Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Thomas Reed, a prisoner at HMP Holme House, on 3 February 2022

A report by the Prisons and Probation Ombudsman

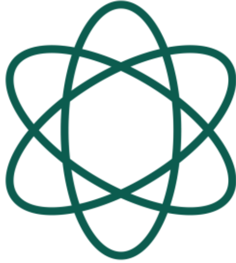
Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

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

T I 020 7633 4100

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 Thomas Reed died on 3 February 2022 of cardiac amyloidosis (the build-up of an abnormal protein called amyloid in the heart) and atherosclerotic ischemic heart disease (hardening of the arteries which leads to reduced blood flow to the heart) while a prisoner at HMP Holme House. He was 89 years old. We offer our condolences to Mr Reed's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Reed received at Holme House was partially equivalent to that which he could have expected to receive in the community. She makes several recommendations to ensure clinical processes comply with national guidelines, including long-term condition management and outpatient appointment management. The issues identified did not impact on the outcome for Mr Reed but should be addressed by the Head of Healthcare to improve practice.

5. We found no non-clinical issues of concern.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Reed’s clinical care at HMP Holme House.

7. The PPO investigator investigated the non-clinical issues relating to Mr Reed’s care, including Mr Reed’s location, the security arrangements for his hospital escorts, liaison with his family.

8. The PPO family liaison officer wrote to Mr Reed’s friend, to explain the investigation and to ask if he had any matters he wanted us to consider. He had no questions but asked to receive a copy of our report.

9. Mr Reed’s friend received a copy of the initial report. He did not raise any further issues, or comment on the factual accuracy of the report.

10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out a factual inaccuracy in the clinical review report and this has been amended accordingly.

Previous deaths at HMP Holme House

11. Mr Reed was the twelfth prisoner to die at HMP Holme House since April 2020. Of the previous deaths, 7 were from natural causes, and 3 were self-inflicted. One other death is yet to be determined. There are no similarities between our findings in the investigation into Mr Reed’s death and our investigation findings for the previous deaths.

Key Events

HMP Durham

12. On 17 January 2020, Mr Thomas Reed was sentenced to eighteen years in prison for sexual offences and transferred to HMP Durham. Healthcare staff recorded long term health conditions including asthma, COPD (chronic obstructive pulmonary disease) and chronic kidney disease. These were managed and regularly reviewed based on individual care plans.

13. On 29 June, a prison GP met with Mr Reed to discuss his long-term health conditions and the risks surrounding resuscitation in the event that his breathing or heart stopped. He advised Mr Reed that due to his health conditions, there was no realistic chance that Cardiopulmonary Resuscitation (CPR) would be successful. Mr Reed signed a Do Not Attempt CPR order, which meant that staff would not attempt CPR if his heart or breathing stopped.

HMP Holme House

14. On 14 July 2020, Mr Reed transferred to HMP Holme House, who were able to support his reduced mobility and increased healthcare needs. At the initial healthcare screening, healthcare staff recorded Mr Reed's health conditions and created the appropriate care plans to manage these. The prison GP re-prescribed Mr Reed's medications.

15. Mr Reed was located in the prison inpatient unit so that he could access 24-hour healthcare. His cell door was permanently unlocked so that nursing staff could provide support when needed. Mr Reed's ongoing care needs were regularly reviewed at complex care and multidisciplinary meetings.

16. On 26 July, Mr Reed met with the prison GP to review his Do Not Attempt CPR order. Mr Reed confirmed that it should remain in place.

17. On 23 September, a prison GP reviewed Mr Reed and recorded that the swelling in his ankles had increased and his chest was making a crackling sound. The GP thought that Mr Reed had congestive cardiac failure and requested a chest X-ray and blood samples.

18. Mr Reed's X-ray appointment was scheduled for 11 October at the local hospital, but he was unable to attend because of his mobility issues, which prevented him being able to use transport.

19. On 27 October, Mr Reed told the prison GP that he was struggling to clear his throat. The GP made changes to his asthma medication.

20. On 18 November, a nurse examined Mr Reed and found that he was wheezing when breathing. She completed a NEWS2 assessment (for assessing patients at risk of deterioration), which suggested that he required urgent care. An ambulance was requested, and Mr Reed was taken to A&E by paramedics. Doctors treated Mr Reed's deteriorating COPD and completed a chest X-ray following the missed appointment on 11 October. On 22 November, Mr Reed was discharged back to Holme House.

21. On 16 December, the prison GP completed another review of Mr Reed and recorded that his chest was feeling tight. The GP altered Mr Reed's asthma medication and prescribed steroids.

22. On 17 December, Mr Reed fell in his cell. Healthcare staff examined him and recorded that he had a suspected fractured hip. They called an ambulance and paramedics took him to hospital. On 18 December, Mr Reed had a partial hip replacement, and on 30 December, he was discharged back to HMP Holme House.

23. On 13 January 2022, a healthcare assistant recorded that Mr Reed could not breathe properly. Later that day, a nurse reviewed Mr Reed and recorded that he was tired, drowsy and short of breath. The nurse called the out-of-hours doctor, who advised that Mr Reed should be tested for Covid-19. The test was completed, and the result was negative. Mr Reed was prescribed antibiotics and steroids to help ease his discomfort.

24. On 20 January, a prison GP recorded that Mr Reed was in good spirits but still had a wheeze in his chest. The GP asked administrative staff to refer Mr Reed to the hospital respiratory team, which they did on 24 January.

25. On 30 January, Mr Reed was prescribed a course of antibiotics for a chest infection. The on-call doctor advised nursing staff that if Mr Reed's symptoms got any worse, he may need treatment in hospital.

26. On 31 January, nursing staff completed routine observations which indicated that urgent care was required and organised for his transfer to hospital. A routine COVID-19 swab was taken and showed that Mr Reed was positive for Covid-19. He was isolated in hospital, in line with national guidelines.

27. On the morning of 3 February, the prison GP reviewed Mr Reed. The GP noted that he had "not been going to bed, sitting in recliner chair" and that the swelling in his ankles had worsened again. He increased Mr Reed's medication, requested that a blood sample was taken and documented that a review should be completed in four days, or earlier if required. The requested blood sample was taken later the same day. The results were received on 4 February, reviewed by the GP, and reported as satisfactory. No further action was due to be taken.

28. At 6.27pm, a healthcare assistant recorded that Mr Reed was struggling to clear phlegm from his chest again. She helped Mr Reed with his positioning and gave him a nebuliser (strong asthma medication in vapour form). She completed routine observations which were within normal range.

29. At 10.35pm, Mr Reed asked to go to bed. A nurse noticed that Mr Reed was breathless and gave him two puffs of his inhaler.

30. At 10.40pm, Mr Reed became unresponsive and stopped breathing. Staff did not attempt CPR because of the order in place. They called an ambulance, which arrived at the prison at 12.58am on 4 February, and paramedics confirmed that Mr Reed had died.

Post-mortem report

31. The post-mortem report concluded that Mr Reed died of cardiac amyloidosis (build-up of an abnormal protein called amyloid in the heart) and atherosclerotic ischemic heart disease (hardening of the arteries which leads to reduced blood flow to the heart).

Inquest

32. The inquest into Mr Reed's death concluded on 24 August 2023. The coroner confirmed that Mr Reed died of natural causes.

Tallulah Frankland
Assistant Ombudsman **August 2023**

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Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
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