

**Prisons &
Probation**

Ombudsman
Independent Investigations

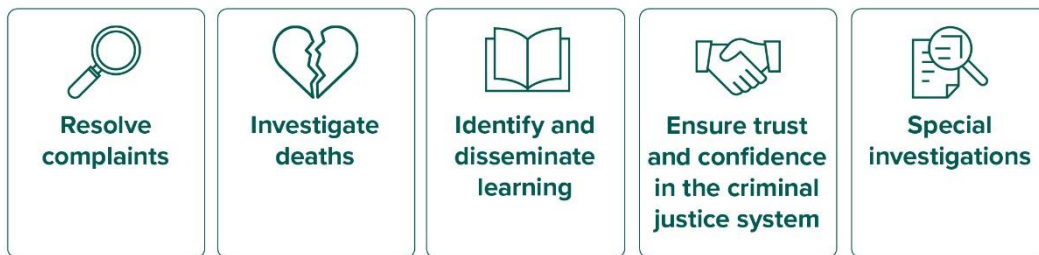
Independent investigation into the death of Mr Colin Haworth, a prisoner at HMP Stafford, on 10 January 2023

A report by the Prisons and Probation Ombudsman

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE



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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.

If my office is to best assist HMPPS in ensuring the standard of care received by those within service remit is appropriate then our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Colin Haworth died in hospital of pneumonia on 10 January 2023, while a prisoner at HMP Stafford. He was 74 years old. I offer my condolences to Mr Haworth's family and friends.

The clinical reviewer found that the care Mr Haworth received at Stafford was equivalent to that which he could have expected to receive in the community. However, she found that on 8 January, the day before Mr Haworth was taken to hospital, a nurse did not properly assess Mr Haworth for clinical deterioration. Had she done so, it is possible that Mr Haworth might have been sent to hospital sooner.

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

Adrian Usher
Prisons and Probation Ombudsman

September 2023

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Summary

Events

1. In August 2016, Mr Colin Haworth was sentenced to seven years imprisonment for sexual offences. He was later convicted of further sexual offences and sentenced to 23 years imprisonment.
2. On 1 September 2017, Mr Haworth was moved to HMP Stafford.
3. Mr Haworth had pre-existing medical conditions including high blood pressure and chronic obstructive pulmonary disease (COPD, a lung condition that causes breathing difficulties).
4. On 4 January 2023, Mr Haworth was taken to hospital as he was having difficulty breathing and was confused. A hospital doctor diagnosed him with influenza.
5. The next day, the hospital discharged Mr Haworth, and he returned to Stafford with a supply of medication. Prison healthcare staff monitored him regularly.
6. On 8 January, Mr Haworth told a nurse that he felt lethargic but better than the day before. The nurse took his observations but did not calculate a NEWS2 score. (National Early Warning Score (NEWS2) is a tool used to assess clinical deterioration. The score calculated determines whether escalation of care is needed.)
7. On 9 January, a prison nurse saw Mr Haworth and noticed he was coughing and was short of breath. She calculated a NEWS2 score which showed that an urgent assessment by a doctor was needed. She requested an ambulance, which took Mr Haworth to hospital for further tests.
8. The next morning, while in hospital, Mr Haworth collapsed in the toilet. Medical staff gave chest compressions to Mr Haworth and were able to stabilise him, however they said that he was not expected to recover.
9. At 3.37pm, Mr Haworth died. A hospital doctor gave his cause of death as pneumonia.

Findings

10. The clinical reviewer found that the care Mr Haworth received at Stafford was of a good standard and equivalent to the care that he could have expected to receive in the community.
11. However, she found that when the nurse who saw Mr Haworth on 8 January should have calculated a NEWS2 score. This would have resulted in a medium risk score, which would have indicated that Mr Haworth needed an urgent review by a doctor.

Other learning

12. We found that when the nurse called a code blue on 9 January, she did not provide relevant information about Mr Haworth's condition to the control room. Control room staff were then unable to provide relevant information to the ambulance service for use in the triage process.

Recommendations

- The Head of Healthcare should ensure that all clinical staff are competent in the use of the NEWS2 assessment tool to identify and respond to potential acute illness.

