

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Christopher Thorpe, a prisoner at HMP Nottingham, on 30 August 2022**

**A report by the Prisons and Probation Ombudsman**

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

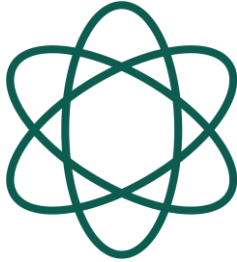
Email: [mail@ppo.gov.uk](mailto:mail@ppo.gov.uk)  
Web: [www.ppo.gov.uk](http://www.ppo.gov.uk)

T | 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

**OGL**

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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 detained people 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 Christopher Thorpe died in hospital from pneumonia on 30 August 2022, while a prisoner at HMP Nottingham. He was 75 years old. I offer my condolences to Mr Thorpe's family and friends.

Mr Thorpe became unwell on 2 June but initially refused to go to hospital. He refused again two days later but was finally sent to hospital on 6 June. Hospital doctors diagnosed him with a severe kidney infection, a blood clot in his leg and a recent stroke. Mr Thorpe remained in hospital for over three months. He tested positive for COVID-19 two weeks before his death. This was listed as a factor that contributed to his death but did not cause it.

The clinical reviewer concluded that the clinical care Mr Thorpe received at Nottingham was of a reasonable standard and was partially equivalent to that which he could have expected to receive in the community.

The clinical reviewer found that staff did not consistently use the standard clinical tool (NEWS2) to monitor Mr Thorpe's deterioration. This is an issue we have raised before with Nottingham, and which the new Head of Healthcare will need to address.

The clinical reviewer also found that prison healthcare staff had not properly assessed Mr Thorpe's mental capacity to make decisions affecting his care.

I am concerned that a complaint made by a hospital consultant about the standard of healthcare Mr Thorpe had received at Nottingham was not followed up. It included comments about the poor behaviour of escorting officers which was not passed to prison managers to address.

I am also concerned that Mr Thorpe, an elderly, unwell man with poor mobility, was inappropriately restrained when taken to hospital.

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

**Kimberley Bingham**  
**Acting Prisons and Probation Ombudsman**

**March 2023**

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# Summary

## Events

1. On 3 May 2022, Mr Christopher Thorpe was remanded in prison custody, charged with attempted murder, and sent to HMP Nottingham.
2. Mr Thorpe was an elderly man with various health needs. He was waiting for a hip replacement and had limited mobility. He also had impaired vision and social care needs. Healthcare staff carried out welfare checks twice daily.
3. Mr Thorpe mostly stayed in his cell while at Nottingham. He ate very little and progressively lost weight during May.
4. On 2 June, Mr Thorpe told staff he felt sick and had abdominal pain. A nurse found he had low blood pressure and urine tests suggested a urinary tract infection (UTI). She requested an ambulance to take him to hospital. However, Mr Thorpe refused to go to hospital. He did so again on 4 June, when he remained unwell.
5. By 6 June, Mr Thorpe had deteriorated further and was taken to hospital. He was escorted by two prison officers and restrained using an escort chain, but it was removed shortly after his arrival at hospital. Doctors diagnosed a serious kidney infection, sepsis, a blood clot in one of his legs and a recent stroke.
6. On 16 June, a hospital consultant telephoned the prison's healthcare unit to complain about Mr Thorpe's clinical care at Nottingham and the poor behaviour of prison officers present with him in hospital (known as bedwatch staff), who he said watched Netflix, fell asleep and did not notice when Mr Thorpe pulled out his feeding tube. A nurse passed the complaint on to the Acting Head of Healthcare.
7. Over the next three months, Mr Thorpe had several transfers between different hospitals. At times he was assessed as being fit for discharge, but he was unable to return to Nottingham as they could not meet his care needs.
8. On 15 August, Mr Thorpe tested positive for COVID-19. Given the time he had spent in hospital, he had clearly caught the virus there.
9. On 30 August, Mr Thorpe's health deteriorated suddenly, and he died in hospital that afternoon.
10. A post-mortem examination found that Mr Thorpe died from pneumonia. It found that COVID-19 and heart disease contributed to his death but did not cause it.

## Findings

11. The clinical reviewer concluded that the care Mr Thorpe received at Nottingham was partially equivalent to that he could have expected to receive in the community.
12. She found that staff did not consistently use National Early Warning Score (NEWS2: a tool to assess clinical deterioration) when Mr Thorpe's health deteriorated in June and did not always take blood pressure readings correctly.

