.

20. On 30 March 2015, Mr Jones saw a prison GP and asked him for a whole body scan and X-ray. He reported a number of symptoms and the doctor thought he might have oesophagitis (an upper respiratory tract infection) or shortness of breath related to tachycardia. The GP referred Mr Jones to the radiology service and an appointment was scheduled for 9 April 2015. The results from the body scan and x-ray showed that although his heart was significantly enlarged, his lungs were clear.

21. On 23 April, Mr Jones saw a prison GP. He told her his shortness of breath was getting worse and had pain in his right upper quadrant. She noted that he appeared to be losing weight. Mr Jones agreed to have some blood tests and a nurse completed the tests the next day. The results did not identify any problems.

22. On 30 April, Mr Jones went to A&E with abdominal pain. He refused hospital admission to investigate the full reasons for it. He was diagnosed with cardiomegaly (enlarged heart), worsening heart failure and fast atrial fibrillation (irregular heartbeat). His case was discussed at a mental health multi disciplinary team meeting at the prison and the team felt a GP needed to complete a capacity assessment.

23. The capacity assessment started in May and concluded in August 2015. A prison GP and the mental health team decided that Mr Jones did have capacity to make decisions and that, even though his health was declining, it was his wish not to comply with medical advice, which they should not override.

24. On 20 May, a psychiatrist noted in Mr Jones' records that he lacked some insight, and the results of a scan showed an excess of fluid on his stomach and lungs. Mr Jones refused to accept these results and believed that he had an abscess or rupture. The psychiatrist also noted that Mr Jones had a hoarse voice. Mr Jones saw a prison GP later that day and she made a referral for him to see an ear, nose and throat (ENT) specialist.

25. On 30 May, Mr Jones was admitted to A&E with atrial fibrillation and stayed in hospital for 11 days. He saw an ENT specialist who attempted a nasendoscopy (a minute scope which looks at the soft palate and inside the nose), but Mr Jones could not tolerate it. He refused subsequent appointments until doctors carried out the procedure on 11 September. The results suggested a likely malignancy.

26. For the next 21 months, Mr Jones refused to attend hospital appointments relating to heart issues and suspected cancer. He attended one appointment but staff removed him from the clinic due to his aggressive behaviour. At times, he engaged with healthcare staff but there were also instances of difficult and threatening behaviour.

27. On 22 May 2107, a nurse attempted to formulate a care plan for Mr Jones. Although he was pleasant, he would not let her take any observations or carry out any assessments. He decided he wanted a cancer specialist to visit him at the prison and she noted that he had almost completely lost his voice. She tried to persuade him to go to hospital to see a specialist and, although he said that he would, she was doubtful he would commit to this. She spoke to a prison GP about the matter and they made a fast track referral.

28. On 28 May, a nurse saw Mr Jones on the wing as he reported he was having trouble breathing. He insisted he was coughing up bits of heart but she tried to reassure him he was not and, after he refused to let her examine him, she booked a GP appointment.

29. On 31 May, Mr Jones saw a nurse for review. She noted he was wheezing but he refused admission to A&E.

1 June 2017

30. On 1 June, at 2.16pm, a prison GP saw Mr Jones on the wing with a nurse and noted that he was barely audible when he spoke, grey in pallor and wheezing at a high pitch. He thought Mr Jones had deteriorated significantly and was probably nearing the end of his life. The nurse later phoned for a non-urgent ambulance for Mr Jones.

31. At 2.45pm, an officer went into Mr Jones' cell to check on him. Mr Jones was sitting up in bed but did not respond at all when the officer called his name and gently shook his shoulders. The officer called an emergency code blue twice (an emergency code blue indicates that a prisoner is unconscious or having difficulties breathing) but was concerned the call had not transmitted properly. He ran to the wing's phone and called healthcare. An assistant practitioner and paramedic took the call and he, along with two nurses took the emergency bag to the scene. A nurse had been on the phone to the Ambulance Service when the emergency call came through, and asked them to upgrade her previous request to urgent status.

