

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

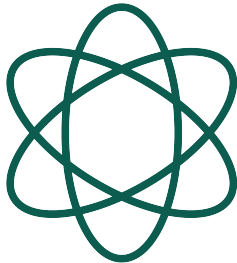
# **Independent investigation into the death of Mr John Gordon, a prisoner at HMP Swaleside, on 17 May 2022**

**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



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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 John Gordon died in hospital on 17 May 2022, while a prisoner at HMP Swaleside. His cause of death was recorded as bronchopneumonia caused by chronic obstructive pulmonary disease (COPD, a lung disease), ischaemic heart disease, hypertension (high blood pressure), atrial fibrillation (an irregular and often fast heartbeat) and cerebrovascular disease (a group of conditions, diseases and disorders that affect the blood vessels and blood supply to the brain which includes stroke). He also had Type 2 diabetes which contributed to but did not cause his death. Mr Gordon was 86 years old. I offer my condolences to his family and friends.
4. The clinical reviewer concluded that the clinical care that Mr Gordon received at Swaleside was equivalent to that which he could have expected to receive in the community.
5. Mr Gordon had a falls risk assessment in place. However, this was not reviewed annually in line with National Institute for Health and Care Excellence (NICE) guidance. The clinical reviewer was concerned that Mr Gordon's falls assessment was not reviewed in April 2022, after he experienced a fall.
6. The clinical reviewer also made a number of recommendations which are not directly related to Mr Gordon's death, but which the Head of Healthcare will need to address.
7. Mr Gordon used a wheelchair which did not fit through his cell door. This meant that he had to fold his wheelchair to get in and out of his cell, increasing the risk of a fall. The wheelchair did not have a foot plate fitted, which caused him discomfort and swelling to his feet.
8. An application for early release on compassionate grounds was not adequately progressed by the Offender Management Unit when hospital staff said that Mr Gordon was reaching the end of his life.

## Recommendations

- The Head of Healthcare should ensure that older prisoners who are at risk of falls have an up-to-date falls risk assessment, updated annually or when their risk changes in line with NICE guidelines.

- The Governor should ensure that prisoners who use a wheelchair are located in a cell suitable for their needs or are provided with a wheelchair that fits through the cell door and that wheelchairs provided to prisoners are properly maintained.
- The Governor should ensure that applications for compassionate release are progressed in a timely manner and submitted as promptly as possible.

## The Investigation Process

9. NHS England commissioned an independent clinical reviewer to review Mr Gordon's clinical care at Swaleside.
10. The PPO investigator investigated the non-clinical issues relating to Mr Gordon's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
11. The Ombudsman's family liaison officer wrote to Mr Gordon's daughter to explain our investigation. Mr Gordon's daughter asked questions relating to Mr Gordon's health and healthcare and was concerned that he was provided with a wheelchair which did not fit through his cell door.
12. We shared the initial report with the Prison Service. There were no factual inaccuracies.
13. We shared the initial report with Mr Gordon's daughter. There were no factual inaccuracies. Mr Gordon's daughter asked a number of questions which do not relate to Mr Gordon's death and have been answered in separate correspondence.

## Previous deaths at HMP Swaleside

14. In the two years before Mr Gordon's death, five prisoners died from natural causes at Swaleside, two as a result of COVID-19. There were five self-inflicted deaths in the same period. Three prisoners have died from natural causes and there have been two self-inflicted deaths at Swaleside since Mr Gordon's death. There are no significant similarities between our findings in this investigation and those of the other deaths.

## Key Events

15. On 4 September 2018, Mr John Gordon was sentenced to 12 years in prison for sex offences. On 24 December 2019, he was transferred to HMP Swaleside.
16. Mr Gordon had the following medical history: a previous stroke, Type 2 diabetes, heart disease, high cholesterol, high blood pressure, angina, COPD, atrial fibrillation, pulmonary embolism (a blood clot in the lungs), poor mobility and poor mental health.
17. In February 2021, Mr Gordon was admitted to hospital for a pulmonary embolism and COVID-19. Following his discharge, he was admitted to the prison inpatient unit.
18. On 22 June, a prison GP and a nurse reviewed Mr Gordon and noted that he could move to a standard residential wing.
19. On 6 July, after Mr Gordon had an occupational therapy assessment and a social care assessment from Kent County Council, he moved to a standard cell on a standard wing. He was assigned daily support with his personal care and wellbeing.
20. On 4 April 2022, a nurse saw Mr Gordon, who had fallen over in his cell. She noted that Mr Gordon was on the floor near to his toilet and had been incontinent of faeces. Mr Gordon was unable to make eye contact, the left side of his face had a drop, he had slurred speech and was leaning to his left side. She took his physical observations and arranged for him to be transferred to hospital by ambulance. Following a risk assessment, prison staff did not use restraints on this or any of Mr Gordon's subsequent hospital admissions.
21. Later that day hospital staff sent Mr Gordon back to Swaleside. Mr Gordon's hospital discharge letter found no neurological deficits and his blood test results were unremarkable. A nurse created a comprehensive care plan to ensure that Mr Gordon was closely monitored.
22. On 7 April, a nurse saw Mr Gordon, who had vomited overnight. She was unable to obtain a blood pressure reading and thought that Mr Gordon may have had a stroke. She called an ambulance, which was later stood down when healthcare staff were able to take Mr Gordon's observations, which were all within the normal range.
23. On 8 April, a prison GP reviewed Mr Gordon. He noted that Mr Gordon appeared confused and disorientated. The GP sent Mr Gordon to hospital for further investigations. The following day, hospital staff sent Mr Gordon back to hospital without a discharge summary.
24. On 10 April, a nurse saw Mr Gordon to give him his medication. She noted that Mr Gordon was confused and had a left side facial drop. She thought that Mr Gordon had had a stroke and arranged for him to be sent to hospital by ambulance. Hospital staff confirmed that Mr Gordon had experienced a large stroke and treated Mr Gordon in the acute stroke unit and the stroke rehabilitation unit.