13. The clinical reviewer also found that while there were entries in Mr Thorpe's medical record to say that staff had assessed that he had mental capacity to make decisions about his care, there was no formal documentation to support the assessments.
14. She also found that there was no formal monitoring of Mr Thorpe's food and fluid intake.
15. The Acting Head of Healthcare took no action in response to the hospital consultant's complaint. He did not share the concerns about bedwatch staff with prison managers.
16. The use of an escort chain on Mr Thorpe when he was taken to hospital was inappropriate given Mr Thorpe's age, poor health and poor mobility.

## **Recommendations**

- The Head of Healthcare should ensure that healthcare staff consistently use the National Early Warning Score (NEWS2) tool to assess unwell prisoners effectively and identify any clinical deterioration.
- The Head of Healthcare should ensure that staff are trained and competent in taking blood pressure readings.
- The Head of Healthcare should ensure that staff are trained in capacity assessments and document formal capacity assessments in the medical record.
- The Head of Healthcare should ensure that when a prisoner's food and fluid intake is unclear, staff start a food and fluid chart and document a plan in the medical record.
- The Head of Healthcare should ensure that external complaints are followed up appropriately and where relevant shared with the prison.
- The Governor should ensure officers on bedwatch duties are aware of the expected standards of behaviour.
- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that, in all cases:
  - a fresh risk assessment is conducted for each separate occasion that a prisoner is escorted out of the prison, taking into account current information on the prisoner's health and risk;
  - healthcare staff complete the medical information section of the escort risk assessment to say whether the prisoner's current medical condition affects their mobility and risk of escape; and
  - authorising managers show that they have taken this information into account when assessing a prisoner's current level of risk.

## The Investigation Process

17. The investigator issued notices to staff and prisoners at HMP Nottingham informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
18. The investigator obtained copies of the relevant extracts from Mr Thorpe's medical and prison records.
19. NHS England commissioned an independent clinical reviewer to review Mr Thorpe's clinical care at HMP Nottingham.
20. The investigator and clinical reviewer jointly interviewed two members of prison healthcare staff by video in November 2022.
21. We informed HM Coroner for Nottinghamshire and Nottingham City of the investigation. She gave us the results of the post-mortem examination. We have sent her a copy of this report.
22. The Ombudsman's family liaison officer contacted Mr Thorpe's daughter to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.
23. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found no factual inaccuracies.

## **Background Information**

### **HMP Nottingham**

24. HMP Nottingham is a resettlement and local prison serving the courts of Nottinghamshire and Derbyshire. It has a current capacity for approximately 900 men. Healthcare for the prison is provided by Nottinghamshire Healthcare NHS Foundation Trust.

### **HM Inspectorate of Prisons**

25. The most recent inspection of HMP Nottingham was in May and June 2022. Inspectors said that it was a challenging prison to run, and although it was improving from the low base of previous recent inspections, progress was still required in many areas.
26. Inspectors said that health services were well led but had become stretched since their last inspection in 2020, and that staff shortages were affecting service delivery. However, most essential provision continued, and governance and oversight arrangements were robust with good processes to identify and mitigate risk. They said the management of long-term conditions was good.

### **Independent Monitoring Board**

27. 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 28 February 2022, the IMB reported that the prison was gradually returning to a more normal regime following the COVID-19 pandemic. This included prisoners having more face to face appointments with healthcare staff.

### **Previous deaths at HMP Nottingham**

28. Mr Thorpe was the ninth prisoner to die at Nottingham since August 2020. Of the previous deaths, one was self-inflicted, and the rest were from natural causes. In previous investigations, we made recommendations about the use of NEWS2 (a tool used to assess clinical deterioration), assessing mental capacity and the use of restraints on prisoners being transferred to hospital.

