Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Rodney Thornton, a prisoner at HMP Moorland, on 30 August 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 Rodney Thornton died on 30 August 2019 of a ruptured abdominal aortic aneurysm while a prisoner at HMP Moorland. Mr Thornton was 78 years old. I offer my condolences to Mr Thornton's family and friends.

I am satisfied that the clinical care Mr Thornton received at Moorland 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.

Sue McAllister, CB
Prisons and Probation Ombudsman **May 2020**

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Summary

Events

1. In December 2014, Mr Rodney Thornton was sentenced to fourteen years and 4 months for indecent assault. He was transferred HMP Moorland on 22 September 2017. Mr Thornton had a number of pre-existing medical conditions including high blood pressure, chronic kidney disease, heart disease and angina.

2. Mr Thornton had an inoperable abdominal aortic aneurysm (an abnormal `bulge' in the aorta, the main artery of the body, causing weakness and potential risk of rupture). A do not attempt cardiopulmonary resuscitation (DNACPR) form was discussed and agreed with Mr Thornton in 2017.

3. At 11.10am on of 30 August 2019, Mr Thornton became unwell. He was seen by the prison nurse who took his observations. The NEWS score indicated that further observations were needed and the nurse made a note to see Mr Thornton after lunch.

4. At 11.32am, Mr Thornton's was found unresponsive. Healthcare staff attended to treat Mr Thornton but they were unclear about the status of his DNACPR because it did not appear to have been reviewed since 2017. Staff called an emergency medical code and an ambulance was called immediately.

5. Paramedics arrived and Mr Thornton was taken to hospital. His health continued to deteriorate and at 2.11pm, it was confirmed that Mr Thornton had died.

6. The post-mortem report gave Mr Thornton's cause of death as a ruptured abdominal aortic aneurysm.

Findings

7. The clinical reviewer concluded that the care Mr Thornton received at Moorland was equivalent to that which he could have expected to receive in the community.

8. However, the clinical reviewer found that Mr Thornton's DNACPR paperwork was not updated as it should have been and healthcare staff were unclear about whether an end of life care plan had been put in place and whether it was up to date.

Recommendations

- The Head of Healthcare should ensure that review dates are formally recorded within the appropriate section of the DNACPR document.
- The Head of Healthcare should ensure that Advance Care Planning must be considered for those prisoners who have a DNACPR in place so that their wishes are respected, such as their preferred place of death.

The Investigation Process

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

11. NHS England commissioned an independent clinical reviewer to review Mr Thornton's clinical care at the prison.

12. We informed HM Coroner for Doncaster and Rotherham of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

    - One of the Ombudsman's family liaison officers contacted Mr Thornton's his next of kin, to explain the investigation and to ask whether she had any matters the family wanted the investigation to consider. She asked the following questions: Was the prison doctor aware that Mr Thornton's wife had died?

    - What interventions were put into place to help Mr Thornton following the death of his wife?

    - Were clinical checks increased for Mr Thornton following his wife's death, due to the increased stress and risks this could have had on his health?

    - Were there scans? How often?

    We have addressed Mr Thornton's next of kin's concerns in this report and in separate correspondence.

13. Mr Thornton's family received a copy of the draft report. They did not make any comments.

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

Background Information

HMP Moorland

15. HMP Moorland holds up to 1,000 men. Care UK provides healthcare services at the prison, including primary care, mental health and substance misuse services.

16. In August 2018, Moorland was selected to be part of the "10 Prisons Project" which seeks to improve safety, security and decency in the prisons involved. The project is focusing on reducing violence, improving living conditions, preventing drugs from entering the prisons and enhancing the leadership and training available to staff.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Moorland was conducted in February 2019. Inspectors reported that an appropriate range of primary health services was available, and most access was reasonable. However, the inspectors found that only 16% of prisoners said that it was easy to see a doctor and there was over a three week wait for routine GP appointments. Steps were being taken to reduce waiting times.

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 February 2018, the IMB reported that a successful recruitment drive had allowed prisoners to return to a full regime. They found that too many prisoners were not attending healthcare appointments and that external appointments were too often cancelled because of a lack of escorts.

Previous deaths at HMP Moorland

19. Mr Thornton was the sixth prisoner to die at HMP Moorland since February 2017. The previous five deaths were from natural causes. There are no similarities between our findings in the investigation of Mr Thornton's death and the other deaths.

Key Events

20. On 19 December 2014, Mr Rodney Thornton was sentenced to fourteen years and four months in prison for indecent assault. He was transferred to HMP Moorland on 22 September 2017.

21. Mr Thornton had a number of pre-existing conditions, including hypertension (high blood pressure), renal vascular disease (a condition affecting blood circulation to the kidneys), chronic kidney disease, ischaemic heart disease and angina (chest pain caused by reduced oxygen supply to heart), for which he received appropriate medication.

22. On his arrival at Moorland, a nurse completed Mr Thornton's health screening, noted his pre-existing medical conditions and reviewed his medications. Mr Thornton had an inoperable abdominal aortic aneurysm (an abnormal bulge in the aorta, the main artery of the body, causing weakness and potential risk of rupture) involving both his renal (kidney) arteries. The hospital vascular team informed healthcare staff at the prison that if the aneurysm were to rupture, Mr Thornton was not to be transferred to hospital but should be kept comfortable.

