

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anthony Noble, a prisoner at HMP Preston, on 8 May 2022

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

OGL

© Crown copyright, 2023

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 Anthony Noble died on 8 May 2022 of coronary artery disease at HMP Preston. He was 76 years old. We offer our condolences to Mr Noble's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Noble received at Preston was equivalent to that which he could have expected to receive in the community. However, she made three recommendations.
5. We found no non-clinical issues of concern.

Recommendations

- The Head of Healthcare should ensure that staff carry out a mental capacity assessment during the reception screening process if a prisoner arrives with signs of dementia or confusion.
- The Head of Healthcare should ensure that staff assess older prisoners' risk of falls during the reception screening process.
- The Head of Healthcare should complete an audit on the use of care plans within HMP Preston.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Noble's clinical care at Preston.
7. The PPO investigator investigated the non-clinical issues relating to Mr Noble's care, including his location, the emergency response and liaison with his family.
8. The PPO family liaison officer wrote to Mr Noble's next of kin, his brother, to explain the investigation and to ask if he had any matters he wanted us to consider. He asked for a copy of our report.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.
10. We sent a copy of our initial report to Mr Noble's brother.

Previous deaths at HMP Preston

11. Mr Noble was the fourth prisoner to die at Preston since May 2020. Of the previous deaths, one was from natural causes and two were self-inflicted. There are no similarities between our findings in the investigation into Mr Noble's death and our investigation findings for the previous deaths.

Key Events

12. On 30 April 2022, Mr Anthony Noble was remanded in prison custody, charged with sexual offences, and sent to HMP Preston.
13. When Mr Noble arrived at Preston, the reception nurse carried out a reception health screen. Mr Noble said he had no health concerns and was not taking any medication. The nurse noted that Mr Noble appeared confused, but the nurse did not assess his mental capacity.
14. On 1 May, a nurse carried out Mr Noble's secondary reception screen. The nurse identified that Mr Noble was incontinent of urine and made a social care referral. However, there is no evidence that the nurse carried out a falls risk assessment (older people should be asked whether they have fallen in the past year and about the frequency of falls).
15. The same day, staff referred Mr Noble for a cognitive assessment because of his confusion. He was assessed on 2 May and this showed significant cognitive impairment. A subsequent assessment showed that he had dementia. He was referred to the memory clinic but died before he was given an appointment.
16. On 3 May, Mr Noble was moved to the prison's inpatient unit after staff identified that he was unable to care for himself. Healthcare staff took his clinical observations daily. These were normal up to 8 May.
17. At around 11.45am on 8 May, a healthcare support worker took Mr Noble's clinical observations and calculated a National Early Warning Score (NEWS2) score of 2. (NEWS2 is a clinical tool used to assess clinical deterioration in adult patients. A score of 2 indicates that a nurse should assess the patient and decide on the monitoring needed.)
18. A member of healthcare staff took Mr Noble's clinical observations shortly after 5.00pm. They calculated a NEWS2 score of zero and noted there were no concerns.
19. Two officers completed a roll check (a count of prisoners) at 5.30pm. They reported no issues.
20. At 6.52pm, a nurse went to Mr Noble's cell to assist with his personal care and found him on the floor with his back against the wall. Mr Noble was not responsive, and the nurse could not find a pulse. She also noticed Mr Noble was cyanosed (blue tinging to the body due to a lack of oxygen). She called a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties) and began CPR.
21. Two members of healthcare staff arrived with emergency equipment. They administered oxygen and used a defibrillator to try to restore Mr Noble's normal heart rhythm. They continued CPR until the paramedics arrived at 7.10pm. Paramedics took over Mr Noble's care, but resuscitation attempts were unsuccessful. At 7.32pm, they pronounced that Mr Noble had died.

Post-mortem report

22. The post-mortem report concluded that Mr Noble died of coronary artery disease.

Louise Richards
Assistant Ombudsman

December 2022

**Prisons &
Probation**

Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100