Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Greensmith a prisoner at HMP Littlehey on 26 January 2019

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*

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 Greensmith died in hospital of pneumonia caused by pulmonary fibrosis (a lung disease) on 26 January 2019 while a prisoner at HMP Littlehey. He also had chronic obstructive pulmonary disease (COPD) which contributed to but did not cause his death. He was 73 years old. I offer my condolences to his family and friends.

When he arrived at Littlehey, Mr Greensmith had several long-term medical conditions. I am satisfied that the care he received was broadly equivalent to that which he could have expected to receive in the community, with some examples of good care.

However, I am concerned that healthcare staff did not accurately use early warning scores to check on his condition and after discussions about Mr Greensmith's resuscitation wishes, they did not communicate this to all relevant staff.

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 **August 2019**

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Summary

Events

1. Mr David Greensmith was recalled to HMP Littlehey in May 2016 for breaching his licence conditions. He had heart disease, high blood pressure, arthritis, osteoporosis, lumbar scoliosis (a curved spine), back pain, a shoulder joint injury and an enlarged prostate. He had had a pacemaker fitted in 2007, heart surgery in 2016. He had limited mobility after a knee replacement and used two walking sticks for short distances and a wheelchair for longer distances.

2. Healthcare staff implemented care plans to manage his conditions. They reviewed him frequently and adjusted his medication. Mr Greensmith's health started to deteriorate over the following months, and he needed palliative care from 28 May 2017.

3. On 18 August 2017, Mr Greensmith signed an order to confirm that he did not want anyone to resuscitate him if his heart or breathing stopped.

4. On 15 January 2019, a nurse examined Mr Greensmith after he reported having trouble breathing at night. She noted that he was pale, sleepy and his breathing was laboured. She heard crackles at the base of both his lungs. His oxygen saturation level was low. She administered oxygen and requested an emergency ambulance. Two officers escorted Mr Greensmith unrestrained to a hospital in Huntingdon, where he died on 26 January.

Findings

5. Mr Greensmith was a frail and elderly man, with a complex medical history and end-stage heart failure. The clinical reviewer concluded that the overall care that Mr Greensmith received at Littlehey was equivalent to that which he could have expected to receive in the community.

6. There were some delays in taking Mr Greensmith's clinical observations and an inconsistent use of the National Early Warning Scores system to monitor his deteriorating health. The clinical reviewer noted that record keeping of Mr Greensmith's observations was poor.

7. Mr Greensmith had several falls. Healthcare staff should have assessed his risk of falls earlier to help prevent them.

8. Staff, including escort staff, were not told that Mr Greensmith had signed an order not to be resuscitated.

Recommendations

- The Head of Healthcare should ensure that clinical staff assess and manage prisoners with deteriorating chronic conditions effectively to enable good standards of care, including that clinical staff:
    - use appropriate assessment and monitoring processes to monitor and record vital signs; and

- receive up-to-date training in using National Early Warning Scores and are aware of the triggers for escalation.

- The Head of Healthcare should ensure that healthcare staff appropriately assess prisoners at risk of falls in line with NICE guidelines and that their assessment is recorded and acted on.
- The Head of Healthcare must ensure that healthcare staff record all relevant information on the medical escort risk assessment form, including information about decisions and orders not to resuscitate prisoners.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Littlehey informing them of the investigation and asking anyone with relevant information to contact her. One prisoner responded with comments about the treatment of older and disabled prisoners at Littlehey generally.

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

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

12. We informed HM Coroner for Cambridgeshire and Peterborough of the investigation. He gave us the cause of Mr Greensmith's death. We have sent the Coroner a copy of this report.

13. The Ombudsman's family liaison officer contacted Mr Greensmith's brother to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond.

14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Littlehey

15. HMP Littlehey is a medium security prison housing approximately 1,200 men. A high proportion of the prison's population are men who have been convicted of sexual offences.

16. Northamptonshire Healthcare NHS Foundation Trust provides healthcare services at the prison. The prison healthcare centre is open on weekdays from 7.30am to 7.30pm, and at weekends from 8.00am to 5.30pm. A local practice provides GP services, and there is a range of nurse-led clinics. There are no inpatient beds at the prison.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Littlehey was conducted in March 2015. Inspectors reported that a small group of GPs who regularly attended the prison had significantly improved patient care. They noted that lifelong conditions were effectively identified and that there was an appropriate range of clinics, led by specialist nurses. They found that hospital appointments for prisoners were rarely cancelled but that risk assessments for allowing prisoners to keep and administer their own medications were not always appropriately reviewed and recorded.

