Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Smithers, a prisoner at HMP Gartree, on 28 July 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 David Smithers died in hospital on 28 July 2020, while a prisoner at HMP Gartree. He died of pneumonia following a stroke. He was 77 years old. I offer my condolences to Mr Smithers' family and friends.

In the early hours of 23 July, Mr Smithers rang his emergency cell bell. When staff responded, they saw that he was unsteady on his feet and gasping for breath. A nurse assessed him and had no concerns. Another nurse assessed him when the day shift started and again, she had no concerns.

Later that morning, an officer saw that Mr Smithers had fallen and his head was bleeding. This time, a nurse decided to send him to hospital. He was diagnosed with a severe stroke and died five days later.

The clinical reviewer found that the standard of healthcare Mr Smithers received at Gartree was not equivalent to that which he could have expected to receive in the community. She considered that nurses should have suspected a stroke much sooner than they did and sent Mr Smithers to hospital earlier. However, she was unable to say whether the delay affected the outcome.

I am concerned that the control room failed to call for an ambulance immediately when the officer radioed a medical emergency code. The control room did not call for an ambulance until 13 minutes later.

The Head of Healthcare at Gartree will also need to follow up safeguarding concerns raised by the ambulance crew.

I am also concerned that Mr Smithers was restrained when he was taken to hospital. It was not justified by an appropriate risk assessment that took into account Mr Smithers' age and poor health. We have made repeated recommendations to Gartree about their inappropriate use of restraints on sick and elderly men. I have asked the Prison Group Director for East Midlands to assure me that action will be taken to address this.

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 **March 2021**

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Summary

Events

1. In October 2010, Mr David Smithers was remanded in custody for attempted murder. He was later sentenced to 21 years in prison. In March 2016, he was moved to HMP Gartree.

2. Mr Smithers had several long-term health conditions including heart dysfunction, high blood pressure and diabetes. He was prescribed appropriate medication for these conditions.

3. At around 8.00pm on 22 July 2020, an officer asked for a member of healthcare staff to see Mr Smithers in his cell because he was lying in his bed and, although he was breathing, he was not responding. A prison paramedic attended. She noted that all Mr Smithers' clinical observations were within normal range but asked wing staff to keep an eye on him.

4. At around 2.30am on 23 July, Mr Smithers pressed his emergency cell bell. When an operational support grade (OSG) responded and saw Mr Smithers was unsteady on his feet and gasping for air, she called a code blue (a medical emergency code used to indicate that a prisoner is unconscious or having breathing difficulties). A nurse responded. She noted that Mr Smithers was groaning, but that he refused to speak when she asked what was wrong. He indicated that he had abdominal pain and the nurse noted that his catheter was full, so she emptied it. She took his observations and noted that they were all within normal ranges.

5. Later that morning, another nurse went to assess Mr Smithers. She noted that he was lying on his bed groaning and that he did not speak when she asked him what was wrong, he just moved his arm up over his chest/abdomen area. She noted that all his observations were normal.

6. At around 10.41am, when an officer went to Mr Smithers' cell to do a welfare check, he saw that Mr Smithers had fallen on the floor and his head was bleeding. He called a code red (a medical emergency code used to indicate severe blood loss). A nurse attended. She told the control room that an ambulance was needed, and they called for one at 10.54am.

7. Ambulance paramedics arrived at the prison at 11.08am, but they did not see Mr Smithers until 11.32am. They assessed that Mr Smithers had probably had a stroke and they took him to hospital. Two officers accompanied him and restrained him using double cuffs. When he arrived at hospital, he was diagnosed with a severe stroke. He died in hospital five days later.

8. A hospital doctor gave the cause of death as pneumonia caused by a stroke.

Findings

9. The clinical reviewer found that Mr Smithers' care was not equivalent to that which he could have expected to receive in the community. When Mr Smithers presented with loss of speech, was restless and unsteady on his feet, the nurses should have suspected a stroke and should have called for an ambulance.

10. The clinical reviewer was also concerned that Mr Smithers' fall and head injury could have been avoided if a stroke had been suspected when Mr Smithers was seen by the nurses. However, the clinical reviewer could not say whether the delay in sending Mr Smithers to hospital affected the outcome.

