

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Keith Jackson a prisoner at HMP Moorland on 1 July 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 Keith Jackson died in hospital from heart disease on 1 July 2019, while a prisoner at HMP Moorland. He was 78 years old. I offer my condolences to those who knew him.

Mr Jackson had several long-term conditions, including heart disease, when he was sent to prison. The clinical reviewer found that while much of the nursing care Mr Jackson received at Moorland was good, there were some aspects of his care that were not equivalent to that he could have expected to receive in the community. In particular, healthcare staff did not properly assess the deterioration in Mr Jackson's condition in the days before his death and there were delays in fulfilling Mr Jackson's wishes about his end of life care.

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**

**January 2020**

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# Summary

## Events

1. On 25 April 2017, Mr Keith Jackson was sentenced to 15 years in prison and sent to HMP Leeds. He was moved to HMP Moorland on 22 November 2018.
2. Mr Jackson had ischaemic heart disease and other long-term conditions when he was sent to prison. When he was moved from Leeds to Moorland, he had outstanding hospital appointments with the cardiology and audiology departments, and the memory clinic. Moorland was sent reminders, but Mr Jackson was not taken to these appointments.
3. On 18 June 2019, Mr Jackson was admitted to hospital after passing out. Hospital doctors considered his heart condition had deteriorated significantly and he was diagnosed with dilated myopathy (thinning heart muscle). He was discharged back to the prison on 25 June, but prison healthcare staff were not made aware of his return so they did not assess him.
4. Mr Jackson's condition deteriorated on 27 June. On 28 June, prison healthcare staff held a multidisciplinary meeting and assessed that Mr Jackson was a palliative care case (where a person has an illness that cannot be cured, palliative care makes them as comfortable as possible). Mr Jackson requested a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order but a GP was not available that day to arrange it.
5. On 29 June, Mr Jackson was readmitted to hospital with a frozen shoulder. He was discharged the same day. A hospital doctor contacted the prison to express concern that a DNACPR order was not in place for Mr Jackson.
6. At around 6.00am on 1 July, while carrying out routine checks on Mr Jackson, a nurse was concerned that his symptoms suggested a thrombosis and a urinary infection. She requested an ambulance and Mr Jackson was admitted to hospital. The hospital implemented a DNACPR order. Mr Jackson was given antibiotics but failed to respond. That afternoon, he had a cardiac arrest and died.

## Findings

7. The clinical reviewer found that while much of the nursing care Mr Jackson received in prison was good, there were aspects that were not equivalent to that he could have expected to receive in the community.
8. There was no handover of care between Leeds and Moorland when Mr Jackson was moved in November 2018, which meant that he missed several outstanding hospital appointments.
9. Healthcare staff were unaware that Mr Jackson had been discharged from hospital on 25 June, and so no one assessed him on his return to Moorland.
10. When Mr Jackson's condition deteriorated on 27 June, a nurse took his clinical observations, but she did not record his overall NEWS score using the NEWS2 tool. (The NEWS2 tool is used to assess whether a patient's condition is deteriorating and what level of clinical care they need.) His overall score would

have indicated a significant deterioration, which should have prompted closer monitoring. We are concerned that we made a previous recommendation about this following the death of a prisoner at Moorland in April 2018.

11. There was a delay in prison healthcare staff implementing a DNACPR order for Mr Jackson because a GP was not available. No one followed this up, which resulted in the hospital putting a DNACPR order in place for Mr Jackson on the day he died.

## **Recommendations**

- The Heads of Healthcare at Leeds and Moorland should ensure that when a prisoner is transferred, there is a formal transfer of care, which includes information about long-term conditions and outstanding appointments.
- The Governor and Head of Healthcare at Moorland should ensure there is an effective system in place to ensure healthcare staff are made aware when a prisoner returns from hospital.
- The Head of Healthcare at Moorland should ensure clinical staff are trained to use NEWS2 and follow the correct escalation procedures, and that this training is provided on a rolling basis.
- The Head of Healthcare at Moorland should ensure that prisoner requests for Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders are discussed promptly and, where appropriate, implemented without delay.