32. On arrival healthcare staff checked for signs of life but there were none. They started manual CPR (cardio pulmonary resuscitation – a life saving technique) and used a defibrillator (a medical device that gives electric shocks) to try to resuscitate Mr Jones. The defibrillator did not advise that the team shock Mr Jones so they continued with manual CPR and ventilated him via an oxygen cylinder and mask. At approximately 3.00pm, a prison GP and an assistant practitioner arrived and helped, but Mr Jones did not respond. Paramedics arrived at 3.15pm and declared that Mr Jones had died.

Contact with Mr Jones' family

33. The prison appointed a Family Liaison Officer (FLO) to notify Mr Jones' next of kin, his brother, of his death. At 5.10pm, she contacted HMP Berwyn to request that they deploy a FLO to visit Mr Jones' brother in North Wales, given the distance from Guys Marsh to his address. Because of staffing issues, HMP Berwyn could not help until the next day. The FLO contacted North Wales Police for assistance. When police arrived at the address, Mr Jones' sister in law told

the police that Mr Jones' brother had also recently died, and she gave the police the address of Mr Jones' other brother. There was no reply at the alternative address when police visited at 8.15pm, and neighbours were unable to help further.

34. On 2 June at 9.30am, the FLO telephoned Mr Jones' sister in law to confirm the address she had given police and to establish that it was correct; she also obtained Mr Jones' brother's mobile phone number. She spoke to Mr Jones' brother at 11.10am, although family members had already told him that Mr Jones had died. She stayed in contact to offer advice and support.

35. Mr Jones' funeral was held on 5 July and a FLO attended, along with three members of the chaplaincy. The prison contributed to the costs of the funeral in line with national guidance.

Support for prisoners and staff

36. After Mr Jones' death, a prison manager 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.

37. The prison posted notices informing other prisoners of Mr Jones' 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 Jones' death.

Post-mortem report

38. The coroner concluded that the cause of Mr Jones' death was 1a) ischaemic heart disease, 1b) coronary artery atherosclerosis, and 2) laryngeal cancer.

Findings

Clinical care

39. The clinical reviewer found that the care Mr Jones received was equivalent to that which he could have expected to receive in the community. Two prison GPs referred Mr Jones to specialists when he exhibited concerning symptoms (in April and May 2015). Mr Jones' challenging behaviour and subsequent refusal to attend appointments meant that a full understanding of his illnesses and the stage to which they had progressed was hard to establish and treat.

40. Staff remained mindful of Mr Jones' mental state and his capacity to make decisions. They satisfied themselves that his decisions to refuse appointments and sometimes medication were within his capability.

The Emergency Response

41. PSI 03/2013 'Medical Emergency Response Codes' states that Governors must ensure that emergency protocols enable staff to clearly and concisely convey the nature of the medical emergency simultaneously to all interested parties and contact the communication or control room.

42. When an officer found Mr Jones unresponsive in his cell, he attempted to call an emergency code over the radio but the radio would not connect to the network. He ran to a phone on the wing to call for assistance. A nurse was already ordering the non-urgent ambulance at the time and, on hearing what had happened, she asked emergency services to consider the request urgent.

43. It is not unusual for prisons to have dead spot areas where radios do not work. The officer took reasonable action in telephoning from the wing office to get Mr Jones appropriate assistance and the nurse arranged for the ambulance to be sent urgently.

44. While we are satisfied with the officer's actions, even a short delay can have a significant impact on a person's chance of survival. We make the following recommendation:

The Governor should review the effectiveness of the radio network to ensure that staff can communicate appropriately in an emergency.

Family Liaison

45. Although it is a policy requirement that prisons send a representative to visit the next of kin in person and promptly, we appreciate that the recent death of the next of kin and difficulty in finding an alternative relative meant that it was difficult to deliver the news of Mr Jones' death in a timely manner. We are satisfied that the prison took reasonable steps to inform Mr Jones' family of his death.

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