Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Hardy a prisoner at HMP Swaleside on 31 March 2019

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 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.

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 David Hardy died in hospital on 31 March 2019 from bronchopneumonia and heart failure while a prisoner at HMP Swaleside. He was 75 years old. I offer my condolences to those who knew him.

The clinical reviewer found that the standard of care Mr Hardy received at Swaleside was good and was equivalent to that he could have expected to receive in the community.

However, about four months before Mr Hardy's death, a prison manager refused a request by healthcare staff for Mr Hardy to be taken to hospital. I am satisfied that Mr Hardy was taken to hospital the following day and that the delay did not contribute to his death, but I am concerned that the decision-making process was not properly recorded.

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 **September 2019**

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Summary

Events

1. On 19 January 1998, Mr David Hardy was sentenced to life imprisonment for murder. On 18 April 2002, he was moved to HMP Swaleside.

2. In November 2018, Mr Hardy developed a foot ulcer. Despite the healthcare team's best efforts to explain the consequences of refusing treatment (infection and possible amputation), Mr Hardy frequently declined care and medication. Mental health staff assessed he had the mental capacity to make decisions about his treatment.

3. In December, Mr Hardy required treatment in hospital after he fell out of bed. He was briefly discharged to HMP Elmley but returned to Swaleside at the beginning of January 2019. He was admitted to hospital again in mid-January after a fall, and in February he was moved to a larger, better equipped prison cell.

4. At the beginning of March, Mr Hardy's health seriously deteriorated. He was shivery, passing black stools caused by a bleed in his stomach, and required a blood transfusion. He was discharged after three days after refusing all further treatment.

5. In mid-March, Mr Hardy was readmitted to hospital with an infection secondary to his foot ulcers. He was not considered fit for an amputation operation, even if he had consented. Mr Hardy continued to deteriorate and died in hospital on 31 March.

6. The post-mortem report concluded that Mr Hardy died from bronchopneumonia and heart disease. Foot ulcers were a contributory factor.

Findings

7. The clinical reviewer was satisfied that the care Mr Hardy received at Swaleside was equivalent to that he could have expected to receive in the community. Staff monitored his condition, referred him to secondary care when appropriate and assessed his capacity to refuse treatment.

8. We are, however, concerned that there is no record of the decision-making process when a prison manager refused to send Mr Hardy to hospital at the request of nurses in December 2018. Mr Hardy went to hospital the next day and we are satisfied that the delay did not contribute directly to his death. However, we consider that the prison manager and healthcare staff should have documented the reasons for his refusal.

Recommendations

- The Governor and Head of Healthcare should ensure that a record is made of the decision-making process in any case where prison staff do not agree to a request by healthcare staff for a prisoner to be taken to hospital.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Swaleside 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 Hardy's prison and medical records.

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

12. We informed HM Coroner for Mid Kent and Medway District of the investigation. The coroner gave us the results of the post-mortem. We have sent the coroner a copy of this report.

13. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out one factual inaccuracy and this report has been amended accordingly.

Background Information

HMP Swaleside

14. HMP Swaleside, which is on the Isle of Sheppey, is part of the Long-Term and High Security estate. It houses up to 1,112 men. IC24 Integrated Care provides primary healthcare at Swaleside. There is 24-hour nursing cover, which includes a qualified nurse and a health care assistant at night. Minster Medical Group provides GP cover from 9.00am to 5.00pm Monday to Friday, while Medoc provides an out of hours GP service.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Swaleside was in December 2018. Inspectors reported that health services had improved and were reasonably good but a few areas were still concerning. The chronic staffing shortages had started to reduce. The prison's inpatient unit provided good care for patients with complex needs. A lack of escorts led to the cancellation of too many hospital appointments, long delays and risks to prisoners' health.

Independent Monitoring Board

16. 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 they continued to receive complaints about the treatments offered and waiting times for healthcare services. They noted that prison staffing was profiled to provide six escorted visits to hospital a day but demand was much higher, which resulted in many cancelled appointments.

Previous deaths at HMP Swaleside

17. Mr Hardy's was the 14th death at HMP Swaleside since March 2017. Of the previous deaths, nine were from natural causes, three were self-inflicted and one was drug-related. There has been one death since, which was self-inflicted.

18. In our investigation into a previous natural causes death on 1 January 2018, we were concerned that the prisoner was not taken to hospital when a prison paramedic called for an emergency ambulance. We made a recommendation, which the prison accepted, that the Governor and Head of Healthcare should ensure that prison and healthcare staff understand their respective roles and responsibilities in the decision-making process when prisoners need to go to hospital.

