Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Davie, a prisoner at HMP Ashfield, on 3 January 2022

A report by the Prisons and Probation Ombudsman

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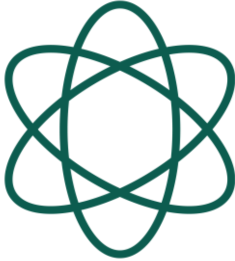
Our vision

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

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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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Michael Davie died in hospital of pneumonia and infected leg ulcers on 3 January 2022, while a prisoner at HMP Ashfield. He was 83 years old. I offer my condolences to Mr Davie's family and friends.

The clinical reviewer found that the care Mr Davie received for his leg wounds was not equivalent to that which he could have expected to receive in the community. She found that prison healthcare staff should have made referrals to specialist services for advice on managing Mr Davie's leg wounds much earlier than they did. She also found that Ashfield did not have a local Standard Operating Procedure (SOP) for wound care guidance and Mr Davie had no formal care plan in place. This resulted in an inconsistent level of care depending on the experience and knowledge of the nurse who was treating him at the time.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Sue McAllister CB
Prisons and Probation Ombudsman **March 2023**

Contents

Summary 1

The Investigation Process 3

Background Information 4

Key Events 5

Findings 8

Summary

Events

1. In May 2018, Mr Michael Davie was convicted of sexual offences and sentenced to 16 years and four months imprisonment. He was moved to HMP Ashfield on 21 May 2019.

2. In July 2020, prisoners raised concerns that Mr Davie was unwell and thought his legs were infected. A nurse visited Mr Davie but noted no concerns. She agreed to monitor the condition of his legs.

3. From July to August 2021, Mr Davie continued to complain about his legs and broken skin. Healthcare staff treated him for cellulitis (a bacterial skin infection), varicose eczema (a skin condition often caused by poor quality veins) and vasculitis (inflamed blood vessels which impacts blood circulation).

4. In September, the prison GP sought advice from a dermatologist on how to manage the condition of Mr Davie's legs. The dermatologist provided a formal diagnosis and care plan.

5. In October, a prison nurse recorded that the condition of Mr Davie's legs continued to deteriorate. She recorded she would make a referral to tissue viability services for further advice but there was no record she did this. Another prison nurse made a referral one month later. The service provided a care plan.

6. On 29 December, a nurse completed observations on Mr Davie and noted he appeared confused and was struggling to respond to her. She called a medical emergency code and staff called an emergency ambulance. Paramedics attended and Mr Davie was admitted to hospital.

7. Mr Davie died in hospital on 3 January 2022.

8. The post-mortem report concluded that Mr Davie died of pneumonia (lung infection), infected leg ulcers and heart disease.

Findings

9. The clinical reviewer found that the care provided for Mr Davie's leg wounds was not equivalent to that which he could have expected to receive in the community. She found that staff should have sought specialist advice on managing the condition of Mr Davie's legs much sooner than they did. She also noted that Mr Davie did not have a formal care plan in place for his wound care and that Ashfield did not have a local policy for wound care and management. She considered that this contributed to inconsistent care in managing the condition of his legs.

10. The clinical reviewer also found that Mr Davie did not have care plans in place for his long-term conditions, including his risk of cardiovascular disease. This is an issue we have raised with Ashfield before. We were told that an audit would be carried out by March 2022.

11. We found that despite the prison being aware of Mr Davie's limited mobility, they did not request a wheelchair accessible taxi to take him to a hospital appointment. This meant he missed his appointment.

Recommendations

- The Head of Healthcare should ensure referrals to secondary services are completed in line with NICE guidance.
- The Head of Healthcare should:
  - create a Standard Operating Procedure for tissue viability;
  - ensure patients with tissue viability needs have a formal individualised care plan; and
  - provide staff with refresher training on wound management.
- The Head of Healthcare should confirm that an audit of prisoners with long-term conditions has been carried out and that all prisoners with long-term conditions now have care plans in place.
- The Director should ensure that vehicles used to transport prisoners meet their mobility needs.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Ashfield informing them of the investigation and asking anyone with relevant information to contact him. One prisoner responded and raised concerns about the care Mr Davie received for his leg wounds.