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 January 2018, the IMB reported that the prison's working relationship with the local hospice was positive, enabling men to opt for end-of-life care, where they could be surrounded by family and friends. The IMB had concerns about whether the number of trained Family Liaison Officers was sufficient to deal with the large number of deaths in custody. It reported that the End-of-Life Suite, completed in 2013, continued to be unused due to a lack of funding.

Previous deaths at HMP Littlehey

19. Mr Greensmith was the sixteenth prisoner to die at HMP Littlehey since January 2016, including fifteen who died from natural causes. There has been one death since Mr Greensmith's death which is under investigation. We made a previous recommendation in March 2019 about decisions not to resuscitate prisoners which Littlehey agreed to implement. We are disappointed that this is again an issue in this case.

Key Events

20. On 13 May 2008, Mr David Greensmith was sentenced to twelve years in prison for sexual offences. On 6 May 2016, he was released on licence but was recalled to HMP LIttlehey on 23 May for breaching his licence conditions. Mr Greensmith had several complex medical conditions, including heart disease, high blood pressure, arthritis, osteoporosis, lumbar scoliosis (curved spine), back pain, a shoulder joint injury and an enlarged prostate. He had had a pacemaker fitted in June 2007, heart surgery in March 2016 and had had a knee replacement. He had limited mobility and used two walking sticks for short distances and a wheelchair for longer distances.

21. At an initial health screen, a nurse noted that Mr Greensmith was generally unwell, and needed a lot of medication to manage his conditions. A prison pharmacist reviewed his medications to ensure that he could safely administer them. The pharmacist decided at that time that Mr Greensmith could keep and administer weekly supplies of medication but this position later changed. A prison GP, reviewed him and checked his observations. His blood pressure was low (91/64mmHg), his pulse was normal (81bpm) and his oxygen saturation level was low (94%). He did not arrange for the low readings to be rechecked.

22. Healthcare staff reviewed Mr Greensmith's coronary heart disease annually and regularly took blood samples to monitor his sugar levels, levels of iron in his blood and prostate-specific antigen levels.

23. Mr Greensmith wanted to maintain his independence and had disagreements with healthcare staff about the medications he considered that he should be allowed to keep and administer himself rather than have to collect and take in front of healthcare staff. A prison GP, developed a good rapport with Mr Greensmith and she often talked to him about his care and encouraged him to continue with medication or treatment.

2017

24. During February 2017, nurses frequently saw Mr Greensmith as he said that he felt very ill. On 17 February, a nurse noted that he did not collect his morphine medication as it made him constipated.

25. On 1 March, Mr Greensmith attended his first coronary heart disease review. He told a nurse that he felt terrible and had stopped taking all his pain medications as they blocked his bowels and were not helping. She checked his observations which were all in the normal range, and arranged blood tests. A prison GP reviewed the blood test results and noted that they were normal given his conditions.

26. In May, a nurse reviewed Mr Greensmith and after she discussed his treatment with him, she created a palliative care plan.

27. On the night of 17 August, Mr Greensmith fell in his cell as he tried to get to the toilet. A nurse examined him and noted that he felt very fatigued and unsteady on his feet. She referred him to a prison GP. The prison GP reviewed him but Mr Greensmith denied that he had fallen. He told the prison GP that he wanted to

discuss his pain medication and recurrent knee problems. The prison GP said that she would review his medication when she received an updated hospital letter. There is no further information about this in the records.

28. On 18 August, the palliative care consultant reviewed Mr Greensmith. Mr Greensmith's health had deteriorated further and he signed an agreement to confirm that he would refuse treatment and an order not to be resuscitated if his heart or breathing stopped. The records do not give further information to explain the circumstances in which Mr Greensmith would refuse treatment.

29. In October, Mr Greensmith fell again in his cell. The next day, a nurse examined him and noted no obvious injuries or bruising.

30. On 6 December, Mr Greensmith had his second coronary heart disease review with a nurse. He told her that he felt weak all the time and sometimes confused names and events. She noted that his pulse was irregular and arranged for him to have an electrocardiogram (ECG). A nurse completed the ECG on 18 December and noted that Mr Greensmith had an irregular heart rhythm. She referred him to a prison GP. The prison GP completed the review and noted that the ECG confirmed Mr Greensmith's previous history of heart damage.

2018

31. A nurse completed a falls risk assessment and created a falls prevention plan on 3 January 2018 as Mr Greensmith had fallen in his cell on four occasions since he arrived at Littlehey.

32. In March, Mr Greensmith had periods of constipation and diarrhoea. A prison GP examined him and noted that he had lost 2kg in the past few months. Her assessment concluded that the changes were most likely due to his medication. However, she also discussed the possibility that it could be bowel cancer. With Mr Greensmith's agreement, the prison GP referred him urgently to the colorectal surgery service and the cardiology service at a hospital. A colorectal appointment was made for 12 March. However, Mr Greensmith refused to attend. The appointment was rescheduled for 22 March. Mr Greensmith again refused to attend.