## The Investigation Process

12. 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.
13. The investigator obtained copies of relevant extracts from Mr Jackson's prison and medical records.
14. NHS England commissioned a clinical reviewer to review Mr Jackson's clinical care at the prison.
15. We informed HM Coroner for South Yorkshire East district of the investigation. She gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
16. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

# Background Information

## HMP Moorland

17. HMP Moorland holds up to 1,000 men. Care UK runs healthcare services at the prison, including primary care, mental health and substance misuse services. Nurses are available from 7.30am to 7.30pm each day. The prison does not have an inpatient facility.
18. In August 2018, Moorland became one of the sites participating in the '10 Prisons Project'. The project (with the aid of a £10m funding injection) seeks to improve safety, security and decency at the prisons by focusing on reducing violence, living conditions, preventing drugs entering the establishments and enhancing leadership training available to Governors and their staff.

## HM Inspectorate of Prisons

19. The most recent inspection of HMP Moorland was in February 2019. Inspectors reported that healthcare staffing levels and the skills mix were generally appropriate, but some pressures had been placed on frontline staff when short-term cover could not be afforded. Although staff were stretched, inspectors were satisfied that most needs were being met. Inspectors reported that there were waits of over three weeks for a routine GP appointment, which was too long, but the prison was taking steps to reduce waiting times.

## Independent Monitoring Board

20. 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 2019, the IMB said it was satisfied healthcare services at Moorland were equivalent to those available in the community. The IMB found that there was still a high rate of non-attendance at GP clinics, but it was pleased to see that the cancellation rate of scheduled hospital appointments had gone down. The IMB noted that the Head of Healthcare had implemented the PPO recommendations made following a death in custody due to natural causes.

## Previous deaths at HMP Moorland

21. There have been three other deaths at HMP Moorland since July 2017, all from natural causes. We have previously made a recommendation that all healthcare staff are trained in the use of the National Early Warning System (NEWS) assessment tool.

## Key Events

22. On 9 February 2017, Mr Keith Jackson was convicted of sexual offences. On 25 April 2017, he was sentenced to 15 years in prison and sent to HMP Leeds.
23. On 22 November 2018, Mr Jackson was moved to HMP Moorland. A nurse completed the reception screen and noted Mr Jackson had heart disease and reduced mobility. At the time of his transfer, Mr Jackson had outstanding hospital appointments with the cardiology and audiology departments, and with the memory clinic, but these were not mentioned in any of the documents that accompanied Mr Jackson.
24. Mr Jackson had a secondary health screen within seven days. The nurse offered Mr Jackson screening for several infectious diseases (which he accepted) and his blood pressure was in the acceptable range. Care plans were implemented for ischaemic heart disease, hypertension (high blood pressure) and kidney disease and his long-term conditions were regularly reviewed.
25. On 18 June 2019, Mr Jackson passed out on the wing. A nurse assessed him and sent him to hospital. Hospital doctors considered his heart condition had deteriorated significantly and diagnosed him with dilated myopathy (stretched, thinning heart muscle). He was discharged on 25 June with a plan to review him as an outpatient in six to eight weeks' time. No one told prison healthcare staff that he had returned to Moorland, so they did not assess him.
26. The hospital provided a discharge summary on 27 June, and prison healthcare provided Mr Jackson with nursing support to assist him with day-to day activities.
27. On 27 June, a nurse reviewed Mr Jackson at approximately 7.30pm. He was not eating or drinking properly and had not opened his bowels for several days. He declined an abdominal examination and signed a disclaimer to that effect. The nurse discussed the situation with a Matron and they agreed staff would monitor Mr Jackson overnight. Staff continued to take observations, and although there were fluctuations, his readings settled to within normal range by 11.00pm.
28. The nurse had told Mr Jackson that if he collapsed or went into cardiac arrest, she would have no choice but to treat him as a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order was not in place. She had also made an on-call manager aware of her care plan.
29. On 28 June, a nurse recorded that the multidisciplinary team also assessed Mr Jackson. Staff considered he was a palliative care case. Mr Jackson requested a DNACPR order, but a GP was not available that day to arrange one.
30. On 29 June, Mr Jackson was readmitted to hospital with a frozen shoulder but was discharged the same day. A hospital doctor contacted the prison as he was concerned that Mr Jackson did not have a DNACPR order in place.
31. On 1 July, at approximately 1.45am, a healthcare assistant recorded that Mr Jackson had fallen out of bed. He was not in any pain, and she took his observations and made him comfortable. She moved his mattress to the floor to

prevent any further falls and gave him drinks and a buzzer to summon staff. She checked him again at 3.00am and had no concerns.

