

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Christopher Howarth, a prisoner at HMP Lewes, on 10 March 2020

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 Christopher Howarth died in hospital of multiple organ failure on 10 March 2020 while a prisoner at HMP Lewes. This was caused by recurrent abdominal cellulitis (a serious bacterial skin infection) and morbid obesity. He also had chronic kidney failure and Type 2 diabetes which did not cause but contributed to his death. He was 72 years old. I offer my condolences to Mr Howarth's family and friends.

The clinical reviewer found the clinical care that Mr Howarth received at Lewes was good and equivalent to that which he could have expected to receive in the community. However, I am concerned that before he was discharged from hospital in February, his care plan was not discussed at a multidisciplinary meeting.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Elizabeth Moody
Deputy Prisons and Probation Ombudsman

March 2021

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Summary

Events

1. In October 2015, Mr Christopher Howarth was sentenced to 10 years in prison for sexual offences and sent to HMP Lewes.
2. Mr Howarth had several chronic health conditions, including gout, high blood pressure, high cholesterol and heart problems, and had previously had two hip replacements. Mr Howarth weighed 30 stones and was morbidly obese. While in prison, Mr Howarth received personal care from two carers each morning. He had a bariatric bed because of his weight and used a Zimmer frame. He received help with his personal care from other prisoners in the evening.
3. Between October 2015 and December 2019, Mr Howarth had several hospital admissions and appointments.
4. On 25 December, Mr Howarth was taken to hospital by ambulance after reporting shortness of breath and increased leg swelling. He remained in hospital until 17 February.
5. On the morning of 19 February, Mr Howarth's carers reported that they had safeguarding concerns about his reduced mobility since his return to Lewes. Healthcare and prison staff were concerned that they could not meet his needs in prison.
6. Later that day, healthcare staff reported that Mr Howarth was unable to support his weight and appeared to have a resurgence of his cellulitis. A prison GP examined Mr Howarth and prescribed antibiotics to treat his inflamed abdomen. The GP said that Mr Howarth should go to hospital if he became worse. Mr Howarth continued to deteriorate, and he was taken to hospital that evening.
7. He remained in hospital, where he died of multiple organ failure on 10 March.

Findings

8. The clinical reviewer found that the care that Mr Howarth received at Lewes was good and equivalent to that which he could have expected to receive in the community.
9. However, she concluded that Mr Howarth's care plan should have been discussed at a multidisciplinary (MDT) meeting before he returned to prison on 17 February, given the length of time he had been in hospital. She made several recommendations about communication which the Governor and Head of Healthcare will need to address.

Recommendations

- The Governor and Head of Healthcare should ensure that when a prisoner has been in hospital for four weeks or more, MDT meetings are set up and documented before he returns to prison.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Lewes informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
11. The investigator did not visit HMP Lewes due to the COVID-19 pandemic. She obtained electronic copies of relevant extracts from Mr Howarth's prison and medical records.
12. The investigator interviewed five members of staff on 19, 29 and 30 June.
13. NHS England commissioned a clinical reviewer to review Mr Howarth's clinical care at the prison. The clinical reviewer conducted joint interviews with the investigator. All the interviews were conducted by telephone because of the COVID-19 restrictions in place.
14. We informed HM Senior Coroner for Brighton and Hove of the investigation. She gave us a provisional cause of death. We have sent the Coroner a copy of this report.
15. Our family liaison officer contacted Mr Howarth's daughter to explain the investigation and to ask if she had any matters she wanted us to consider. As we did not get a response, our initial report said that she had no specific questions and did not want to receive a copy of this report. After the pre-inquest review on 8 October, we were informed that Mr Howarth's wife and daughter did want a copy.
16. Mr Howarth's family received a copy of the draft report. They pointed out some factual inaccuracies and omissions and disagreed with the clinical reviewer's finding that the care Mr Howarth received at Lewes was of a good standard and was equivalent to that which he could have expected to receive in the community. This report has been amended accordingly. Mr Howarth's family also raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.
17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Lewes