33. On 3 April, a prison GP met Mr Greensmith to find out why he had refused to attend his appointments. Mr Greensmith said that he was sorry and was ashamed for not going. He said his bowels had settled. He admitted that he had fallen during the night as he tried to get to the toilet. He refused a commode and promised to attend any rescheduled appointments. Mr Greensmith told her that he was terrified of leaving the prison. The hospital appointments were rebooked twice but each time, Mr Greensmith refused to attend.

34. On 11 June, a prison GP visited Mr Greensmith in his cell as he had failed to attend hospital appointments about a range of conditions. Mr Greensmith said that he no longer had bowel problems and the prison GP should "do as she felt fit". The prison GP told him that she wanted him to attend his referrals.

35. On 21 June, a palliative care consultant reviewed Mr Greensmith. She noted that his major concern was heart failure but for the last six months, Mr Greensmith had had significant bowel problems as he alternated between

constipation and severe diarrhoea. Mr Greensmith said that his quality of life was poor, he had no dignity and he was severely fatigued. She did not think that Mr Greensmith was fit enough for medical investigations and concluded that he could be at the end stage of heart failure.

36. On 10 July, Mr Greensmith told a prison GP that he had reflected on their discussion the previous month. He said that he had been using tactics for several years to avoid dealing with his health but he just wanted to die. He gave permission for blood tests to check his blood count and the prison GP said that they could discuss how he felt. Mr Greensmith attended his colorectal referral on 17 July, where hospital staff booked him an appointment for a CT scan.

37. A prison GP reviewed Mr Greensmith on 11 and 12 September after she established that his CT scan results were normal. She said that he should consider if he wanted to be referred for spinal surgery as his bowel problems seemed to have settled. On 24 September, Mr Greensmith told the prison GP that he wanted to be referred again for consideration of spinal surgery.

38. After Mr Greensmith fell in his cell on 27 September, a nurse examined him but noted no injuries and no treatment was needed.

39. From October 2018, Mr Greensmith's bowel problems returned. He had periods of severe diarrhoea and abdominal pain. On 7 October, a senior nurse arranged for Mr Greensmith to go to hospital for an assessment. Hospital staff diagnosed an acute bowel obstruction, administered intravenous antibiotics and noted that Mr Greensmith was dying. Hospital staff arranged for Mr Greensmith to move to a hospice on 8 October. Hospice staff reported that they had made Mr Greensmith comfortable with a pain-relieving patch and pain relief tablets intermittently and he did not appear to be at the end of his life. They were concerned about his inappropriate behaviour towards nurses (he had made inappropriate comments) and contacted the prison for him to return to Littlehey.

40. Mr Greensmith returned to Littlehey on 18 October. A nurse completed his reception screen and noted that Mr Greensmith had his pain relief patches. She noted that he was at high risk of falls as he had had a recent fall in the hospice and had cut his left elbow. As he had diarrhoea, she arranged for him to have sufficient supplies of pads and pants as he was still mainly independent.

41. A prison GP reviewed Mr Greensmith on 19 October. She described him as looking "perkier" than on previous occasions. Mr Greensmith told her that he wanted carers to help him (which was arranged) and he was scheduled to have a review with a prison GP as she suspected he had bowel cancer and end-stage heart failure. The prison GP completed her review at Littlehey on 29 October. She noted that although he was frail, he looked better than when he was in the hospice and that the spinal surgeons had declined surgery as the operation was very high risk. She recommended that Mr Greensmith should continue with his current pain relief medication and concluded that if he deteriorated again, he could not return to the hospice (because of safeguarding concerns) and any end-of-life care would have to be delivered at Hinchingbrooke Hospital.

42. On 4 November, a nurse arranged for Mr Greensmith to be admitted to hospital as his abdomen was distended. However, two days later, hospital staff

discharged him as he had been rude to hospital staff. Back at Littlehey, staff monitored his distension and ensured that he took his bowel medication.

2019

43. On 15 January 2019, a nurse examined Mr Greensmith as he had trouble breathing at night. She checked him and noted that he was pale, sleepy and his breathing was laboured. She heard crackles at the base of both his lungs. His oxygen saturation level was low (74 -76%). She administered oxygen which increased his saturation level to 89% (still a little low) and requested an emergency ambulance. Two officers escorted Mr Greensmith unrestrained to the hospital.

44. Hospital staff treated Mr Greensmith with intravenous antibiotics, intravenous fluids and oxygen therapy. His condition deteriorated and he died in hospital on 26 January.