32. At approximately 6.00am, a nurse checked Mr Jackson and was concerned that his leg was swollen, and his urine was very dark. She considered that he might have a deep vein thrombosis and a urinary tract infection. She wanted him to be assessed in hospital and requested an ambulance. The control room log states that an ambulance was called for Mr Jackson at approximately 6.20am.
33. At 6.44am, paramedics arrived at the prison and assessed Mr Jackson. At 7.44am, the ambulance left the prison with Mr Jackson. He was not restrained. He arrived at a hospital at 8.10am and the hospital implemented a DNACPR order.
34. Hospital staff gave Mr Jackson fluids and antibiotics, but he did not respond. He had a cardiac arrest and hospital staff pronounced him dead at 12.23pm.

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

35. Mr Jackson was not in contact with any family members and specifically asked that staff did not try to trace them.
36. Mr Jackson's funeral was on 19 July. A prison chaplain and a prison workshop instructor, attended. In line with national policy, the prison paid for the funeral costs.

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

37. After Mr Jackson's death, a prison 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.
38. The prison posted notices informing other prisoners of Mr Jackson'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 Jackson's death.

### **Post-mortem report**

39. The post-mortem report concluded that Mr Jackson died from ischaemic cardiomyopathy (a condition where the heart muscle is weakened as a result of coronary artery disease). Chronic kidney disease was listed as a contributing factor.

# Findings

## Clinical care

40. The clinical reviewer found that while much of Mr Jackson's care at Moorland was good, aspects of his care were not equivalent to that he could have expected to receive in the community.
41. The clinical reviewer noted that there was no formal transfer of care when Mr Jackson was moved from Leeds to Moorland. At the time, Mr Jackson had outstanding hospital appointments with the cardiology and audiology departments, and with the memory clinic, but there was no mention of these on the Person Escort Record that accompanied Mr Jackson, nor of his long-term conditions. Despite reminders being sent to Moorland, Mr Jackson was not taken to his hospital appointments. We make the following recommendation:

**The Heads of Healthcare at Leeds and Moorland should ensure that when a prisoner is transferred, there is a formal transfer of care, which includes information about long-term conditions and outstanding appointments.**

42. On 25 June, Mr Jackson was discharged from hospital after a week's stay. Prison healthcare staff were not made aware of his return to Moorland and so did not assess him (his discharge summary was not received until two days later). Healthcare staff did not have the opportunity to put in place an appropriate continuity of care plan as soon as they should have. We make the following recommendation:

**The Governor and Head of Healthcare at Moorland should ensure there is an effective system in place to ensure healthcare staff are made aware when a prisoner returns from hospital.**

43. On 27 June, Mr Jackson's condition deteriorated, and staff took frequent observations. They did not, however, calculate and record an overall National Early Warning System (NEWS) score using the NEWS2 tool. (The NEWS2 tool is used to monitor whether a patient is deteriorating and to assess what level of clinical care they need.) The clinical reviewer considered that if they had used the NEWS2 tool, his score should have prompted an escalation in care. There were also inconsistencies in using NEWS2 on 29 June.

44. We made a recommendation about this to Moorland following the death of a prisoner in April 2018. The recommendation was accepted, and we were told it had been implemented. We are, therefore, concerned that we need to make the same recommendation again.

**The Head of Healthcare should ensure that all clinical staff are trained to use NEWS2 and follow the correct escalation procedures, and that this training is provided on a rolling basis.**

45. On 28 June, Mr Jackson asked to discuss a DNACPR order with healthcare staff but a GP was not available. No effort seems to have been made to deal with this when a doctor was next on site.

46. On 29 June, Mr Jackson was readmitted to hospital with a frozen shoulder. Hospital staff contacted the prison because they were very concerned that no DNACPR order was in place. Mr Jackson was discharged that day, but still nothing was arranged to discuss a DNACPR order with him. The hospital eventually arranged the order themselves when Mr Jackson was readmitted to them for the final time on 1 July. We make the following recommendation:

**The Head of Healthcare should ensure that prisoner requests for Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders are discussed promptly and, where appropriate, implemented without delay.**

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