23. On 15 December, a do not attempt cardiopulmonary resuscitation (DNACPR) order (which means that, in the event of cardiac or respiratory arrest, no attempt at resuscitation will be made; all other appropriate treatment and care will continue to be provided) was discussed and agreed with Mr Thornton.

24. Mr Thornton refused treatment for kidney disease in September 2018.

25. On 6 May 2019, Mr Thornton had a CT scan. The results showed that the aortic aneurysm had increased in size. Healthcare staff made a referral to the hospital's vascular team for review. On 20 May, a prison GP noted that no further action was needed, as the vascular team had advised that surgery was still not an option.

26. On 6 August, a prison GP reviewed Mr Thornton after he complained of lower back pain. Mr Thornton said that he did not have any abdominal pain and did not feel the pain was worse or new. She asked for blood tests to be completed and referred him for a further review.

Events of 30 August

27. At 11.10am on 30 August, a nurse reviewed Mr Thornton in his cell. Mr Thornton said that he was feeling unwell, dizzy and had been sick in the morning. She recorded Mr Thornton's observations. His NEWS score was 2, which meant that more observations were needed. She recorded that she would review Mr Thornton after lunch.

28. At 11.32am, a prisoner told an officer that Mr Thornton was unresponsive in his cell. The officer radioed an emergency code blue. Three nurses attended. They found Mr Thornton lying on his bed, pale, clammy and unresponsive. His vital signs had deteriorated. Healthcare staff inserted a nasal airway and gave Mr Thornton oxygen using a breathing mask.

29. A nurse recorded in Mr Thornton's medical record, "DNACPR unclear at time of incident as photocopy/not until the end of life and had not been reviewed since 2017", meaning she was unclear whether an end of life plan had been put in place which would have recorded Mr Thornton's wishes including his preferred place of death, and whether it was up to date.

30. Paramedics arrived at 11.55am. Mr Thornton was more responsive but remained unwell. He was transferred to hospital at 12.30pm with the DNACPR document. Mr Thornton was admitted to hospital as an inpatient but his health deteriorated and at 2.11pm, it was confirmed that Mr Thornton had died.

Post-mortem report

The post-mortem report gave Mr Thornton's cause of death as a ruptured abdominal aortic aneurysm. Hypertension, chronic kidney disease and ischaemic heart disease contributed to but did not cause his death.

Contact with Mr Thornton's family

31. On 30 August, the prison appointed a Supervising Officer (SO) as the family liaison officer (FLO). At 1.15pm, the FLO contacted Mr Thornton's next of kin to inform her that Mr Thornton was in hospital. Mr Thornton's next of kin told the FLO that due to the nature of his offence, she could not visit him but wanted to be informed when he died. The FLO contacted Mr Thornton's' next of kin at 2.40pm later that day to inform her of his death and to offer condolences. The FLO continued to provide support to Mr Thornton's family.

32. In line with national guidance, the prison made a financial contribution to Mr Thornton's funeral.

Support for prisoners and staff

33. The prison held a hot debrief after Mr Thornton's death, and staff were given the opportunity to discuss the incident and to discuss any issues arising, and for managers to offer support.

34. The prison posted notices informing staff and prisoners of Mr Thornton's death, and offering support.

Findings

Clinical care

35. The clinical reviewer concluded that the clinical care Mr Thornton received at Moorland was of a good standard and equivalent to that which he would have received in the community.

36. Mr Thornton had several complex health conditions which healthcare staff managed well. The clinical reviewer found that Mr Thornton's nursing and medical care was appropriate, compassionate and responsive. There is evidence that overall, appropriate monitoring and assessment processes were in place to monitor and manage Mr Thornton's long-term conditions.

37. While the clinical reviewer is satisfied that Mr Thornton's DNACPR decision was reviewed by the multidisciplinary team on a regular basis (most recently on 2 August 2019), this was not formally recorded in the relevant section of the DNACPR document. Although we are satisfied this did not impact on the care Mr Thornton received during the emergency response, we make the following recommendation:

    The Head of Healthcare should ensure that review dates are formally recorded within the appropriate section of the DNACPR document.

38. Advance care planning (ACP) is a discussion about future care between a prisoner and the care providers which includes discussion about the prisoner's concerns, wishes, and preferences for types of care or treatment that may be beneficial in the future. The clinical reviewer found that while there was reference to "end of life care planning" recorded in Mr Thornton's medical records on the 3 September 2018, she found no evidence of a relevant care plan being in place for Mr Thornton and was unclear why an ACP was not completed for (and with) him. This would have considered decisions such as his preferred place of death. We recommend:

    The Head of Healthcare should ensure that Advance Care Planning must be considered for those prisoners who have a DNACPR in place so that their wishes are respected, such as their preferred place of death.

39. The clinical reviewer has made two recommendations about resuscitation and ensuring healthcare staff are made aware of a significant life event of prisoner to provide additional support, which we do not repeat in this report but which the Head of Healthcare will wish to address.

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