Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Smales, a prisoner at HMP Leeds, on 13 January 2020

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 John Smales died on 13 January 2020 of a heart attack at HMP Leeds. He was 74 years old. I offer my condolences to Mr Smales' family and friends.

Mr Smales was a frail man with poor health and reduced mobility. Healthcare staff appropriately managed his many chronic conditions. The clinical reviewer was satisfied that the care he received at Leeds was of a good standard and equivalent to that which he could have expected to receive in the community.

However, the clinical reviewer found that healthcare staff did not consistently use the National Early Warning Score (a tool to assess deterioration in unwell patients) as they should have done and that there was a missed opportunity to escalate Mr Smales' care when his condition started to deteriorate.

The investigation found that prison staff did not record or share significant information with the staff on night duty about Mr Smales feeling unwell as they should have done.

I am also concerned that when Mr Smales was found unresponsive in his cell on 13 January, staff provided conflicting accounts about the emergency response which made it difficult for the investigation to establish exactly what action was taken. This has highlighted the importance for accurate record keeping.

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 **June 2021**

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Summary

Events

1. On 20 December 2017, Mr John Smales was sentenced to 24 years in prison for sexual offences and sent to HMP Leeds. He had a complex medical history of chronic kidney disease (he attended dialysis three times a week), three heart attacks, heart disease, high blood pressure and had had a stroke in 2016.

2. Healthcare staff developed care plans to manage Mr Smales' conditions. They frequently reviewed him and adjusted his medications as necessary.

3. On 12 January 2020, Mr Smales told prison staff that he felt unwell. Nurses visited him four times in his cell but did not note that his condition was deteriorating. On the fifth visit to his cell, a nurse found Mr Smales unresponsive in bed.

4. Staff attempted cardiopulmonary resuscitation (CPR). Paramedics arrived and at 1.53am, confirmed that Mr Smales had died.

5. Mr Smales died from a heart attack caused by coronary artery thrombosis.

Findings

6. The clinical reviewer concluded that the care Mr Smales received at Leeds was equivalent to that which he could have expected to receive in the community. Healthcare staff provided a good standard of support, and prompt and responsive primary care.

7. The clinical reviewer did, however, identify some concerns.

8. The clinical reviewer was concerned that when Mr Smales was unwell on 12 January, healthcare staff did not use the National Early Warning Score (a tool to assess deterioration in unwell patients) as they should have done and that there was a missed opportunity to escalate his care when his condition began to deteriorate.

9. Although an officer called healthcare staff to check on Mr Smales on two occasions, there is no evidence that this was recorded in the wing observation book or flagged up to any other member of staff who might have had direct contact with him.

10. Due to discrepancies in record keeping, we are unable to confirm the full sequence of events when Mr Smales was found unresponsive in his cell on 12 January.

Recommendations

- The Head of Healthcare should ensure that healthcare staff use the National Early Warning Score (NEWS2) to assess prisoners effectively and ensure that any clinical deterioration is appropriately addressed.

- The Governor should ensure that staff record significant information about the welfare of prisoners in the wing observation book.
- The Governor and Head of Healthcare should remind staff to keep accurate records when they are involved in an emergency response.
- The Governor should ensure that staff assigned to wear Body Worn Video Cameras (BWVC), activate them at the earliest opportunity during a reportable incident.
- The Governor and Head of Healthcare should ensure that any staff named in this report are given the opportunity to read the report at the draft stage in line with paragraph 1.11 of PSI 58/2010.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Leeds informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

12. The investigator obtained copies of relevant extracts from Mr Smales' prison and medical records.

13. NHS England commissioned a clinical reviewer to review Mr Smales' clinical care at the prison.

14. The investigator interviewed three members of staff and a prisoner at Leeds on 11 and 12 February 2020. The investigator clinical reviewer jointly interviewed prison and healthcare staff at Leeds on 12 February. The investigator conducted a telephone interview with a nurse on 14 February.