Key Events

19. On 19 January 1998, Mr David Hardy was sentenced to life imprisonment for murder and sent to HMP Leeds. On 18 April 2002, he was moved to HMP Swaleside.

20. Mr Hardy had asthma and emphysema (a lung condition). He often declined interventions from the healthcare team.

21. In November 2018, Mr Hardy complained of foot pain. A prison GP assessed him and suspected cellulitis (a painful skin infection). The GP wanted Mr Hardy to go to hospital but he refused to go. He prescribed antibiotics and warned Mr Hardy of the risks of the infection spreading, including sepsis and possible amputation.

22. Healthcare staff monitored Mr Hardy's foot daily but he frequently refused to let them treat him. A mental health nurse assessed Mr Hardy and concluded that he had the mental capacity to make decisions about his treatment.

23. Mr Hardy refused offers of a move to the prison's inpatient unit but on 6 December, he was moved there at the Governor's direction. (Prison managers and healthcare staff considered it would be more difficult to evacuate him from the wing in the event of an emergency.) Mr Hardy did not object.

24. On 7 December, blood tests showed that Mr Hardy had developed diabetes, but he declined to be assessed by a GP.

25. On 9 December, Mr Hardy allowed a nurse to carry out a full set of observations. She was unhappy with the results which she believed were suggestive of sepsis. She thought that Mr Hardy should be taken to hospital. Mr Hardy agreed to go. The manager of the inpatient unit recorded that she spoke to a prison manager, who agreed in principle but said it would have to wait until the next day. The manager of the inpatient unit told the prison manager she was unhappy with this plan and he said he would elevate the matter to the manager in charge of the prison.

26. A nurse took another set of observations. She agreed they were concerning and went to speak to the prison manager herself. She recorded that the manager was adamant Mr Hardy should wait until the next day.

27. On 10 December, Mr Hardy was taken to hospital but discharged himself on 11 December after refusing all treatment offered. The discharge summary said he had an infected foot ulcer, raised blood pressure indicative of diabetes and that he had been advised of the risks associated with self-discharge.

28. Mr Hardy returned to the prison's inpatient unit and was moved to a room designed for patients with mobility issues. He complied with the move but would not discuss his diabetes or take any antibiotics for his foot ulcer. Staff explained the importance of treatment to him again the following day, but he still refused.

29. On 16 December, Mr Hardy fell out of bed. He was admitted to hospital with pain in his hip and shoulder and both were treated (a collar was applied to his arm and his hip was operated on). An X-ray showed evidence of a serious bone

infection in his left foot and he accepted intravenous antibiotics. He refused further antibiotics and physiotherapy.

30. On 21 December, Mr Hardy was discharged to HMP Elmley. Elmley had beds with rails and the nurse manager at Swaleside was worried about him falling out of the Swaleside bed and causing himself further injury in the early stages of his healing. He did not always take his medication and he became incontinent of faeces and urine. He continued to decline most attempts to treat him.

31. On 4 January 2019, Mr Hardy was moved back to Swaleside. Staff continued to monitor and treat him daily, and reminded him that he could have his foot treated in hospital.

32. On 11 January, Mr Hardy fell from his bed in the early hours of the morning. He allowed staff to clean him and his clinical observations were normal.

33. Mr Hardy's condition gradually deteriorated. He seemed confused, had continence issues and his wound got worse.

34. On 16 January, a psychiatrist assessed Mr Hardy's mental capacity. He concluded that Mr Hardy was not depressed and showed no mental impairment or illness. He assessed that Mr Hardy was fully capable of making decisions about his treatment.

35. On 18 January, Mr Hardy was admitted to hospital having fallen the day before. He agreed to go, and his foot was also examined. The hospital discharged him on 19 January with a course of antibiotics.

36. On 3 February, Mr Hardy had another fall in his cell and was taken to hospital. He was discharged the next day.

37. On 8 February, an occupational therapist assessed Mr Hardy. The next day, Mr Hardy was moved to a larger cell with an air mattress on the bed and bed rails.

38. On 12 February, a prison GP and nurses spoke again to Mr Hardy about the importance of him accepting treatment and medication (he had declined to attend for an MRI scan on his foot). The GP explained that the MRI would help to see whether the infection in his foot had spread to the bone and whether amputation should be considered. The GP recorded that Mr Hardy understood all the implications of not accepting treatment.

39. On 13 February, a prison GP reiterated the previous advice. Mr Hardy said he would accept pain relief if he needed it, but he would not take antibiotics.