11. We are concerned that when the officer called the code red, the control room did not call an ambulance immediately. They did not call for one until 13 minutes later, when the nurse told them that an ambulance was needed.

12. We are also concerned that staff applied double cuffs to Mr Smithers when he was taken to hospital. There was no healthcare input to the risk assessment and there is no evidence that the authorising manager took Mr Smithers' physical health into account when deciding to use restraints.

13. We have made repeated recommendations to Gartree about the inappropriate use of restraints. We are concerned to be making these recommendations again, despite the prison accepting previous recommendations and assuring us that authorising managers would be reminded about the need for proportionate decisions on restraints. I have asked the Prison Group Director for East Midlands to assure me that action will be taken.

14. The ambulance paramedics recorded that after they arrived at the prison, they had to wait 24 minutes before they could see Mr Smithers because he was behaving aggressively. Prison staff said this was not the case. In the absence of CCTV, we have not been able to establish what happened.

15. The ambulance paramedics also recorded concerns that Mr Smithers had been left to deteriorate over 24 hours, and that they were unhappy with the attitude of healthcare staff towards him and the lack of urgency displayed towards a time critical patient. The nurses we interviewed refuted these criticisms and, in the absence of CCTV or body-worn cameras, we are unable to say whether the paramedics' concerns were well-founded.

Recommendations

- The Head of Healthcare should ensure that:
    - The FAST tool is in place as an additional template on the clinical system.
    - All healthcare staff are able to recognise stroke symptoms using the FAST tool.
- The Governor should ensure that control room staff understand they must call an ambulance as soon as an emergency code is called.

- The Governor should revise the risk assessment form for hospital escorts to make it clear that:
    - healthcare staff must provide information on the prisoner's current state of health and mobility; and
    - prison managers must confirm that they have read and taken into account the healthcare information about the prisoner's current state of health and mobility in determining the level of security needed
- The Prison Group Director for the East Midlands should write to the Ombudsman setting out what he is doing to satisfy himself that managers at Gartree undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.
- The Governor should ensure that all staff understand the importance of ambulance staff having prompt access to prisoners in medical emergencies.
- The Head of Healthcare should contact the ambulance service for details of the ambulance crew's concerns and take any appropriate action in response, including disciplinary action if appropriate.
- NHS England should follow up the safeguarding report and take any appropriate action in response.

The Investigation Process

16. The investigator issued notices to staff and prisoners at HMP Gartree informing them of the investigation and asked anyone with relevant information to contact her. One prisoner responded.

17. The investigator obtained copies of relevant extracts from Mr Smithers' prison and medical records.

18. NHS England commissioned a clinical reviewer to review Mr Smithers' clinical care at the prison. The clinical reviewer conducted joint interviews with the investigator. Due to coronavirus restrictions, the interviews were conducted by telephone.

19. We informed HM Coroner for Leicester City and South District of the investigation. The coroner gave us the cause of death. We have sent the coroner a copy of this report.

20. One of the Ombudsman's family liaison officers contacted Mr Smithers' sister to explain the investigation and to ask if the family had any matters they wanted the investigation to consider. She did not respond.

21. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP Gartree

22. HMP Gartree, which is near Market Harborough in Leicestershire, holds up to 700 men most of whom are sentenced to life imprisonment and other indeterminate sentences. Care and Custody (Health) Ltd provided healthcare from April 2017 until November 2018. Nottinghamshire Healthcare Foundation Trust now provides the service. Nursing staff are available 24 hours a day.

HM Inspectorate of Prisons

23. The most recent full inspection of HMP Gartree was in November 2017. Inspectors reported that health provision had deteriorated. The service was suffering from serious nursing staff shortages and a high reliance on agency staff. Owing to staff shortages, long-term conditions were managed by the GP. Not all patients with long-term conditions had been identified and care plans were not always in place to manage chronic conditions such as diabetes and asthma. Inspectors noted that a new health provider had recently taken over and there was a reasonable expectation that matters would improve.

24. In September 2020, HMIP conducted a scrutiny visit (a slimmed down inspection during the coronavirus pandemic) at Gartree. Inspectors reported that healthcare services had improved since their last visit, particularly in the care of patients with long-term conditions. Health care services were well led and most of the previous recommendations had been addressed.