## Key Events

29. On 3 May 2022, Mr Christopher Thorpe was remanded in prison custody, charged with attempted murder, and sent to HMP Nottingham. He was 74 years old at the time of his remand.
30. Mr Thorpe had osteoporosis (bone crumbling) and was awaiting a hip replacement. He had poor mobility as a result and used a walking frame to move around his cell. He also had incontinence and impaired vision. Healthcare staff carried out welfare checks twice a day and assisted him with his personal care. He was frequently found soaked in urine and told staff he was unable to get to the toilet in time, but he often refused to wear incontinence pads. He also ate very little, despite encouragement from staff.
31. On 2 June, Mr Thorpe told staff he felt sick and had abdominal pain. A nurse took his clinical observations and found that his blood pressure was low. Urine tests indicated that Mr Thorpe might have a urinary tract infection (UTI). The nurse called for a non-emergency ambulance to take Mr Thorpe to hospital. However, when paramedics arrived, Mr Thorpe refused to go to hospital. He signed a disclaimer saying he understood the potential consequence of refusing to go. A member of the healthcare staff asked someone in the mental healthcare team to assess Mr Thorpe's mental capacity to make decisions about his care. A mental health nurse assessed Mr Thorpe on 3 June and recorded that they considered that he had capacity.
32. On 4 June, healthcare staff found Mr Thorpe in bed with his clothes soaked in urine. His blood oxygen level was very low, and his blood pressure was low. He was monitored throughout the day and his blood oxygen level improved but his blood pressure fell further. He again refused to go to hospital.
33. On 6 June, a pharmacy technician went to Mr Thorpe's cell to administer his medication. He found him in bed, soaked in urine, shivering with cold and physically weak. A prison paramedic attended and after assessing Mr Thorpe, suspected he had sepsis (a potentially life-threatening condition that occurs when the body's response to an infection damages its own tissues). He was taken to hospital. Two officers remained with Mr Thorpe while he was in hospital (known as bedwatch officers). Initially, Mr Thorpe was restrained by handcuffs, although these were removed shortly after he arrived in hospital.
34. At hospital, Mr Thorpe was diagnosed with an acute kidney infection and sepsis, which had probably resulted from a UTI. A few days later, scans showed that Mr Thorpe had a blood clot in his left leg and had had a stroke, both of which were likely to have happened in recent weeks.
35. On 16 June, a hospital consultant telephoned the prison's healthcare unit to express his concerns about the clinical care that Mr Thorpe had received there, particularly with regard to the failure to identify his blood clot and stroke. He also complained about the conduct of the officers on bedwatch duty who he said were watching Netflix, fell asleep and did not notice when Mr Thorpe pulled out his feeding tube. The nurse passed on the comments to the Acting Head of Healthcare, who took no further action.

36. Mr Thorpe was in hospital for nearly three months, during which time he was transferred between hospitals six times. He had some periods of improvement and on more than one occasion, he was assessed as fit for discharge from hospital. However, he was unable to return to Nottingham as the prison could not meet his care needs.
37. Mr Thorpe tested positive for COVID-19 on 27 July and again on 15 August. Given the time he had spent in hospital, he had clearly caught the virus there both times.
38. In the last week of August, Mr Thorpe was clinically stable, and discussion continued between prison and hospital staff about where would be the most appropriate place for Mr Thorpe as he was medically fit for discharge. However, he became unwell on 30 August and his health deteriorated very rapidly. He died in hospital that afternoon.

### **Contact with Mr Thorpe's family**

39. On 8 June, the prison appointed a prison chaplain as the family liaison officer (FLO). The same day, the FLO and a colleague visited Mr Thorpe's named next of kin, one of his sons, to explain that he was unwell in hospital. One of Mr Thorpe's daughters subsequently took over as the named next of kin and the FLO kept in contact with her over the following weeks.

### **Support for prisoners and staff**

40. After Mr Thorpe's death, a prison manager spoke with the bedwatch staff who were with Mr Thorpe when he died to check if they needed any support.
41. Mr Thorpe had little contact with other prisoners before being taken to hospital and had been out of the prison for a long time when he died. However, the prison posted notices informing other prisoners of Mr Thorpe's death and offering support.

### **Post-mortem report**

42. The post-mortem report gave the cause of death as aspiration pneumonia (pneumonia caused by breathing something into the lung which leads to an infection). Ischaemic heart disease (a restriction in the blood supply to the heart due to blockages in the arteries) and COVID-19 were given as underlying conditions that contributed to but did not cause the death.

# Findings

## Clinical Care

43. The clinical reviewer concluded that the care Mr Thorpe received at Nottingham was of a reasonable standard and that it was partially equivalent to that which he could have expected to receive in the community.

## Monitoring clinical deterioration

44. The clinical reviewer found that healthcare staff did not always use the NEWS2 tool to assess Mr Thorpe's clinical deterioration. (The National Early Warning Score (NEWS2) allocates a score of 0-3 for each of six physical observations: respiratory rate; blood oxygen level; pulse; blood pressure; temperature and level of consciousness. The scores determine whether the patient's care should be escalated.) When healthcare staff saw Mr Thorpe on the morning of 4 June, they did not take a full set of clinical observations and did not calculate a NEWS2 score. They calculated NEWS2 scores during several interactions that afternoon but failed to do so on the last occasion. On one occasion, the NEWS2 score indicated that escalation was needed but this was not done. The clinical reviewer also found that staff did not always take blood pressure readings correctly.
45. In two of our investigations into deaths at Nottingham since August 2020, we have found that staff have not used NEWS2 consistently. We are aware that a new Head of Healthcare took up post in November 2022 and this is an issue they urgently need to address. We recommend:

