

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Thomas Curley a prisoner at HMP Preston on 10 March 2018

A report by the Prisons and Probation Ombudsman

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*



© Crown copyright 2017

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

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 Thomas Curley died on 10 March 2018 of frailty at HMP Preston. He was 78 years old. I offer my condolences to Mr Curley's family and friends.

Mr Curley was an elderly, frail man with multiple chronic conditions. He spent his first five years in prison custody at HMP Wymott before being moved to Preston for palliative care after failing to respond to treatment for pneumonia. The clinical reviewer found that Mr Curley's health needs were assessed and reviewed regularly and that he received good, supportive palliative care at Preston.

I am satisfied that Mr Curley received care 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

September 2018

Contents

Summary	1
The Investigation Process	2
Background Information	3
Key Events	5
Findings.....	8

Summary

Events

1. Mr Thomas Curley received an 18-year prison sentence in February 2013 and was sent to HMP Wymott. He had a history of poor health and very poor mobility. Healthcare staff at Wymott created care plans to manage his medical conditions, nutritional needs and mental health.
2. On 18 January 2018, Mr Curley had a hip operation. Hospital doctors said that prison staff should consider moving him to the regional inpatient unit at HMP Preston where healthcare staff could monitor his complex clinical needs. Due to a lack of available beds, Mr Curley was returned to Wymott on 16 February.
3. On 17 February, Mr Curley fell over in his cell. He was admitted to hospital and treated for pneumonia. He did not respond to treatment and on 2 March, was moved to Preston for palliative care.
4. Healthcare staff provided Mr Curley with end of life care and he died at 7.16pm on 10 March.

Findings

5. The clinical reviewer found that Mr Curley received a good standard of clinical care at Wymott and Preston. Healthcare staff appropriately assessed his clinical needs and sought advice from the community palliative care specialist to manage his end of life care.
6. We are satisfied that Mr Curley's care was equivalent to that which he could have expected to receive in the community.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Preston informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
8. The investigator obtained copies of relevant extracts from Mr Curley's prison and medical records.
9. NHS England commissioned a clinical reviewer to review Mr Curley's clinical care at the prison.
10. We informed HM Coroner for Lancashire County Council of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.
11. The investigator wrote to Mr Curley's sister to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.
12. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out a factual inaccuracy and this report has been amended accordingly.

Background Information

HMP Preston

13. HMP Preston is a local prison holding up to 811 adult men. Lancashire Care Foundation Trust provided healthcare services at the prison. On 1 April 2017, Spectrum CIC took over healthcare services. There is an inpatient unit for up to 30 prisoners, which is used as a regional facility, including for end of life care.

HMP Wymott

14. HMP Wymott is a medium secure prison holding over 1,100 adult men. Lancashire Care NHS Foundation Trust provides healthcare services at the prison. A private company provides GP services and out of hours medical cover. There are no inpatient beds, but there is 24-hour nursing cover.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Preston was in March 2017. Inspectors noted that health care provision had deteriorated. Care for prisoners with long term conditions was inconsistent and care plans were inadequate. Inspectors found that the standard of care on the inpatient unit was generally good.
16. The most recent inspection of HMP Wymott was in October 2016. Inspectors reported that the wing for older prisoners and those with disabilities provided excellent care. The healthcare department gave good care, although medication issues undermined this. The relationship with local hospitals was good.

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.
18. In its latest annual report for HMP Preston, for the year to 31 March 2017, the IMB reported that despite poor staffing, the healthcare team had continued to make valiant efforts to maintain an effective healthcare service, including healthcare assessment as part of prisoner induction. Inpatient care was available according to clinical need and was supported by the prison service where the prisoner needed a two or three-man unlock.
19. In its latest annual report for HMP Wymott for the year to 31 May 2017, the IMB reported that the provision of healthcare fell woefully short of the statutory duty to provide a standard equivalent to that outside the prison. The Board noted that in 2016, the Care Quality Commission rated it as highly unsatisfactory. Although the Board reported some improvements in the second half of the last reporting period, these had not been sustained and in fact there has been a regression in many areas.

Previous deaths at HMP Preston

20. Mr Curley was the ninth prisoner to die at Preston since March 2015. He was the eighth prisoner to die from natural causes and one took his own life. There were no similarities between Mr Curley's death and previous deaths at Preston.