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 30 November 2019, the IMB reported that Nottinghamshire NHS Trust had taken over the provision of health services – both mental and physical. Despite some initial issues with staffing levels, the Board welcomed this new provider, and feedback from some of the prisoners indicated that there had been improvements in some areas. The number of cancelled or missed appointments had reduced sharply over the past year, partly as a result of an increased effort by healthcare staff to address this, and also increased availability of prison staff to escort prisoners to outside appointments.

Previous deaths at HMP Gartree

26. Mr Smithers was the sixth prisoner to die at Gartree since July 2018. Of the previous deaths, four were from natural causes and one was self-inflicted. We have previously made recommendations to Gartree about ensuring the use of restraints on sick and elderly prisoners is proportionate to the risk they pose.

Key Events

27. On 23 October 2010, Mr David Smithers was remanded in custody for attempted murder. He was later sentenced to a minimum of 21 years in prison. He was moved to HMP Gartree in March 2016.

28. Mr Smithers had several long-term health conditions including heart dysfunction, high blood pressure and diabetes. He was prescribed medication for these conditions. However, Mr Smithers did not always take his medication because he said that it gave him unwanted side effects. Mr Smithers also had poor mobility and used a walking stick and wheelchair.

29. On 18 May 2020, Mr Smithers had a routine heart and diabetes review. All results were within the normal range.

30. On 22 July at around 8.00pm, a prison officer did a welfare check on Mr Smithers and noticed that although Mr Smithers was breathing, he was not responding. The officer asked for a member of healthcare staff to assess him. A prison paramedic examined Mr Smithers in his cell. She noted that all his clinical observations were within normal ranges. She also noted that he was able to lift his legs and arms on command, had no signs of facial droop and was able to speak. She asked wing staff to keep an eye on him and said that healthcare staff would review him the next day.

31. At 9.10pm, a nurse recorded that she had looked into Mr Smithers' cell during the night round and saw him moving and touching his head.

Events of 23 July 2020

32. At around 2.30am on 23 July, Mr Smithers pressed his emergency cell bell. An operational support grade (OSG) answered it and asked Mr Smithers what was wrong. Mr Smithers did not respond. She noticed that Mr Smithers seemed unsteady on his feet and he started gasping for air, so she called a code blue (a medical emergency code used to indicate that a prisoner is unconscious or having breathing difficulties).

33. A nurse responded to the code blue. She noted that when she arrived, Mr Smithers was lying on his back on his bed and was groaning. She asked him what was wrong and recorded that he refused to speak but pointed to his lower abdomen and indicated that he was in discomfort. Mr Smithers' catheter bag was bulging, so she emptied it but it refilled straightaway. She also noted that although Mr Smithers was groaning and not speaking, he was able to follow her instruction to move his legs and lift his arms. She noted that all his observations were within normal ranges. She recorded that Mr Smithers would have a full review in the morning and that she told wing staff to contact her immediately if they had any more concerns.

34. Later that day, another nurse saw Mr Smithers and noted that he was still lying in bed groaning. She noted that when she asked him if he was in pain, he did not speak but just groaned loudly and moved his right arm up and down his chest/abdomen area. She recorded that all his observations were within normal ranges. She noted that she would ask the GP to review Mr Smithers.

35. At around 10.41am, when an officer went to Mr Smithers' cell to do a welfare check, he saw Mr Smithers on the floor with blood on his head. He immediately called a code red (a medical emergency code used to indicate severe blood loss). A nurse attended and noted that Mr Smithers had a head wound, was groaning loudly and had mucus around his mouth. She asked Mr Smithers to squeeze her hand, but he was unable to do so. She advised that he needed to go to hospital. At 10.54am, the control room called an ambulance.

36. At 11.08am, ambulance paramedics arrived at the prison, but they recorded that they did not see Mr Smithers until 11.32am. The paramedics suspected that Mr Smithers had had a stroke. At approximately 12.20pm, they took him to hospital by ambulance. Mr Smithers was escorted by two officers, using the double cuffing method. (Double cuffing is when the prisoner's hands are handcuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs.)

37. When Mr Smithers arrived at hospital he was diagnosed with a severe stroke. A prison manager authorised the removal of restraints at 2.20pm. The hospital said the prognosis was poor, and Mr Smithers was put on an end of life pathway. Mr Smithers rapidly deteriorated and died on 28 July.