25. On 6 May, a nurse telephoned hospital staff who told her that Mr Gordon was now receiving end-of-life care and that they had stopped all supportive treatment. She noted that the hospital had agreed for Mr Gordon to remain an inpatient until his death to receive palliative care.
26. A nurse arranged for a hospital consultant to complete the relevant paperwork in order for them to submit an application for early release on compassionate grounds. On 16 May, a nurse telephoned the hospital to chase the compassionate release paperwork from the consultant, which they had not received.
27. On 17 May, Mr Gordon died in hospital.

### **Post-mortem report**

28. A post-mortem examination established that Mr Gordon died of bronchopneumonia. This was caused by COPD, ischaemic heart disease, hypertension, atrial fibrillation and cerebrovascular disease. He also had Type 2 diabetes which contributed to but did not cause his death.

## Non-Clinical Findings

### Falls risk and mobility

29. The clinical reviewer found that Mr Gordon had a falls risk assessment in place which was last reviewed in February 2021. However, she said that it should have been reviewed annually, particularly after Mr Gordon fell in April 2022, in line with National Institute for Health and Care Excellence (NICE) guidance falls in older people: assessing risk and prevention. We make the following recommendation:

**The Head of Healthcare should ensure that older prisoners who are at risk of falls have an up-to-date falls risk assessment, updated annually or when their risk changes in line with NICE guidelines.**

30. Mr Gordon used a wheelchair to mobilise both inside and out of his cell. Mr Gordon's daughter told the investigator that the wheelchair he was given was inappropriate for his needs and did not fit through the cell door.
31. The Equalities, Diversity and Inclusion Lead said that Swaleside has a limited number of cells that are specifically designed for wheelchair users and disabled prisoners. He said that standard cell doors are 60 centimetres wide, and a standard wheelchair is 63.5 centimetres wide. To enter and leave his cell, Mr Gordon had to stand up and fold his wheelchair. He said that when Mr Gordon was at Swaleside all the accessible cells were occupied by prisoners with disabilities. He said that he raised this issue at management meetings and transfers to other establishments were requested for some of their disabled prisoners, but he said that other establishments were slow to accept them. He said that they had looked into converting standard cells to accessible cells, but this proved to be unviable.
32. Healthcare staff noted that Mr Gordon's wheelchair had no foot plates which resulted in his feet hanging down and causing swelling to his feet.
33. While we accept that there were insufficient cells adapted for prisoners with a disability and who use wheelchairs, it was not appropriate for Mr Gordon to have to fold his wheelchair every time he needed to come out of and return to his cell. Mr Gordon was vulnerable to falling over and having to do this to enter and leave his cell made him even more vulnerable to falls. It was not appropriate that the wheelchair that he was provided with did not have a footplate, and it should have been repaired at the earliest opportunity. We make the following recommendation:

**The Governor should ensure that prisoners who use a wheelchair are located in a cell suitable for their needs and that wheelchairs provided to prisoners are properly maintained and suitable for their needs.**

### Compassionate release

34. Release on compassionate grounds is a means by which prisoners who are terminally ill and in the last few months of life can be permanently released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. The criteria for early release are set out in the Early Release on Compassionate Grounds Policy Framework. Among the criteria is that

the risk of reoffending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of HM Prison and Probation Service (HMPPS).

35. On 6 May 2022, hospital staff concluded that Mr Gordon was reaching the end of his life and he was receiving palliative care. It was agreed that he would remain in hospital as his life expectancy was thought to be short. A hospital consultant was asked to complete the relevant compassionate release paperwork. On 16 May, a nurse chased the compassionate release paperwork because it had not been received by the healthcare department. The clinical reviewer found that the consultant letter was written on 6 May and sent to the Governor.
36. The then Head of the Offender Management Unit said that, on 11 May, a copy of Mr Gordon's police national computer (PNC) record and order for imprisonment were put in his early release on compassionate grounds (ERCG) file. He said that he therefore assumed that the application may have been discussed. He said that he started to collate the information needed to submit the application, but there was no formal email request made and the form was never completed.
37. We accept that on 6 May, when Mr Gordon was reaching end-of-life, hospital staff expected that he would remain in hospital. However, at that time it was unclear exactly how long Mr Gordon would live. It is important for prison staff to promptly commence and complete an application for compassionate release so that the Secretary of State can consider an application. We make the following recommendation:

**The Governor should ensure that applications for compassionate release are progressed in a timely manner and submitted as promptly as possible.**

38. On 1 May 2023, at the inquest the Coroner concluded that Mr Gordon died from natural causes.



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