Key Events

Background

21. On 25 February 2013, Mr Thomas Curley was sentenced to 18 years in prison for sexual offences and sent to HMP Wymott.
22. Mr Curley had a history of poor health which included chronic obstructive pulmonary disease (COPD – a collection of lung diseases including chronic bronchitis and emphysema), hypertension, non-Hodgkin lymphoma (a blood cancer that affects a type of white blood cell) which did not require treatment, hip and knee replacements and multiple pulmonary embolisms. He had very poor mobility and walked with the aid of two crutches. He used a wheelchair when he went outside. Nurses created care plans to manage his medical conditions, nutritional needs and mental health. He was regularly monitored by the prison's mental health in-reach team, social care team and received physiotherapy to help with his declining mobility.
23. Mr Curley regularly attended appointments to monitor his medical conditions. He was admitted to hospital on six occasions for infections and deteriorating health. On several occasions, he made threats to self-harm because he could not cope with his poor health. Prison staff monitored him under the Assessment, Care in Custody and Teamwork (ACCT) process and he received regular support from the prison's mental health team.
24. On 30 December 2017, a nurse saw Mr Curley in his cell. She noted that he had influenza and his oxygen saturation level was 73% (low). She gave him oxygen which increased his saturation level to 94%. He had an irregular pulse and his blood pressure was high (157/98). She arranged for an emergency ambulance to take him to hospital. Two prison officers accompanied him and did not use restraints. The prison's family liaison officer contacted Mr Curley's sister and told her Mr Curley was in hospital.
25. On 2 January, Mr Curley told the prison bedwatch officers he felt depressed about his poor health. Prison staff monitored him under the ACCT process.
26. Hospital doctors diagnosed a respiratory infection and treated Mr Curley with intravenous fluids and antibiotics. On 18 January 2018, he was moved to another hospital for a hip operation. The hospital social care team assessed Mr Curley on 19 January and noted his short-term memory was poor. Mr Curley said he had a prisoner 'buddy' at Wymott who provided help and support.
27. On 2 February, a hospital nurse told a prison nurse that Mr Curley needed a speech and language assessment because he had difficulty swallowing. He was also nil by mouth due to the high risk of developing aspiration pneumonia. Hospital doctors decided Mr Curley should remain in hospital and considered for discharge to the regional inpatient unit at HMP Preston for continuous monitoring of his complex medical needs.
28. A speech and language assessment took place on 8 February and recommended that Mr Curley needed a soft diet. Because Preston did not have an available bed, Mr Curley was returned to the older prisoners' wing at Wymott

on 16 February. Nurses monitored Mr Curley every 15 minutes and noted he appeared confused and frail.

29. On 17 February, Mr Curley fell over in his cell. A nurse assessed him and noted that Mr Curley was conscious, his blood pressure was 105/ 70 (normal) and his oxygen saturation level was 94% (slightly low). He arranged for an emergency ambulance to take Mr Curley to hospital. Two officers went with him and did not use restraints. The family liaison officer contacted Mr Curley's sister and told her Mr Curley was in hospital again.
30. Hospital doctors diagnosed pneumonia (swelling of lung tissue caused by infection) and treated Mr Curley with intravenous fluids and antibiotics. Mr Curley did not respond to treatment and hospital doctors decided he should receive end of life care. Mr Curley's sister visited him in hospital and agreed with the hospital doctors that Mr Curley should not be resuscitated if his heart or breathing stopped.

HMP Preston

31. On 2 March 2018, Mr Curley was moved to the regional bed inpatient unit at Preston for palliative care. He was still considered a Wymott prisoner. A nurse completed Mr Curley's initial health screen and noted his medical conditions and prescribed medication. This included morphine for pain relief. Nurses created an end of life care plan to ensure that Mr Curley remained comfortable and pain free. It was noted that Mr Curley was being monitored under the ACCT process.
32. On 3 March, a nurse saw Mr Curley and noted that he was frail and had lost a lot of weight. Prison managers stopped ACCT procedures because Mr Curley did not express any intent to self-harm when he arrived at Preston. Prison and healthcare staff frequently monitored Mr Curley in the inpatient unit.
33. On 4 March, a nurse gave Mr Curley Oramorph (liquid morphine) because he could not swallow tablets. Prison and healthcare staff adopted an open-door policy to enable staff to enter Mr Curley's cell easily. Nurses gave Mr Curley a sedative when he became agitated and contacted a hospice for advice and support.
34. Nurses continued to monitor Mr Curley in accordance with his care plans. On 7 March, nurses increased his observations to hourly. A community palliative care nurse advised the use of a syringe driver to administer Mr Curley's pain relief medication.
35. On 9 March, a nurse noted that Mr Curley continued to refuse oral fluids. He remained settled and did not complain of pain.
36. On 10 March, a prison GP saw Mr Curley and noted that he appeared comfortable. Mr Curley did not respond to healthcare staff during the day and he died at 7.16pm.

Contact with Mr Curley's family

37. On 19 January, Wymott appointed a chaplain as the family liaison officer. On 30 December 2017, he telephoned Mr Curley's sister, his nominated next of kin, and told her Mr Curley was in hospital.
38. When Mr Curley went to hospital again on 17 February 2018, the family liaison officer arranged for Mr Curley's sister to visit him in hospital. Mr Curley's sister asked to be informed of Mr Curley's death by telephone.
39. At 8pm on 10 March, the family liaison officer telephoned Mr Curley's sister and informed her of Mr Curley's death. He remained in contact with Mr Curley's sister until Mr Curley's funeral on 4 April. The prison contributed to the funeral costs in line with national instructions.

Support for prisoners and staff

40. After Mr Curley's death, a prison manager debriefed the staff involved in Mr Curley's care to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
41. Both Preston and Wymott posted notices informing other prisoners of Mr Curley's death. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Curley's death.

Cause of death

42. The Coroner accepted the cause of death provided by a prison GP at HMP Preston and decided that a post-mortem examination was not required. The GP gave the cause of death as frailty.

Findings

Clinical care

43. Mr Curley was an elderly, frail man with a history of poor health, reduced mobility and multiple chronic conditions. The clinical reviewer considered that healthcare staff assessed and reviewed his clinical needs appropriately.
44. After Mr Curley developed pneumonia in hospital after a hip operation, he was moved to HMP Preston for end of life care. Healthcare staff sought advice from a community palliative care specialist to ensure Mr Curley was comfortable and pain free. The clinical reviewer found many examples of good, supportive clinical care by healthcare staff.
45. We agree with the clinical reviewer that Mr Curley's care was equivalent to that which he could have expected to receive in the community.

**Prisons &
Probation**

Ombudsman
Independent Investigations