

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ralph Clarke, a prisoner at HMP Stafford, on 7 February 2021

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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Summary

1. 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.
2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Ralph Clarke died in hospital of old age on 7 February 2021, while a prisoner at HMP Stafford. He also had type 2 diabetes and chronic kidney disease which contributed to but did not cause his death. He was 105 years old. I offer my condolences to Mr Clarke's family and friends.
4. The clinical reviewer concluded that the health care Mr Clarke received was of a reasonable standard and equivalent to that which he could have expected to receive in the community.
5. The clinical reviewer was, however, concerned that there was no evidence that the decision not to transfer Mr Clarke to a hospice was communicated to him. She also noted that some key decisions about Mr Clarke's care were not documented in his medical record as they should have been. She made two recommendations which we repeat below.
6. We did not find any non-clinical issues of concern.

Recommendations

- The Head of Healthcare should ensure that all decisions that affect the management of a patient are recorded in SystemOne records.
- The Head of Healthcare should ensure that all decisions made about the care and treatment of a patient are discussed with that patient and recorded or that a record is made that the decision was made 'in the best interest of the patient' due to a proven lack of capacity.

The Investigation Process

7. NHS England commissioned an independent clinical reviewer to review Mr Clarke's clinical care at HMP Stafford.
8. The PPO investigator investigated the non-clinical issues, including aspects of the prison's response to COVID-19 and shielding prisoners; Mr Clarke's location; the security arrangements for his journey and admission to hospital; liaison with his family; and whether early release was considered.
9. The PPO's family liaison officer wrote to Mr Clarke's next of kin, his daughter, to explain the investigation. She did not respond to our letter.
10. 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.

Previous deaths at HMP Stafford

11. Mr Clarke was the 11th prisoner to die at Stafford since February 2019. All the previous deaths were from natural causes. There have been two further deaths from natural causes since Mr Clarke's death.

Key Events

12. In December 2016, Mr Ralph Clarke was remanded into prison custody charged with historic sexual offences. On 19 December, he was sentenced to 16 years in prison and in January 2017 he was transferred to HMP Stafford.
13. Mr Clarke had been previously diagnosed with type 2 diabetes and osteoarthritis and had previously had a heart attack and a stroke, which had left him frail. He used a walking stick to get around and was also registered blind. Care plans were created, and he was referred to specialist clinics at the prison to manage his care. He signed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order (which meant that if his heart or breathing stopped no attempt at resuscitation would be made). A social care package was put in place for him from November 2019.
14. Due to Mr Clarke's age and frailty, the prison appointed a family liaison officer (FLO). The FLO contacted Mr Clarke's next of kin, his daughter, to inform her of her father's condition. The FLO remained in contact with his family, keeping them updated.
15. On 1 April 2020, Mr Clarke was advised to shield because he was at high risk of severe illness if he contracted COVID-19. A shielding care plan was created in line with the COVID-19 guidelines for prisons.
16. In January 2021, he was admitted to hospital twice for short periods with community acquired pneumonia. When he returned to Stafford, he was bed bound and increasingly frail and needed 24-hour nursing care. However, he retained the mental capacity to make informed choices about his care.
17. On 21 January, the FLO saw Mr Clarke in his cell and discussed with him the possibility of moving him to Katharine House Hospice for end of life care. Later that day he said he did want to move to Katharine House when it became necessary. The FLO telephoned Mr Clarke's daughter to inform her of a deterioration in her father's condition, and the possibility that he might be moved to a hospice. The FLO remained in contact with her, keeping her updated.
18. Mr Clarke's condition continued to deteriorate and he became doubly incontinent. On 3 February, he was sent to hospital by emergency ambulance with a suspected bowel obstruction. He remained in hospital and died there at 6.30pm on 7 February.

Cause of death

19. No post-mortem examination was held, as the coroner accepted the cause of death certified by the hospital as old age. He also had type 2 diabetes and chronic kidney disease which did not cause but contributed to his death.

Sue McAllister CB
Prisons and Probation Ombudsman

December 2021

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