15. We informed HM Coroner for West Yorkshire of the investigation. He gave us the results of the post-mortem examination. The case was suspended while we waited for the post-mortem results. We have sent the coroner a copy of this report.

16. One of the Ombudsman's family liaison officers contacted Mr Smales' next of kin, his son, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not respond to our letter.

17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Leeds

18. HMP Leeds is a local prison which can hold a maximum of 1,218 prisoners who are on remand, convicted or sentenced. The prison serves the courts of West Yorkshire. Care UK provides health services, including mental health services. The prison has 24-hour primary healthcare cover.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Leeds was in December 2019. Inspectors found that the prison had continued to face significant challenges but had improved in many areas since the previous inspection. There was good local leadership of healthcare services and clinical records were of high quality.

20. Prisoners had prompt access to a range of primary care services and clinic waiting times were acceptable. The management of long-term conditions was good.

Independent Monitoring Board

21. 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 December 2018, the IMB reported that overall, and notwithstanding the difficult operational environment, prisoners were treated with humanity and respect given the current staff constraints.

22. The IMB noted that the Healthcare Outreach Team responded urgently to emergency radio code calls at the request of the prison officers. They found that the Healthcare team attended 430 emergency calls about breathing difficulties (but linked to suspected drug use), in 2018 compared with 452 in 2017, a drop of 2.8%.

Previous deaths at HMP Leeds

23. Mr Smales was the 20th prisoner to die at Leeds since January 2018. Of the previous deaths, 10 were from natural causes, eight were self-inflicted and one was a drug-related death. There were no similarities between Mr Smales' death and the previous deaths. There have been five deaths since Mr Smales' death, one from natural causes, three self- inflicted deaths and one drug-related death, three of which are currently under investigation.

Key Events

24. On 20 December 2017, Mr John Smales was sentenced to 24 years in prison for sexual offences and sent to HMP Leeds.

25. Mr Smales had had poor health for several years which included chronic kidney disease and he attended dialysis three times a week. He also had a history of heart attacks, heart disease, high blood pressure, and had had a stroke in 2016.

26. Healthcare staff completed reception screens and the prison GPs prescribed appropriate medications. Healthcare staff created care plans to monitor his conditions and ensured that he attended his dialysis appointments.

27. Mr Smales shared a cell. Mr Smales occupied the bottom bunk bed. The cellmate told the investigator that Mr Smales used a walking stick. The cellmate said that on Thursday 9 January 2020, Mr Smales was feeling unwell and complained of feeling dizzy. On Friday afternoon (on 10 January), Mr Smales attended his dialysis appointment.

28. The cellmate said that on Saturday 11 January, Mr Smales went to collect his medication and then spent the day in bed sleeping, which was unusual.

Events of 12 January 2020

29. On Sunday afternoon (12 January), the cellmate asked an officer to contact healthcare staff because Mr Smales was not feeling well. The officer said that she asked for a nurse to visit Mr Smales in his cell. A nurse visited Mr Smales at 4.27pm.

30. Mr Smales told the nurse that for the past two days he had felt unwell and had a cough, shortness of breath, fatigue and was struggling to sleep. She noted that he had mild generalised lower abdominal pain. She checked his observations and noted that he did not have any chest pain or headache but reported mild backache. The nurse also noted that he was taking his medications and that his last blood test showed that he was anaemic with a slightly low vitamin D level and low blood pressure. She used the National Early Warning Score (NEWS2) tool (to prompt nursing staff to request a medical review at specific trigger points) to categorise the severity of Mr Smales' illness. She calculated a NEWS score of 2 (meaning the patient should be monitored at least every 4-6 hours). She told Mr Smales to increase his fluid intake and noted that he had a scheduled prison GP appointment in two days' time (on 14 January).

31. Later that night, Mr Smales pressed his emergency cell bell and an officer responded. Mr Smales told her that he felt sick and had stomach pains. She contacted healthcare staff and asked for a nurse to visit him. The officer did not record this information in the wing observation book or tell the night staff.