Contact with Mr Smithers' family

38. On 25 July, when Mr Smithers' health deteriorated, the prison appointed a family liaison officer (FLO) and a deputy FLO. Mr Smithers' sister was listed as his next of kin, so the deputy FLO contacted her to say that Mr Smithers was very unwell in hospital. It was agreed that Mr Smithers' sister would be kept up to date by telephone. The following day when Mr Smithers died, the FLO called Mr Smithers' sister to tell her.

39. The prison offered a contribution to Mr Smithers' funeral in line with Prison Service policy, but it was paid for with a funeral bond that he had already arranged before he died.

Support for prisoners and staff

40. After Mr Smithers' death, a prison manager debriefed the staff involved in Mr Smithers' care to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

41. The prison posted notices informing other prisoners of Mr Smithers' death, and offered support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Smithers' death.

Cause of death

42. No post-mortem examination was carried out as the coroner accepted the cause of death provided by a hospital doctor. The doctor gave Mr Smithers' cause of death as pneumonia caused by a stroke. Atrial fibrillation (irregular heart rate) and hypertension (high blood pressure) were listed as contributory factors.

Findings

Clinical Care

43. The clinical reviewer concluded that the clinical care Mr Smithers received at Gartree was not equivalent to that which he could have expected to receive in the community.

44. The clinical reviewer was very concerned that healthcare staff did not suspect sooner that Mr Smithers had had a stroke. She noted that the FAST tool should be used for rapid assessment of a potential stroke. The FAST test is positive if one or more of the following are present:

- **F**acial weakness: asymmetry of mouth or eye as in facial drooping
- **A**rm weakness
- **S**peech difficulty: slurring or difficulty in finding names for commonplace objects
- **T**ime to call 999 if any of these three signs are present.

45. Mr Smithers presented with loss of speech, was very restless and unsteady on his feet in the early hours of 23 July. Neither nurses, who both saw Mr Smithers that morning, associated his inability to speak with a stroke. When the first nurse was interviewed, she said that she thought Mr Smithers was choosing not to speak as he was known to not engage with healthcare staff. She also thought he may have had a urinary tract infection and been confused. The second nurse said she did not suspect that Mr Smithers had had a stroke because he could move his limbs and did not have a facial droop. She also thought that Mr Smithers had chosen not to speak.

46. That same day, Mr Smithers fell in his cell and sustained a head injury. This could have been avoided if a stroke had been suspected and an ambulance had been called earlier. At interview both nurses said that, in hindsight, they wished that they had called an ambulance sooner.

47. We are concerned that Mr Smithers did not receive hospital care as soon as he should have. The clinical reviewer noted that Mr Smithers' stroke was severe, and it is possible that the outcome would have been no different if he had been sent to hospital earlier. However, it is very important that healthcare staff know how to recognise stroke symptoms and call an ambulance straightaway as prompt treatment may be crucial. We recommend:

The Head of Healthcare should ensure that:

- **The FAST tool is in place as an additional template on the clinical system.**
- **All healthcare staff are able to recognise stroke symptoms using the FAST tool.**

Emergency response

48. Prison Service Instruction (PSI) 03/2013 'Medical Emergency Response Codes', issued in February 2013, says that prisons should have a local protocol in place that gives guidance to staff on efficiently communicating the nature of a medical emergency and ensures that there are no delays in calling an ambulance. Gartree's local protocol is clear that an ambulance should be called immediately when a medical emergency code is radioed, in line with PSI 03/2013.

49. An officer radioed a code red at 10.41am, when he saw Mr Smithers' head was bleeding, but an ambulance was not requested until 13 minutes later, when a nurse contacted the control room and told them that an ambulance was needed.

50. We recommend:

The Governor should ensure that control room staff understand they must call an ambulance as soon as an emergency code is called.

Restraints, security and escorts

51. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and considers the prisoner's health and mobility.

52. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment said that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

53. Prison Service Instruction (PSI) 33/2015 says:

> "Normal practice is for male Category B and Escape-List prisoners to be double cuffed while on escort. All other prisoners will be single cuffed unless the individual risk assessment indicates that double cuffing is required and is proportionate."

