

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Mark Smith a prisoner at HMP Kirkham on 26 February 2019

**A report by the Prisons and Probation Ombudsman**

## 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 Mark Smith died in hospital on 26 February 2019 of multiple organ failure, caused by pneumonia and septicaemia, while a prisoner at HMP Kirkham. He was 41 years old. I offer my condolences to Mr Smith's family and friends.

I am satisfied that the standard of care Mr Smith received at Kirkham and at his previous prison, HMP Northumberland, was equivalent to that he could have expected to receive in the community. However, opportunities were missed by healthcare staff at both prisons to use the National Early Warning Score (NEWS) tool, which might have alerted staff earlier to the deterioration in Mr Smith's health.

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 15 January 2018, Mr Mark Smith was sentenced to six years' imprisonment for manslaughter and sent to HMP Preston. He transferred to HMP Northumberland on 22 February 2018.
2. Mr Smith had a long history of drug and alcohol abuse which had left him with a number of physical issues including deep vein thromboses and leg ulcers.
3. On 23 January 2019, Mr Smith reported that he felt unwell. Over the following days he saw nurses, was given paracetamol and referred to a GP. The GP prescribed a course of antibiotics which Mr Smith did not finish.
4. On 29 January, Mr Smith was moved to HMP Kirkham. A nurse at Northumberland assessed him as fit for transfer. When Mr Smith arrived at Northumberland, the reception nurse noted he was coughing and wheezing but he was assessed as suitable for standard location.
5. On 30 January, Mr Smith saw a nurse complaining that he still felt unwell and she referred him to a GP. On 31 January, he saw a GP who noted that Mr Smith's pulse and respiratory rate were high, and his oxygen saturation level was low. He also had the shakes, said he was hot and experiencing chest pain. The GP arranged for Mr Smith to be taken to hospital.
6. Hospital staff initially treated Mr Smith for a respiratory infection and then for pneumonia. His condition deteriorated and by 21 February, hospital staff said he had kidney failure, sepsis (a serious complication of an infection) and endocarditis (heart muscle infection). He continued to deteriorate, and on 26 February, at approximately 11.50am, hospital doctors recorded that Mr Smith had died.

## Findings

7. The clinical reviewer was satisfied the care Mr Smith received at Northumberland and Kirkham was equivalent to that he could have expected to receive in the community. She considered, however, that there were occasions at both prisons where the National Early Warning Score (NEWS) tool should have been used. This might have alerted staff earlier to the deterioration in Mr Smith's health.

## Recommendations

- The Heads of Healthcare at HMP Northumberland and HMP Kirkham should ensure staff know how to use the National Early Warning Score (NEWS) tool and that they use it where appropriate.

## The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Kirkham 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 Smith's prison and medical records.
10. NHS England commissioned a clinical reviewer to review Mr Smith's clinical care at the prison.
11. We informed HM Coroner for Blackpool and Fylde of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
12. One of the Ombudsman's family liaison officers contacted Mr Smith's son, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not respond to her letter.
13. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and, where we agree, this report has been amended.

# Background Information

## HMP Kirkham

14. HMP Kirkham is an open prison in the North West holding over 600 men. There are 25 small residential units with single rooms and a 77-bed admissions unit including reception and a first night centre.
15. NHS England has commissioned Spectrum Community Health CIC to provide health and social care services at the prison since April 2017.

## HMP Northumberland

16. HMP Northumberland is a training prison holding up to 1,348 men, predominately from the North East of England. Sodexo Justice Services manage the prison, G4S provide the primary healthcare services.

## HM Inspectorate of Prisons

### *HMP Kirkham*

17. The most recent inspection of HMP Kirkham was in June and July 2018. Inspectors reported that Kirkham continued to be an effective open prison. Health services and governance were mostly good, as was health promotion, although access to nurse and doctor appointments was too limited. Support for those with palliative care needs was considered excellent and integrated mental health services were also effective.

### *HMP Northumberland*

18. The most recent inspection of HMP Northumberland was in August 2017. Inspectors found that prisoners had good access to GPs and waiting times were low. The Care Quality Commission identified a number of areas where standards fell short and issued 'requirement to improve' notices covering: safe care and treatment and good governance.

## Independent Monitoring Board

19. 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.

### *HMP Kirkham*

20. In its latest annual report, for the year to December 2018, the IMB reported that prisoners were treated fairly and humanely, and most living conditions were good. A mobile health unit, housed at Kirkham, provided health promotion and wellbeing sessions. A pharmacy team was in place including a nurse prescriber who worked with the drug recovery programme.

### *HMP Northumberland*

21. In its latest annual report, for the year to 31 December 2017, the IMB found that the overall quality of healthcare was reasonable. Measures had been put in place to address long-standing concerns about GP waiting times. Feedback from prisoners suggested their experiences of healthcare had improved

### **Previous deaths at HMP Kirkham**

22. Mr Smith was the first prisoner to die at HMP Kirkham since February 2017.

### **Previous deaths at HMP Northumberland**

23. There were seven deaths at HMP Northumberland between February 2017 and February 2019. Three were from natural causes, one was drug related, one was self-inflicted and in one, the cause of death was unascertained. There were no similarities with Mr Smith's case. There have been two deaths at Northumberland since February, both from natural causes.