32. The nurse returned to Mr Smales' cell at 7.47pm and checked his observations. She calculated his NEWS2 score of 5 (meaning the patient should be assessed at least hourly and that clinical advice should be sought) and arranged for the night nurse to check on him.

33. During the night there are two nurses with radios on duty to respond to calls. They are referred to as Hotel 3 (a primary care nurse) and Hotel 4 (a substance misuse nurse). Nurse A was Hotel 3 and Nurse B was Hotel 4.

34. In his written statement, an officer said that at approximately 9.00pm, he responded to Mr Smales' emergency cell bell. Mr Smales told him that he had a pain in his abdomen and right side. The officer arranged for the duty nurse to visit him. He said that the duty nurse told him that she would visit Mr Smales as soon as she could.

35. The officer noted that at 10.30pm, the cellmate rang the emergency cell bell and told him that Mr Smales was feeling unwell. The officer said that he reassured them he would tell the duty nurse.

36. Nurse A was the duty nurse for the night. She went to check on Mr Smales at 11.16pm. Mr Smales had soiled himself and said that he felt weak. With the help of the cellmate, Nurse A changed his clothes and helped him back to bed.

37. In her statement, Nurse B said she immediately responded when Nurse A called her on the radio to come to Mr Smales' cell with an 'ambu bag' (a hand-held device to deliver oxygen to patients with breathing difficulties) and a blood pressure machine. She said that when she arrived at the cell Nurse A had already used a blood pressure machine and wanted a second opinion. Nurse B noted that she scored Mr Smales' NEWS2 score as 6 because of his low blood pressure and with Nurse A, they agreed to monitor him in an hour or two. Nurse A noted she would review Mr Smales after one hour to decide the next steps for his care.

Events of 13 January 2020

38. At approximately 1.30am on 13 January, Nurse A returned to Mr Smales' cell to check on him. She was accompanied by a Custodial Manager (CM), and three officers. Mr Smales was unresponsive on his bed. The CM radioed a medical emergency code blue (indicating that a prisoner is unresponsive or having difficulty breathing) and staff in the communications room called for an ambulance immediately.

39. In her statement, the CM said that she and an officer began CPR. She also said that there was a delay in Nurse B attending Mr Smales' cell once the code blue had been called.

40. In her written statement, Nurse B said that she responded to the emergency call within 2 – 3 minutes and assisted the prison staff with CPR by controlling Mr Smales' head when Nurse A was using the ambu bag to give oxygen. She said that when the paramedics arrived, she went to obtain a printout of his medical record for the paramedics and returned to the cell.

41. In an officer's written statement, he confirmed the CM and Nurse A's account of events. He said that Nurse B attended Mr Smales' cell after CPR had started. The log of events does not mention Nurse B being present during the emergency response.

42. Records show that the ambulance was called at 1.35am and arrived at the prison at 1.45am. The paramedics continued with emergency treatment. At 1.53am, a paramedic confirmed that Mr Smales had died.

Contact with Mr Smales' family

43. On 13 January, the prison appointed a family liaison officer (FLO). The police told Mr Smales' next of kin, his son, that his father had died. The FLO contacted Mr Smales' son to update him and offer him support.

44. The prison arranged and paid for Mr Smales' funeral in line with national instructions.

Support for prisoners and staff

45. After Mr Smales' death, the CM 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.

46. The prison posted notices informing other prisoners of Mr Smales' 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 Smales' death.

Post-mortem report

47. The Coroner found that Mr Smales' cause of death was an acute myocardial infarction (a heart attack) due to a coronary artery thrombosis blocking the blood supply to his heart.

48. The post-mortem report noted that Mr Smales was prone to developing thrombosis as a result of severe coronary artery atheroma (fatty deposits on the arteries) which had been treated with bypass grafts. The atheroma had caused a previous heart attack and chronic damage to the heart including the enlargement of his heart.