13. The investigator obtained copies of relevant extracts from Mr Davie's prison and medical records.

14. NHS England commissioned an independent clinical reviewer to review Mr Davie's clinical care at the prison. The investigator and clinical reviewer interviewed the Head of Healthcare at Ashfield.

15. We informed HM Coroner for Avon of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

16. The Ombudsman's family liaison officer contacted Mr Davie's next of kin, his son, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not respond.

17. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies. They provided an action plan which is annexed to this report.

Background Information

HMP Ashfield

18. HMP Ashfield is a Category C prison, operated by Serco and holding approximately 400 men who have been convicted of sexual offences. Hanham Secure Health provides healthcare services.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Ashfield was in March 2019. Inspectors reported that the health and social care provisions were of a good standard and most prisoners were satisfied with the quality of healthcare received. The inspection found not all prisoners with long-term health conditions had care plans in place and made a recommendation for this to be implemented, which the prison accepted.

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 30 June 2021, the IMB reported that Ashfield was a well-managed prison. They said that healthcare services were equal to those provided in the community. The IMB assessed that the prison was a safe environment and that prisoners were treated humanely.

Previous deaths at HMP Ashfield

21. Mr Davie was the fourth prisoner to die at Ashfield since January 2020. All the previous deaths were from natural causes. We have made previous recommendations about ensuring that all prisoners with long-term conditions have care plans in place. We were told in February 2022 that a lead nurse was now in post and that audits would be conducted.

Key Events

22. In May 2018, Mr Michael Davie was convicted of sexual offences and sentenced to 16 years and four months imprisonment. On 21 May 2019, he was moved to HMP Ashfield.

23. On 6 July 2020, following several complaints by prisoners that Mr Davie was unwell, a nurse went to see him. Mr Davie told her that other prisoners were concerned his legs were infected. The nurse did not note any concerns but agreed to monitor him. Mr Davie had already been given compression stockings to manage swelling and pain in his legs.

24. From July to August 2021, Mr Davie continued to complain about his legs and broken skin. Healthcare staff treated him for cellulitis (a bacterial skin infection), varicose eczema (a skin condition often caused by poor quality veins) and vasculitis (inflamed blood vessels which impacts blood circulation).

25. On 1 September, a prison GP reviewed Mr Davie's legs. He noted that prescribed medication was not helping and referred Mr Davie to a dermatologist (a medical professional who specialises in skin conditions.)

26. On 7 September, a dermatologist confirmed Mr Davie had varicose eczema and provided prison healthcare with a treatment plan, including regular wound redressing and a list of creams they could prescribe, which they followed.

27. On 2 October, a prison nurse recorded that Mr Davie's leg wounds were open and not healing. She noted she would escalate this to the advanced care practitioner, as she considered Mr Davie required a referral to the tissue viability service (specialist advice for wounds that are taking a long time to heal). There was no record this was done.

28. On 4 October, a prison GP reviewed Mr Davie. He recorded the condition of his legs continued to decline despite following the dermatologist's treatment plan. He also noted his leg veins looked swollen, so referred Mr Davie to a vascular surgery service (to investigate issues of blood circulation) for further advice.

29. On 13 October, a prison nurse completed observations on Mr Davie as he attended healthcare with chest pain and shortness of breath. She called a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties), as there were concerns Mr Davie may have had a heart attack. Paramedics attended and he was admitted to hospital. The healthcare unit made daily calls to the hospital for updates.

30. On 9 November, Mr Davie was discharged from hospital and returned to Ashfield. While in hospital he was treated for sepsis. His leg ulcers were also investigated further and a treatment plan was created for vasculitis, which prison healthcare staff followed.

31. The following day, a rheumatologist contacted the healthcare unit and told them Mr Davie had tested positive for cytomegalovirus (CMV - a common virus related to the herpes virus that causes cold sores and chickenpox).

32. On 17 November, a prison nurse saw Mr Davie and was concerned his legs may have become infected. She said she would make a referral to the tissue viability specialists. Again, there was no record this was done.

33. On 23 November, a prison nurse saw Mr Davie to re-dress his leg wounds. She noted they were saturated with green fluid, suggesting an infection. She made a referral to the tissue viability specialists.

34. On 25 November, Mr Davie was due to attend a rheumatology appointment at hospital. He could not attend as he was unable to get into the taxi arranged by the prison, due to his poor mobility.