**The Head of Healthcare should ensure that healthcare staff consistently use the National Early Warning Score (NEWS2) tool to assess unwell prisoners effectively and identify any clinical deterioration.**

**The Head of Healthcare should ensure that staff are trained and competent in taking blood pressure readings.**

## Capacity assessments

46. The clinical reviewer found that while there were several entries in Mr Thorpe's medical record to say that staff had assessed he had mental capacity to make decisions about his care, there was no formal documentation to support the assessments. She noted that there was a detailed entry from the mental health nurse who assessed Mr Thorpe on 3 June, but again, no formal capacity assessment documentation. We recommend:

**The Head of Healthcare should ensure that staff are trained in capacity assessments and document formal capacity assessments in the medical record.**

## Monitoring food and fluid intake

47. Mr Thorpe ate very little for the whole of the time he was at Nottingham. Food was brought to his cell on many occasions, but there is little evidence of him eating it, and uneaten food is recorded at times. His fluid intake was also irregular. In June, his food and fluid intake was noted as minimal. On 6 June, a pharmacy technician noted that Mr Thorpe was extremely thin, and that uneaten food and cartons of milk were stacked up on his desk. Although both healthcare and prison staff made many attempts to encourage Mr Thorpe to eat and drink, there was no formal monitoring of this and no care plan around his nutritional and fluid intake. We recommend:

**The Head of Healthcare should ensure that when a prisoner's food and fluid intake is unclear, staff start a food and fluid chart and document a plan in the medical record.**

## Complaint from the hospital

48. There is no record that anyone from the prison contacted the hospital consultant who made the complaint, despite the fact that he asked for someone to call him back. At interview, the Acting Head of Healthcare at the time said that he did not follow up the complaint or carry out any learning lessons exercise. He also said that he did not pass on the consultant's complaint about bedwatch officers' behaviour to the prison. He said that his understanding was that the hospital consultant would formally follow up their concerns through the Care Quality Commission (CQC), and therefore he waited for a notification from them before responding.
49. We consider that, at the very least, the Acting Head of Healthcare should have followed up the phone call from the hospital consultant to see if there were any lessons to be learnt and passed the complaint about bedwatch officers to a prison manager. We recommend:

**The Head of Healthcare should ensure that external complaints are followed up appropriately and where relevant shared with the prison.**

**The Governor should ensure that officers on bedwatch duties are aware of the expected standards of behaviour.**

50. The clinical reviewer considered whether, from the evidence available to us, there were any clear indications that Mr Thorpe showed symptoms of either DVT or a stroke while in prison. They concluded that there were none, and in the circumstances, we could only comment on the Acting Head of Healthcare's failure to act on the consultant's complaint.

## Use of restraints

51. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk

of escape, the risk to the public and takes into account the prisoner's health and mobility.

52. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when he has a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.
53. The investigator asked Nottingham for the risk assessment completed when Mr Thorpe was taken to hospital on 6 June. He was told that one was not completed for that day and that the risk assessment completed on 2 June was used instead. That risk assessment recorded in the healthcare section that Mr Thorpe had poor mobility. The security section recorded that Mr Thorpe was assessed at low risk on all the categories listed, such as escape and risk to the public. The level of restraint authorised was double handcuffs on the basis that Mr Thorpe was a remand prisoner.
54. Mr Thorpe was an elderly man with poor mobility. It is unlikely that handcuffs were proportionate on 2 June, and by 6 June, Mr Thorpe was even more unwell. HMPPS policy requires that a fresh risk assessment should be completed for each hospital visit. This was not done on 6 June, and one should have been completed which took account of Mr Thorpe's health and the actual risk he presented at that time.
55. We note that restraints were used for a short time as the ambulance left the prison with Mr Thorpe at around 10.19am and restraints were removed at around 11.05am. However, we consider that the decision to restrain Mr Thorpe for his journey to hospital on 6 June was not made in line with the High Court judgment. We recommend:

**The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that, in all cases:**

- a fresh risk assessment is conducted for each separate occasion that a prisoner is escorted out of the prison, taking into account current information on the prisoner's health and risk;
- healthcare staff complete the medical information section of the escort risk assessment to say whether the prisoner's current medical condition affects their mobility and risk of escape; and
- authorising managers show that they have taken this information into account when assessing a prisoner's current level of risk.

## **Inquest**

56. The inquest held on 30 August 2023, concluded that Mr Thorpe died from natural causes and that the cause of death was aspiration pneumonia, which was caused by frailty and malnutrition, and that ischaemic heart disease contributed to but did not cause the death.

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