Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lawrence Gray, a prisoner at HMP Wealstun, on 27 January 2022

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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

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 Lawrence Gray died in a hospice from lung cancer on 27 January 2022, while a prisoner at HMP Wealstun. Mr Gray was 42 years old. I offer my condolences to Mr Gray's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Gray received at Wealstun was equivalent to that which he could have expected to receive in the community. However, she made three recommendations.

5. We are concerned that on the night of 18 December 2021, a hospice nurse recorded that when she responded to Mr Gray's buzzer, she found that he was confused and had urinated on the floor. She said that the two prison escort officers with Mr Gray appeared to be both asleep. This was unacceptable and should be investigated.

Recommendations

- The Head of Healthcare should ensure that patients suffering from low blood sugars are reviewed with an appropriate timescale to support with ongoing assessment and documentation within the SystmOne records.

- The Head of Healthcare should ensure that patients with diagnosed Long Term Conditions are referred into appropriate clinics through the reception screening template and in line with NICE Guidance NG57 Physical Health of People in Prison.

- The Head of Healthcare should ensure that care planning is initiated and reviewed as appropriate for patients with Long Term Conditions.

- The Governor should commission an investigation into allegations that prison bedwatch staff were asleep while on duty on the night of 18 December 2021, with a view to considering whether disciplinary action is appropriate.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Gray's clinical care at HMP Wealstun.

7. The PPO investigator has investigated non-clinical issues, including Mr Gray's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

8. The PPO family liaison officer wrote to Mr Gray'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. The action plan is annexed to this report.

Previous deaths at HMP Wealstun

10. Mr Gray was the only prisoner to die at Wealstun since January 2020.

Key Events

11. In October 2019, Mr Lawrence Gray was sentenced to three years imprisonment for violent offences. He was released on licence on 29 December 2020 but was recalled to prison on 21 July 2021 for breaching his licence conditions. He was moved to HMP Wealstun on 7 October.

12. Mr Gray had chronic obstructive pulmonary disease (COPD – the term for a group of serious lung diseases), gastritis (the term for a group of conditions which cause inflammation to the stomach lining), anxiety, depression, and past opiate addiction.

13. On 22 October, Mr Gray attended the primary care clinic where the nurse noted concerns of headaches, kidney pain, loss of appetite and weight loss. She asked the prison GP to investigate further.

14. On 28 October, the GP reviewed Mr Gray and noted that he seemed unwell. The GP requested blood and urine tests, and prescribed paracetamol for the headaches.

15. On 29 October, the pharmacy technician who dispensed Mr Gray's medication to him noticed he was looking unwell and he told her that he felt sick and dizzy. She asked an officer to request a healthcare visit for Mr Gray. A nurse visited Mr Gray later that day and recorded his observations and weight.

16. On 30 October, a nurse reviewed Mr Gray and noted that he appeared grey and lethargic and was unable to stand up straight. She told prison staff that he needed to attend A&E urgently for review and they arranged for Mr Gray to be escorted to hospital.

17. After various tests, scans and biopsies, hospital doctors suspected that Mr Gray had lung cancer. On 13 November, Mr Gray was discharged back to Wealstun.

18. On 25 November, at an outpatient appointment, hospital staff told Mr Gray that he had terminal cancer. They told him that any treatment would be palliative only. Mr Gray began radiotherapy on 30 November.

19. On 6 December, the hospital team decided to admit Mr Gray in order to support ongoing care and pain management. On 14 December, they decided Mr Gray would be better supported at a hospice, as his treatment had not been effective. Mr Gray was moved to the hospice on 15 December. He died there on 27 January 2022.

Cause of Death

20. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Gray’s cause of death as metastatic non-small cell lung cancer (cancer that has formed in the lungs and spread to other parts of the body). The doctor noted that Mr Gray also had chronic obstructive pulmonary disease which did not cause but contributed to his death.

Non-Clinical Findings

21. Mr Gray's clinical records show that on the night of 18 December 2021, a hospice nurse responded to Mr Gray's call buzzer and found that the two prison escort officers with Mr Gray appeared to be both asleep. The nurse recorded that Mr Gray appeared confused and there was a puddle of urine on the floor. She asked the escort officers if they had seen what had happened and one of them said, 'I saw him sat over there and heard him weeing on the floor and told him to go to the toilet'. The nurse recorded that this was inappropriate, and they should have given Mr Gray a bottle or helped him to the toilet.

22. Prison Service Instruction (PSI) 33/2015 on External Prisoner Movement says that officers on bedwatch duty should, 'Remain professional and vigilant at all times and not allow themselves to be unnecessarily distracted from their primary role of closely supervising the prisoner'. Clearly it is unacceptable for bedwatch officers to fall asleep on duty. We would also have expected a more caring attitude towards a terminally ill prisoner who was clearly confused and needed help to get to the toilet. We recommend:

    The Governor should commission an investigation into allegations that prison bedwatch staff were asleep while on duty on the night of 18 December 2021, with a view to considering whether disciplinary action is appropriate.

Louise Richards **December 2022**
Assistant Ombudsman

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