Contact with Mr Greensmith's family

45. On 23 July 2018, the prison appointed a prison Chaplain as the family liaison officer (FLO) and an officer as the deputy family liaison officer. They visited Mr Greensmith that day and he told them that his nominated next of kin was a friend. However, when they contacted his friend, she declined to be his next of kin. The FLO told Mr Greensmith on 2 August. In response, Mr Greensmith said that he did not have a next of kin.

46. When Mr Greensmith's health deteriorated and he was in hospital, the FLO visited him and Mr Greensmith told him that his brother would be his next of kin. The FLO telephoned Mr Greensmith's brother on 22 January 2019 to let him know that Mr Greensmith was seriously ill in hospital. He went to the hospital and gave his brother more information about Mr Greensmith's condition. The family liaison officers maintained regular contact with Mr Greensmith's brother and sister-in-law. They helped arrange family visits and provided updates about Mr Greensmith's health.

47. When Mr Greensmith died, the FLO telephoned his brother to break the news and offer his condolences and support by telephone, as previously agreed with them. Littlehey arranged and paid for Mr Greensmith's funeral, which was held on 15 March 2019.

Support for prisoners and staff

48. After Mr Greensmith's death, the duty manager debriefed the escorting staff to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

49. The prison posted notices informing other prisoners of Mr Greensmith'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 Greensmith's death.

Cause of death

50. The Coroner established that Mr Greensmith had died of pneumonia caused by pulmonary fibrosis (a lung disease). Mr Greensmith also had COPD which contributed to but did not cause his death.

Findings

Clinical care

51. The clinical reviewer, concluded that overall, the care that Mr Greensmith received was equivalent to that which he could have expected to receive in the community. She noted that Mr Greensmith was frail and elderly, with a complex medical history and end-stage heart failure. She found that healthcare staff provided a good standard of care and support and that Mr Greensmith received prompt and responsive primary care. She noted that Mr Greensmith was assigned a named prison GP, who he saw to ensure consistency of approach and continuity of care.

52. We agree that some aspects of his care were positive such as healthcare staff discussing Mr Greensmith's treatment options and encouraging him to attend his hospital appointments. However, as the clinical reviewer noted, there were also shortcomings in some areas.

53. The clinical reviewer was critical of the lack of records about Mr Greensmith's clinical observations and National Early Warning Scores (NEWS, a clinical assessment to monitor unwell patients). She said that using NEWS was helpful for monitoring unwell and deteriorating patients. There were sometimes delays in taking his clinical observations, which made it difficult for the staff involved in his care to note any improvement or deterioration. A nurse the only nurse who used the NEWS system in January 2019 to help detect deterioration in Mr Greensmith's condition. While this was good practice, there is no record of any other healthcare staff using the NEWS system. We therefore recommend that:

The Head of Healthcare should ensure that clinical staff assess and manage prisoners with deteriorating chronic condition effectively to enable good standards of care, including that clinical staff:

- **use appropriate assessment and monitoring processes to monitor and record vital signs; and**
- **receive up-to-date training in using National Early Warning Scores and are aware of the triggers for escalation.**

Falls risk assessment

54. After his first fall, healthcare staff should have assessed Mr Greensmith, with a view to keeping him safe. In line with the National Institute for Health and Care Excellence (NICE) guidelines for assessing and preventing falls in older people, an assessment after his second fall should have highlighted the hazards, interventions needed and the need for a medication review to determine what effect his medication might have had on his stability. Although Mr Greensmith fell on three occasions before January 2018, no adjustments were made and there was nothing to alert staff to his very high risk of falls. Mr Greensmith should have been referred for a falls risk assessment before 3 January 2018. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff appropriately assess prisoners at risk of falls in line with NICE guidelines and that their assessment is recorded and acted on.

55. The clinical reviewer made a number of recommendations about Mr Greensmith's clinical care in the years before he died. These were unlikely to have changed the outcome for Mr Greensmith so we do not repeat them here, although the Head of Healthcare will need to address them.

Decision not to resuscitate

56. From August 2017, Mr Greensmith had an order in place not to be resuscitated if his heart or breathing stopped. All relevant staff, including escort staff, should have been made aware of the order and Mr Greensmith's wishes. We are concerned that this did not happen and that Mr Greensmith's resuscitation wishes were not recorded on the escort risk assessments after Mr Greensmith signed the order. If the issue of resuscitation had arisen, prison escort staff would not have been aware of Mr Greensmith's wishes. We make the following recommendation:

The Head of Healthcare must ensure that healthcare staff record all relevant information on the medical escort risk assessment form, including information about decisions and orders not to resuscitate prisoners.

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