## Key Events

24. On 15 January 2018, Mr Mark Smith was sentenced to six years' imprisonment for manslaughter and sent to HMP Preston. He transferred to HMP Northumberland on 22 February 2018.
25. Mr Smith had a history of alcohol dependency and intravenous drug use dating back to 1995. He had completed various programmes during previous prison sentences. His drug use had left Mr Smith with a number of physical issues including deep vein thromboses and recurrent leg ulcers.
26. On 23 January 2019, Mr Smith told a counsellor during a counselling session, that he had a temperature and felt unwell. She told him to make an appointment to see a nurse. A nurse gave him paracetamol that day, but there is no record she took any observations.
27. On 24 January, Mr Smith spoke to a nurse at the medication hatch. He told her he thought he had a chest infection and she made him an appointment to see her the next day.
28. On 25 January, Mr Smith saw a nurse. She recorded he had had cold symptoms for four days. She recorded that his temperature was 38.9°C (the average is 37°C), his pulse at 112 beats per minute was high and his oxygen saturation level (at 88%) was low. She referred him to a prison GP but did not calculate his National Early Warning Score (NEWS). The NEWS tool assists with detection of and responses to clinical deterioration.
29. On 25 January, a prison GP saw Mr Smith and recorded he had a productive cough with brown phlegm but no blood. Mr Smith told him he had had the cough for eight days and that he was shaking at night. The prison GP listened to Mr Smith's chest and recorded crackles. He diagnosed a chest infection and prescribed doxycycline (an antibiotic). The NEWS tool was not used on this occasion either but a sputum sample was requested. There is no record that this was collected.
30. On 29 January, Mr Smith was moved to HMP Kirkham. A nurse recorded that he was medically fit to travel, but she recorded no observations or any detail about how she reached that conclusion. The nurse subsequently told the Acting Head of Healthcare that she was satisfied there were no issues of concern.
31. A nurse carried out Mr Smith's reception screen at Kirkham. He recorded that Mr Smith had not completed the course of doxycycline as he said it had been ineffective. Mr Smith had some medication loose in a box with him which was not easily identifiable, so it was taken from him. The nurse also recorded that Mr Smith had a chesty cough and wheezing but declared him fit for normal location.
32. On 30 January, a nurse recorded that Mr Smith had been unwell for two weeks and he complained of a cough and a sore throat. His oxygen saturation reading was low (80%) and he was breathless at rest. The nurse did not use the NEWS tool, but she referred Mr Smith to a prison GP.

33. On 31 January, a prison GP saw Mr Smith. She recorded he had been unwell, had upper central chest pain when he coughed, felt so short of breath it was making him anxious, reported getting the shakes, that his face was very hot, and his cellmate was concerned about his breathing. She recorded his temperature and blood pressure were normal, but his pulse was high (122 beats per minute) as was his respiratory rate (32 breaths per minute). Mr Smith's oxygen saturation reading (82%) was low. The prison GP concluded that Mr Smith's symptoms were consistent with congestive cardiac failure and that he required admission to hospital.
34. Mr Smith was admitted to the hospital that afternoon. As a prisoner in the custody of an open establishment, he was not restrained. One officer accompanied him.
35. Hospital staff treated Mr Smith for a respiratory infection and expected him to be in their intensive care unit for two to three days. By 4 February, the hospital was treating Mr Smith for pneumonia. He was being ventilated and his family had been informed and were visiting.
36. On 8 February, a nurse recorded he had spoken to hospital staff and they said Mr Smith had had a scan which showed no improvement to the consolidation of fluid on his lungs.
37. On 13 February, the Head of Healthcare recorded that hospital staff told her Mr Smith had had a tracheotomy (an opening made into the windpipe to aid breathing) and was expected to stay in the intensive care unit for another week (and hospital for possibly another month). Mr Smith's condition remained delicate and subject to peaks and troughs. Prison healthcare staff frequently contacted hospital staff for updates.
38. On 21 February, a nurse, a prison nurse, visited Mr Smith in hospital. A hospital nurse told her he had acute kidney injury (kidney failure), sepsis and endocarditis (heart muscle infection).
39. By 23 February, hospital staff had placed defibrillator pads in permanent place in case of cardiac arrest and by 25 February he had deteriorated so the hospital had put a DNACPR (do not attempt cardiopulmonary resuscitation) order in place as any CPR attempts would be futile.
40. On 26 February, at approximately 11.50am, hospital doctors recorded that Mr Smith had died.

### **Contact with Mr Smith's family**

41. On 4 February, the prison appointed two officers as the prison's family liaison officers (FLOs). On 4 February, a FLO contacted Mr Smith's named next of kin and met with her on 7 February to explain her role and offer support. The FLOs maintained contact with the family throughout Mr Smith's illness and in the period leading up to his funeral.
42. Mr Smith's funeral was held on 26 March and a FLO and deputy governor attended from the prison. In line with national policy, the prison contributed to the funeral costs.

### **Support for prisoners and staff**

43. After Mr Smith's 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.
44. The prison posted notices informing other prisoners of Mr Smith's death and offering support.

### **Post-mortem report**

45. The post-mortem report concluded that Mr Smith died from multiple organ failure, which had been caused by lobar pneumonia (a type of pneumonia that is characterised by acute inflammation of the entire lobe or lung) and septicaemia (an infection caused by bacteria entering the bloodstream).

# Findings

## Clinical care

46. The clinical reviewer found that the care Mr Smith received at HMP Northumberland and HMP Kirkham was equivalent to that he could have expected to receive in the community. However, she advised wider use of the NEWS tool at both establishments.
47. The clinical reviewer noted that the National Early Warning Score (NEWS) tool was developed to improve the detection and response to clinical deterioration in patients with acute illness. She identified occasions at Northumberland (on 25 January) and Kirkham (30 January) where the NEWS tool should have been used. We make the following recommendation:

**The Heads of Healthcare at HMP Northumberland and HMP Kirkham should ensure staff know how to use the National Early Warning Score (NEWS) tool and that they use it where appropriate.**

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