The PSI goes on to say:

> "Handcuffs will not normally be used … if the prisoner's medical condition or advanced age or physical impairment renders restraints inappropriate. Restraints will not normally be necessary for example, when the prisoner's mobility is severely limited, e.g. due to advanced age or disability unless there are grounds for believing that an escape attempt may be made with external assistance."

54. Mr Smithers was taken to hospital and restrained using the double cuffing method. The risk assessment does not show that the authorising manager took Mr Smithers' ill health into account. He did not consider whether other options

may have been more appropriate given Mr Smithers' current state of health and his poor mobility.

55. Additionally, the risk assessment form had no input from healthcare staff: the section that should have been completed by healthcare staff was missing. When a prison manager was asked about this, he told the investigator that, as Mr Smithers was taken out to hospital as an emergency, he suspected that there had not been time for healthcare staff to complete their section. He went on to say that Mr Smithers was double cuffed as that is standard when a prisoner is taken out to hospital.

56. We have made recommendations about the use of restraints at Gartree in two recent investigations. During our investigation into a death that occurred in April 2019, we found that a 77-year old who was taken out to hospital after he had stopped breathing and had to be resuscitated, was double cuffed even though he was a Category D (the lowest security category) prisoner. We found in that case, as in this one, that the healthcare section of the risk assessment form had not been completed. In June 2020, the prison accepted our recommendation and said: *Managers are to be informed by the Governor via email of the Graham Judgement and that they are to be fully aware of the need to ensure that the risk of using a restraint on an individual is balanced against the risk to their health and life; the managers ultimate decision on use/non-use of restraints must reflect the recommendations made by healthcare. All sections including the healthcare assessment must be completed before any senior manager signs off the escort risk assessment.*

57. During our investigation into a death that occurred in April 2020, we found that a 72-year old who was very ill with COVID-19 symptoms, was double cuffed when taken out to hospital. We expressed concern that Gartree continued to use restraints inappropriately on sick and elderly men, despite the prison reassuring us previously that authorising managers would not take decisions without healthcare input and would carefully consider whether use of restraints was proportionate. We made two recommendations in that case: to revise the escort risk assessment form and for the Prison Group Director to write to the Ombudsman setting out what he is doing to satisfy himself that managers at Gartree are making appropriate decisions on the use of restraints. We have not yet had a response so make the same recommendations in this report:

The Governor should revise the risk assessment form for hospital escorts to make it clear that:

- **healthcare staff must provide information on the prisoner's current state of health and mobility; and**
- **prison managers must confirm that they have read and taken into account the healthcare information about the prisoner's current state of health and mobility in determining the level of security needed.**

The Prison Group Director for the East Midlands should write to the Ombudsman setting out what he is doing to satisfy himself that managers at Gartree undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

Other concerns

58. The ambulance log shows that the hospital paramedics arrived at Gartree at 11.08am but were not on scene with Mr Smithers until 11.32am. The paramedics noted that they were delayed entering Mr Smithers' cell because they were asked to wait in the doorway because he was lashing out. When the officers who were at Mr Smithers' cell were interviewed, we asked about this delay and they said that as far as they were aware there was no delay in the paramedics entering the cell.

59. There was no CCTV on the wing and no body-worn video camera (BWVC) footage, so we cannot say why there was a delay of 24 minutes before the paramedics entered the cell. However, we recommend:

The Governor should ensure that all staff understand the importance of ambulance staff having prompt access to prisoners in medical emergencies.

60. A paramedic noted that when they assessed Mr Smithers, he was 'unable to respond, cerebrally agitated, with excessive blood and secretions in his airway, had left sided weakness and a pronounced left sided facial droop'. The paramedic thought Gartree had left Mr Smithers to deteriorate for 24 hours and indicated that she was going to report abuse and neglect. The clinical reviewer has noted that NHS England should follow up the safeguarding report.

61. The paramedic also noted that the ambulance crew was unhappy with the attitude of the staff towards Mr Smithers and the lack of urgency towards a time critical patient. Both nurses denied using or hearing any derogatory comments. We recommend:

The Head of Healthcare should contact the ambulance service for details of the ambulance crew's concerns and take any appropriate action in response, including disciplinary action if appropriate.

NHS England should follow up the safeguarding report and take any appropriate action in response.

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