Findings

Clinical care

49. The clinical reviewer concluded that the clinical care Mr Smales received at Leeds was equivalent to that which he could have expected to receive in the community.

50. The clinical reviewer did, however, identify some concerns.

Use of NEWS scores

51. When Mr Smales reported that he was feeling unwell on 12 January, healthcare staff appropriately monitored him.

52. When Mr Smales' condition began to deteriorate, a nurse recorded his NEWS2 score as 2 at 4.27pm, which then increased to 5 when she assessed him again later that evening just over three hours later. However, Nurse A did not use the NEWS2 tool when she saw Mr Smales at around 11.00pm, while Nurse B gave a NEWS score of 6. The clinical reviewer considered that there was a missed opportunity for healthcare staff to escalate Mr Smales' care due to his deteriorating condition, given that his NEWS2 score had increased from 2 to 5 over a relatively short period. The clinical reviewer also considered that consistent use of the NEWS2 tool might have provided a clearer understanding of Mr Smales' clinical state, risk of deterioration and prognosis.

53. Care UK also completed a significant incident (72-hour) report following Mr Smales' death. They noted that the NEWS2 template should have been used for all assessments and that the lack of recorded assessments might have delayed decisions about when it was appropriate to refer Mr Smales to hospital. We make the following recommendation:

    The Head of Healthcare should ensure that healthcare staff use the National Early Warning Score (NEWS2) to assess prisoners effectively and ensure that any clinical deterioration is appropriately addressed.

Record keeping and emergency response

54. An officer did not record anywhere or tell other prison staff that Mr Smales was feeling unwell and that he had seen a nurse before she went off duty. We are concerned that other prison staff responsible for Mr Smales' care and welfare after the officer finished her shift did not, therefore, know that Mr Smales had already been unwell for some hours when he reported feeling unwell at 9.00 and 10.30pm. We would have expected to see an entry in the wing observation book making staff aware of Mr Smales' ill health and contact he had with healthcare staff so that prison staff could take appropriate action to check on him, if necessary. We therefore make the following recommendation:

    The Governor should ensure that staff record significant information about the welfare of prisoners in the wing observation book.

55. Despite checking the records and interviewing staff, we cannot confirm the sequence of events during the emergency response because there are several discrepancies about what actually happened on 13 January.

56. It is unclear who attended Mr Smales' cell on 13 January, who participated in CPR, what equipment was used, if an airway was used and when Nurse B attended. The log of events makes no mention of Nurse B being present during the emergency response. Nurse B did not update Mr Smales' record to show any contact or her involvement with him. It is of concern that Nurse B as Hotel 4 gave a very different account of her actions to the other staff who were present. The CM said that an officer led the emergency response but Nurse A and Nurse B said that this was not the case. We therefore recommend:

The Governor and Head of Healthcare should remind staff to keep accurate records when they are involved in an emergency response.

Body-worn video camera

57. PSI 04/2017, *Body Worn Video Cameras*, states it is mandatory for staff to use BWVCs at any reportable incident (as set out in PSI 11/2012, *Management and Security of the Incident Reporting System*) and that staff should start recording at the earliest opportunity to maximise the material captured by the camera.

58. None of the officers present when Mr Smales was discovered unresponsive used a body-worn video camera (BWVC). At interview the CM said she did not think it was appropriate or decent to activate a camera in such circumstances. We consider that given the discrepancies in the accounts and who was present during the emergency response, the use of BWVC footage would have been useful in Mr Smales' case. As none of the officers used a BWVC, we make the following recommendation:

The Governor should ensure that staff assigned to wear BWVCs, activate them at the earliest opportunity during a reportable incident.

Sharing of PPO reports

59. We consider that it is important for staff who were involved in Mr Smales' care to see the findings of our investigation. We make the following recommendation:

The Governor and Head of Healthcare should ensure that any staff named in this report are given the opportunity to read the report at the draft stage in line with paragraph 1.11 of PSI 58/2010.

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