

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Thomas Clarke, a prisoner at HMP Leeds, on 4 August 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*



© Crown copyright, 2022

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 Thomas Clarke, who was 75 years old, died of aspiration pneumonia on 4 August 2021, while a prisoner at HMP Leeds. We offer our condolences to Mr Clarke's family and friends.
4. The clinical reviewer concluded that the care Mr Clarke received at HMP Leeds was equivalent to that which he could have expected to receive in the community. He made some recommendations about training for healthcare staff involved in Advance Care Planning for prisoners and referrals to the local fall's team, which we have outlined below.
5. We did not find any non-clinical issues of concern.

Recommendations

- The Head of Healthcare should provide training for all healthcare staff on Advance Care Planning, utilising the Dying Well in Custody Charter, so that it is offered to prisoners who would benefit from it.
- The Head of Healthcare should ensure that staff are aware of the referral criteria for the local fall's intervention team for ongoing support for prisoners who have recurrent falls.

Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Clarke's clinical care at HMP Leeds.
7. The PPO investigator has investigated non-clinical issues, including Mr Clarke's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. One of the PPO's family liaison officers wrote to Mr Clarke's next of kin, his sister, to explain the investigation. She did not respond to our letter.
9. 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 Leeds

10. Mr Clarke was the 23rd prisoner to die at Leeds since August 2019. Of the previous deaths, fourteen were from natural causes, seven were self-inflicted deaths and one was from non-natural causes.
11. There are no similarities between our findings in the investigation of Mr Clarke's death and the previous deaths.

Key Events

12. On 11 October 2016, Mr Thomas Clarke was sentenced to 15 years in prison for multiple historic sexual offences. He was sent to HMP Leeds.
13. Mr Clarke had previously been diagnosed with Parkinson's disease and heart disease. He also used a wheelchair to move around and was supported by social carers in the community, three times a day. Mr Clarke had misused alcohol for a number of years and had previously spent three years in a mental health hospital for depression and anxiety.
14. In May 2017, Mr Clarke was diagnosed with dementia. A dementia care plan was created to manage his care and he was regularly reviewed by healthcare staff, the prison's mental health team and social care staff.
15. While at Leeds, Mr Clarke was subject to a number of hospital admissions for conditions related to both his Parkinson's disease and dementia. On each occasion he returned to the prison's healthcare inpatient unit once his condition had improved.

2019

16. On 7 May 2019, a nurse and a doctor, a consultant from Wheatfields Hospice, Leeds, reviewed Mr Clarke to advise on his treatment and ongoing care. The doctor noted that Mr Clarke was extremely unwell. He also noted that he had difficulty chewing solid food. Given his deteriorating condition, the doctor considered it would not be appropriate for him to be resuscitated in the event of a cardiopulmonary arrest. He discussed this with Mr Clarke but considered that Mr Clarke did not have the capacity to make decisions about his care or resuscitation. The following day, the doctor signed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order on Mr Clarke's behalf.

2020

17. On 5 February 2020, a nurse saw Mr Clarke after he reported vomiting a dark brown liquid. She considered he needed to be seen at the hospital and he was sent there by emergency ambulance.
18. While in hospital, Mr Clarke was diagnosed with aspiration pneumonia (a condition caused when solids or liquids are breathed into the lungs). He was admitted to hospital as an inpatient and received intravenous antibiotics. Hospital staff also noted that Mr Clarke had difficulty swallowing, which was caused by a progression of his Parkinson's disease. Mr Clarke was discharged from hospital and returned to the prison on 10 February.
19. Mr Clarke was admitted to hospital as an inpatient due to the symptoms of aspiration pneumonia on four further occasions. Each time, he received a course of intravenous antibiotics and was discharged back to the prison's healthcare inpatient unit once his condition had improved. On 23 February, the hospital informed the prison staff accompanying Mr Clarke that due to his condition, he would continue to be prone to chest infections, and that the only treatment option left open to him was palliative care.

20. In July, the prison made an application for early release on compassionate grounds on Mr Clarke's behalf and submitted it to the Public Protection Casework Section (PPCS) of Her Majesty's Prison and Probation Service (HMPPS). The application was refused on 9 July, on the grounds that Mr Clarke's risk to the public had not reduced.
21. Over the months that followed, Mr Clarke continued to be subject to daily reviews by healthcare and social care staff.

2021

22. On 14 July 2021, the hospice doctor and a nurse saw Mr Clarke after healthcare staff noted a deterioration in his condition. They considered he would benefit from a transfer to a hospice for symptom control and a review of his prescribed medications. Mr Clarke transferred to Wheatfields Hospice the next day.
23. On 21 July, while at Wheatfields Hospice, the prison submitted another application for early release on compassionate grounds on Mr Clarke's behalf. Mr Clarke died before a decision was made.
24. Mr Clarke returned to Leeds on 28 July. He was moved to the prison's palliative care suite to receive end of life care. However, following a fall on 1 August, he was moved back to his previous cell, which gave him more room to move around and minimised the risk of further falls.
25. On 3 August, social carers noted a further deterioration in Mr Clarke's condition. A nurse saw him and noted that he was extremely frail, unable to communicate and that the involuntary spasms caused by his Parkinson's disease were increasing in severity. She telephoned the hospice doctor who advised her that a bed would be made available to Mr Clarke at Wheatfields Hospice the following day.
26. At 11.15am on 4 August, Mr Clarke was taken to Wheatfields Hospice by emergency ambulance. He was accompanied by two prison officers and he was not restrained. Hospice staff told the prison officers accompanying Mr Clarke that it was unlikely he would survive the day.
27. Mr Clarke's condition continued to deteriorate in the hospice, and at 4.45pm, it was confirmed that Mr Clarke had died.

Cause of death

28. The Coroner accepted the cause of death provided by a hospice doctor and no post-mortem examination was carried out. The doctor gave Mr Clarke's cause of death as aspiration pneumonia caused by advanced Parkinson's disease and frailty.

Lisa Burrell
Assistant Ombudsman

December 2021

**Prisons &
Probation**

Ombudsman
Independent Investigations