18. HMP Lewes is a local prison serving the courts of East and West Sussex and holds up to 692 men. Sussex Partnership NHS Foundation Trust provided primary care services when Mr Howarth died. (On 1 April 2020, the provider changed to Care UK.) Lewes has a healthcare centre, with a full-time senior medical officer. Healthcare is provided 24-hours a day. There is also a 12-bed inpatient unit, an outpatient facility, a pharmacy and a range of clinics.
19. Following an inspection by HM Inspectorate of Prisons in 2016, Lewes was placed on 'special measures' for two years. This meant that HM Prisons and Probation Service considered that the prison needed additional, specialist support to improve performance.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Lewes was in January 2019. Inspectors reported that their findings were "deeply troubling and indicative of systematic failure within the prison service". They found that in the three years since their last inspection, very few of their recommendations had been fully implemented. Inspectors also expressed their disappointment that few of the action points arising from the special measures action plan had been carried out. They concluded that, far from delivering better outcomes, two years of 'special measures' had coincided with a serious decline in performance.
21. Inspectors found that many prisoners were negative about healthcare provision and that 67% regarded the overall quality as quite bad or very bad. Inspectors reported that healthcare staff were positive about the new clinical leadership but that many teams were understaffed leading to delays.
22. Inspectors reported that the overall management of long-term health conditions was poor, and patients did not have care plans to inform their ongoing care. Management was GP-led and ad hoc. There were no regular, specialist nurse-led clinics. Systems for managing older prisoners and patients with palliative care needs were also underdeveloped.
23. HMIP carried out an Independent Review of Progress in December 2019 to review the prison's response to the key recommendations from its earlier inspection. They found that good or reasonably good progress had been made in response to two-thirds of the areas they reviewed and that the prison had a new sense of purpose and direction.
24. They reported that health governance structures had improved, and healthcare staff now received clinical and managerial supervision. Care for prisoners with long-term health conditions had also improved but was undermined by the large number of prisoners who did not attend their appointments, and they concluded that the prison had made insufficient progress in this area.

Independent Monitoring Board

25. 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 2020, the IMB reported that healthcare services continued to be delivered through eight different service providers and, while they endeavoured to work together, the IMB was frequently aware of shortcomings in care due to disconnects between suppliers and their processes. This caused problems with the timeliness of prescriptions and the dispensing of medicines, as well as referral between the services for prisoners with complex needs. They noted that Lewes had had healthcare staff shortages and that poor processes and communication had significantly impacted on prisoner care.
26. The IMB noted that the mid-year announcement that a new provider would be in place at Lewes in April 2020 had brought uncertainty for staff, affecting morale, opportunities to recruit and a greater need for temporary staff during the latter months of the reporting year. The IMB also noted social care, delivered by Better Healthcare Services through the local authority, had high levels of service user satisfaction.

Previous deaths at HMP Lewes

27. Mr Howarth was the eighth prisoner to die at Lewes since January 2018. Of the previous deaths, three were from natural causes, two were self-inflicted and two were drug-related deaths. There are no similarities between our findings in the investigation of Mr Howarth's death and those of the previous deaths.

Key Events

28. On 17 July 2015, Mr Christopher Howarth was remanded to HMP Lewes, charged with sexual offences. In October 2015, he was sentenced to ten years in prison and remained at Lewes.
29. Mr Howarth entered prison with a number of chronic health conditions, including gout, high blood pressure, high cholesterol and a heart condition. Mr Howarth was morbidly obese and weighed 30 stones. In prison, Mr Howarth was diagnosed with cellulitis (a potentially serious skin infection), Type 2 diabetes, heart failure, anaemia, chronic kidney disease and peripheral vascular disease (a condition where a build-up of fatty deposits in the arteries restricts blood supply to the leg muscles). Mr Howarth also had several hospital admissions and appointments.