35. On 29 November, the tissue viability service provided advice on types of treatments and bandages they recommended, and how often these should be applied. Prison healthcare staff followed the advice.

36. On 9 December, Mr Davie attended a hospital appointment at the vascular department. After he had returned to Ashfield, a hospital nurse contacted the prison healthcare unit and told them that Mr Davie needed to be admitted to hospital for further investigation into his leg ulcers. He was taken back to hospital the following day.

37. While in hospital, a hospital consultant said he had an active CMV infection, which had likely worsened his vasculitis. Mr Davie was prescribed medication to manage this. He was discharged on 23 December.

38. On 29 December, a nurse completed observations on Mr Davie and noted he appeared confused and was struggling to respond to her. She called a code blue and staff called an emergency ambulance. Paramedics attended and Mr Davie was admitted to hospital. Healthcare staff called the hospital daily for updates.

39. On 3 January 2022, a prison nurse called the hospital for an update. She was told Mr Davie had pneumonia and his condition had declined significantly over the last 12 hours. Mr Davie was pronounced dead at 4.55pm.

Contact with Mr Davie's family

40. On 29 December 2021, the prison made Mr Davie's next of kin, his son, aware that Mr Davie had been admitted to hospital.

41. Due to staff shortages, there was no allocated family liaison officer at the time of Mr Davie's death. At approximately 5.30pm on 3 January 2022, a prison manager attended the hospital to meet with the family and offer his condolences. The following day, the prison appointed a family liaison officer.

42. Mr Davie had a prepaid funeral plan so the prison did not contribute to the funeral costs.

Support for prisoners and staff

43. After Mr Davie's death, a prison manager debriefed staff involved in supervising Mr Davie while in hospital, to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

44. The prison posted notices informing other prisoners of Mr Davie’s death, and offering support.

Post-mortem report

45. The post-mortem report concluded that Mr Davie died of bronchopneumonia (lung infection) and infected leg ulcers, caused by ischaemic heart disease.

Findings

Clinical care

46. The clinical reviewer found that the care provided for Mr Davie's leg wounds was not equivalent to that which he could have expected to receive in the community.

47. Mr Davie had very complex needs relating to the management of his skin, wounds and infections of his legs that required specialist advice and management. While the clinical reviewer found evidence of continued hard work by healthcare staff, who were also dealing with the COVID-19 pandemic at the time, she considered that staff should have sought advice from vascular surgeons and tissue viability services much earlier. Referrals could have been made much sooner, around August 2021, when Mr Davie's legs became more problematic to manage.

48. There were also two instances where prison nurses recorded that they would escalate their concerns or make referrals to secondary services but there is no evidence this was done. We recommend:

    The Head of Healthcare should ensure referrals to secondary services are completed in line with NICE guidance.

49. The reviewer found there was not a formal care plan in place for Mr Davie's wound care and that healthcare staff at Ashfield did not have their own local Standard Operating Procedure (SOP) for wound care management and prevention. She considered this to be a root cause of Mr Davie's inconsistent wound care and Mr Davie's treatment was often dependent on a nurse's experience or understanding of wound care. We recommend:

    The Head of Healthcare should:

    - **create a Standard Operating Procedure for tissue viability;**
    - **ensure patients with tissue viability needs have a formal individualised care plan; and**
    - **provide staff with refresher training on wound management.**

50. The clinical reviewer also found that Mr Davie did not have care plans in place for his long-term conditions, including for his risk of cardiovascular disease. The lack of care plans for prisoners with long-term conditions is an issue we have raised in two previous investigations at Ashfield. We were told in November 2021 that an audit would be completed by March 2022. In February 2022, we were told that a lead nurse on long-term conditions was now in post and that audits would be conducted. We recommend:

    The Head of Healthcare should confirm that an audit of prisoners with long-term conditions has been carried out and that all prisoners with long-term conditions now have care plans in place.

Missed hospital appointment

51. Mr Davie missed an appointment on 25 November as the prison did not request a taxi that was accessible by wheelchair. Mr Davie's poor mobility was recorded in both prison and healthcare records. This resulted in his appointment being rescheduled and we consider this could have been prevented. We recommend:

    The Director should ensure that vehicles used to transport prisoners meet their mobility needs.

Inquest

52. The inquest, held on 5 September 2023, concluded that Mr Davie died from natural causes.

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