40. On 25 February, healthcare staff were concerned as Mr Hardy seemed less responsive than usual. Paramedics attended but left when Mr Hardy made it clear he would not go to hospital.

41. On 27 February, a psychiatrist carried out another mental health assessment. She concluded that Mr Hardy still had the capacity to make decisions about his treatment.

42. On 1 March, Mr Hardy was admitted to hospital again following days of feeling feverish and then passing black stools (which indicated an internal bleed). He

was given a blood transfusion but refused any further hospital treatment. Restraints were not applied.

43. On 3 March, the hospital discharged Mr Hardy. The prison was concerned about their ability to care for him when he was so seriously ill, but the hospital insisted that as he had capacity (but was refusing their offer of treatment) he must be discharged.

44. On 16 March, Mr Hardy was admitted to hospital after expelling black vomit and becoming shivery and confused. Restraints were not applied. Hospital doctors considered it likely that he had contracted an infection secondary to his foot ulcers. Fluids did not improve his condition and he was not considered suitable for other treatments or fit enough for an amputation even if he had consented. Mr Hardy's deterioration continued and on 31 March at 6.00pm, a hospital doctor recorded he had died.

Contact with Mr Hardy's family

45. On 31 March, the prison appointed a custodial manager as Mr Hardy's family liaison officer (FLO). Mr Hardy had said he did not want his family notified of his death and had refused to give any contact details to staff. After Mr Hardy's death, the FLO conducted his own research into Mr Hardy's family but no one could be traced.

46. Mr Hardy's funeral was held on 7 May. The FLO attended and, in line with national policy, the prison paid the costs. A prison manager, a prison chaplain, and an officer attended.

Support for prisoners and staff

47. On 16 November, after Mr Hardy's death, a prison manager visited the hospital and debriefed the escort staff. He told them about the support available from the prison's care team and other avenues of support.

48. The prison posted notices informing other prisoners of Mr Hardy'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 Hardy's death.

Post-mortem report

49. The post-mortem report concluded that Mr Hardy died from bronchopneumonia (inflammation of the lungs), congestive cardiac failure (where the heart is unable to pump blood around the body properly) and coronary artery atheroma (build-up of fatty deposits in the arteries surrounding the heart). Foot ulcers were a contributory factor.

Findings

Clinical care

50. The clinical reviewer concluded that the care Mr Hardy received was equivalent to that he could have expected to receive in the community. He had good access to primary care staff and was assessed promptly and regularly.

51. In the last year of his life, Mr Hardy's mental capacity was assessed by three different psychiatrists who all concluded he had capacity to make decisions about his treatment. A mental capacity care plan was in place to ensure his ability to make decisions was monitored in between formal assessments.

Events of 9 December 2018

52. The clinical reviewer has made a recommendation about the prison's refusal to provide hospital escorts on 9 December 2018, when nurses suspected Mr Hardy had sepsis. The investigator made further enquiries about this.

53. The Head of Healthcare told the investigator that her department had very good relationships with custodial staff and that it was at times genuinely difficult for them to provide escorts. She was confident that where a situation was serious or an absolute emergency, the prison would make the necessary compromises (such as closing a wing) in order to meet healthcare staff's requests. She said that her nurses would have completed a risk assessment setting out their reasons for requesting the escort and security staff would also fill a form in explaining their rationale for agreeing or declining. However, she was not able to provide this documentation.

54. The investigator contacted the prison manager who had declined the nurses' requests for escorts. Initially, he could only remember that he had been told the matter was not an emergency and said that any additional reasons contributing to his decision would be recorded in the observation book. However, no trace of the incident could be found in the observation book. He subsequently told the investigator that he recalled he had no escorts available at all that evening and he had personally told Mr Hardy that he could go to hospital the next day. His opinion was that Mr Hardy was content with the decision.

55. This incident occurred nearly four months before Mr Hardy's death, and was not directly related to it. Furthermore, it does not seem from the discharge summary that Mr Hardy did have sepsis. While we agree with the clinical reviewer that the nurses' entries in the medical record indicate they were very concerned about Mr Hardy's condition, having spoken to the Head of Healthcare we are satisfied that there is not a culture at Swaleside of custodial staff unreasonably over-riding medical opinions.

56. However, we do note that none of the correct paperwork appears to have been completed in relation to this incident, and we make the following recommendation:

The Governor and Head of Healthcare should ensure that a record is made of the decision-making process in any case where prison staff do not agree to a request by healthcare staff for a prisoner to be taken to hospital.

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