Social care needs

30. Better Healthcare provided social care services at Lewes on behalf of Sussex County Council. A social worker assessed Mr Howarth's needs yearly. While in prison, Mr Howarth received personal care from two carers each morning. Due to his weight, Mr Howarth had a bariatric bed and used a Zimmer frame. He received help from other prisoners in the evening to remove his socks.

December 2019 – 17 February 2020

31. On 13 December, Mr Howarth complained that he felt hot, and a request was made for a prison GP to see him the next day. On 14 December, a prison GP examined Mr Howarth, diagnosed cellulitis and prescribed antibiotics. Later that day, healthcare staff saw Mr Howarth again because he was increasingly short of breath and he felt hot. On 15 December, healthcare staff saw Mr Howarth again, this time because he felt shaky. His observations (temperature, blood pressure and pulse rate) were normal and healthcare staff gave him a dose of the prescribed antibiotics.
32. On 18 December, Mr Howarth's carers asked healthcare staff to see him as he had difficulty breathing. On 19 December, a prison GP saw him and recorded that his observations were 'okay' and noted his medications. The GP also recorded that Mr Howarth's stomach was inflamed and affected his mobility.
33. During the night of 24/25 December, Mr Howarth could not stand to get to the toilet. On the morning of 25 December, he complained of shortness of breath on moving, increased leg swelling and difficulty urinating. A nurse took his observations and recorded that he was not short of breath, but she was concerned he might have fluid in his lungs. Later that day, she recorded that Mr Howarth was short of breath, and had chest pain when walking to the toilet, difficulty passing urine and swollen legs. She recorded his observations as stable but was still concerned that he had fluid in his lungs.
34. An ambulance was called at 4.25pm, and Mr Howarth was taken to hospital in a bariatric ambulance and was admitted.

35. On 14 January 2020, the hospital updated Lewes that Mr Howarth was being treated for abdominal cellulitis and that he was receiving intravenous antibiotics and oral diuretics. He was due an ultrasound scan and chest x-ray. He needed assistance with personal care and to move.
36. On 7 February, it was noted that Mr Howarth was medically fit for discharge and was able to move with a Zimmer frame. The Safer Custody department at Lewes said the prison could not accept Mr Howarth back as he continued to have care needs overnight. On 13 February, Safer Custody confirmed that a care package was being organised and the hospital said that they planned to discharge Mr Howarth on 17 February.

17 - 19 February

37. On 17 February, Mr Howarth was discharged from hospital and returned to Lewes in a bariatric ambulance.
38. At 12.36pm on 19 February, a Custodial Manager (CM) was contacted by a nurse saying that he had received a phone call from Mr Howarth's carers raising concerns about his lack of mobility. The CM forwarded the email to the inpatient manager asking why Mr Howarth had been discharged from hospital if he needed further support.
39. The inpatient manager replied and said that healthcare staff should contact the hospital or the discharge co-ordinator about the CM's concerns. She noted that before Mr Howarth was discharged from hospital, the hospital had confirmed that no additional social care package was needed.
40. At 1.10pm, a nurse recorded that the wing carers were finding it difficult to care for Mr Howarth, that they were unable to help him stand or move from his bed and there were concerns he was bed-bound and did not have the appropriate equipment to meet his social care needs. She escalated her concerns to the CM and the inpatient manager.
41. The CM emailed a specialist care manager at Better Healthcare to clarify Mr Howarth's mobility needs since returning to prison. The CM also emailed the social worker to ask for an urgent assessment of his social care needs. The social worker replied that the earliest he could carry out an assessment was 21 February. He advised the CM to call paramedics because he thought the risk of Mr Howarth's skin and health deteriorating in the interim was too high.
42. The CM also received an email from a lead hospital nurse, who said that Mr Howarth had managed to move around the ward with minimal assistance before he was discharged from hospital. The nurse said it was unlikely that a consultant would admit Mr Howarth to an acute bed for physiotherapy and occupational therapy unless there was a clinical need. The CM liaised with Safer Custody and healthcare staff to see if it was possible to refer him to hospital for short-term rehabilitation and care.
43. At about 3.00pm, a nurse reported to the CM that Mr Howarth was unable to support his weight and appeared to have a resurgence of cellulitis. The nurse said that he and another nurse felt Mr Howarth needed hospital input.

44. At 3.50pm, a prison GP examined Mr Howarth and prescribed antibiotics to treat his inflamed abdomen. The GP said that if Mr Howarth's observations became worse, he should go to hospital.
45. At 4.26pm, still concerned, the CM sought guidance from a governor.
46. At 6.00pm, the CM heard back from the specialist care manager that she would try to admit Mr Howarth to hospital due to the high risk of further deterioration. The CM said that the information she had gathered suggested that the prison would not be able to care for Mr Howarth adequately overnight, so hospital was the safest and best option.
47. At 9.12pm, Mr Howarth was taken to hospital in a bariatric ambulance and was admitted.

19 February – 10 March

48. On 24 February, it was recorded that Mr Howarth was receiving intravenous antibiotics in hospital.
49. On 27 February, the hospital told Lewes that it wished to start planning Mr Howarth's discharge and needed to know what equipment was needed. On 28 February, an occupational therapist assessed Mr Howarth and said his mobility had improved, and that discharge could be considered after a physiotherapy and occupational therapy assessment on 9 March. On 3 March, the social worker went to hospital to assess Mr Howarth's needs in anticipation of his return to Lewes.
50. On 4 March, a multidisciplinary team (MDT) meeting was held at Lewes to establish what needed to be in place before Mr Howarth's return. It was recorded that Mr Howarth was mobile, no changes were needed to his social care package on discharge, and his cellulitis was subsiding. The MDT agreed that once the further assessments from 9 March were available, it would meet again to discuss Mr Howarth's discharge in more detail.
51. On the afternoon of 10 March, the hospital telephoned Mr Howarth's wife, who was his next of kin, and told her that his health had deteriorated. His wife was unable to visit and so the hospital contacted his daughter who visited that afternoon.
52. Mr Howarth died at about 10.00pm that night.

Contact with Howarth's family

53. On 10 March, an officer was appointed as the prison's family liaison officer and, at 3.30pm that day, she visited Mr Howarth, with a CM. She met Mr Howarth's daughter, and explained her role and said that family and friends were free to visit Mr Howarth. The prison bed watch officers remained outside Mr Howarth's room while he had visitors.
54. On the morning of 11 March, the officer telephoned Mr Howarth's daughter. She offered her condolences and support. She remained in contact with Mr Howarth's daughter and arranged for the family to visit the prison.

55. Mr Howarth's funeral took place during the week of 6 April. The prison offered to contribute to funeral costs, in line with national instructions.

Support for prisoners and staff

56. The Duty Governor met prison staff who were on bedwatch when Mr Howarth died, to check on them and remind them of the support available to them.
57. The prison posted notices informing other prisoners of Mr Howarth'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 Howarth's death.

Post-mortem report

58. The post-mortem report established that Mr Howarth died of multiple organ failure, caused by recurrent abdominal cellulitis and morbid obesity. Mr Howarth also had acute chronic kidney failure and Type 2 diabetes mellitus, which did not cause but contributed to his death.

Findings

59. The clinical reviewer found that, overall, the care that Mr Howarth received at Lewes was of a good standard and was equivalent to that which he could have expected to receive in the community.
60. She concluded, however, that although there was evidence of good communication between Lewes' safer custody team, healthcare staff, the local authority and community care providers in March, this was not the case before Mr Howarth was discharged from hospital in February. His care plan should have been discussed at an MDT meeting, given the length of time that he had been in hospital. We make the following recommendation:

The Governor and Head of Healthcare should ensure that when a prisoner has been in hospital for four weeks or more, MDT meetings are set up and documented before he returns to prison.

61. The clinical reviewer also made several recommendations about improving communication between the prison and external care providers which the Governor and Head of Healthcare will need to address.

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