The Investigation Process

13. HMPPS notified us of Mr Haworth's death on 10 January 2023.
14. The investigator issued notices to staff and prisoners at HMP Stafford informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
15. The investigator obtained copies of relevant extracts from Mr Haworth's prison and medical records.
16. NHS England commissioned an independent clinical reviewer to review Mr Haworth's clinical care at the prison.
17. We informed HM Coroner for Staffordshire of the investigation. We have sent the Coroner a copy of this report.
18. The Ombudsman's family liaison officer contacted Mr Haworth's next of kin, his friend, to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond to our letter.
19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Stafford

20. HMP Stafford is a Category C training prison for prisoners convicted of sexual offences. It holds around 750 men. Care UK Health and Rehabilitation Services Ltd provides healthcare services.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Stafford was in January 2020. Inspectors reported that waiting times for most healthcare clinics were short and there was a clear application system, with nursing staff triaging potentially urgent issues. Patients with long-term conditions were managed well by a practice nurse and the GP. Reviews of these conditions were reliably scheduled, and care plans were in place. Additional health checks relating to a long-term condition were carried out as required.
22. Inspectors found that arrangements within the prison to provide a rapid response to medical emergencies were sound and resuscitation equipment was checked and maintained regularly. They found that prison and health services staff were clear about how to obtain ambulance support if required, although not all prison staff knew the location of the defibrillators.

Independent Monitoring Board

23. 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 April 2022, the IMB reported that the quality of care delivered by the patient-facing staff was often praised and certainly on par with what could be expected in the community. The IMB noted that medication management in the prison, which they had previously heavily criticised, had improved.

Previous deaths at HMP Stafford

24. Mr Haworth was the 22nd prisoner to die at Stafford since January 2020. Of the previous deaths, one was self-inflicted, and the rest were from natural causes. We have previously made recommendations about using the NEWS2 tool to assess clinical deterioration.

Key Events

25. In August 2016, Mr Colin Haworth was sentenced to seven years imprisonment for sexual offences. He was later convicted of further sexual offences and sentenced to 23 years in prison.
26. On 1 September 2017, Mr Haworth was moved to HMP Stafford.
27. Mr Haworth had several pre-existing medical conditions including high blood pressure and chronic obstructive pulmonary disease (COPD – the term for a group of serious lung diseases, which cause breathing difficulties). Mr Haworth was given a ground floor cell to avoid him having to use the stairs.
28. In September 2018, Mr Haworth had surgery to remove large areas of damaged tissue in his right lung.
29. In February 2019, Mr Haworth’s left lung collapsed. He was taken to hospital, given treatment, and recovered back at Stafford.
30. In July 2022, Mr Haworth told a prison GP that he was coughing up small pieces of metal mesh, which he thought might be related to his previous lung surgery. The GP referred Mr Haworth to the hospital lung team for advice. The hospital lung team said that Mr Haworth needed a CT scan (a scan which shows details images of inside the body). The subsequent CT scan showed that the metal could be staples from his previous lung surgery.
31. In October, Mr Haworth received his annual influenza vaccination.
32. On 4 January 2023, a prison nurse found Mr Haworth was having trouble breathing and he appeared confused. She calculated his NEWS2 score, and it indicated that he needed an emergency hospital assessment. (NEWS2 is a tool used to assess clinical deterioration. Each clinical observation is given a score and then an overall NEWS2 score is calculated, which then indicates whether escalation of care is needed.) She called a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties). Paramedics attended the prison and took Mr Haworth to hospital. A hospital doctor diagnosed Mr Haworth with influenza.
33. The next day, the hospital discharged Mr Haworth, and he returned to Stafford with a supply of medication. Healthcare staff advised that Mr Haworth should be located in a specialist unit so they could monitor him closely, but he refused and said he wanted to stay in his own cell.
34. Later that day, a prison nurse calculated Mr Haworth’s NEWS2 score. The score indicated that Mr Haworth needed an urgent review by a hospital doctor, so she called a code blue. Paramedics attended the prison and told Mr Haworth that he needed to go to hospital. Mr Haworth said that he did not want to go, and so he remained in his prison cell under the close supervision of the healthcare team.
35. On 8 January, Mr Haworth said he was feeling lethargic, although better than the day before. A nurse took his observations, but she did not calculate a NEWS2 score.

36. Over the next few days, the prison healthcare team monitored Mr Haworth using the NEWS2 system.

Events of 9 January 2023

37. On 9 January, a prison nurse saw Mr Haworth and noticed he was coughing and was short of breath. She took his NEWS2 score which showed that he needed an urgent review by a hospital doctor. She called a code blue at 9.15am.
38. An operational support grade (OSG) in the prison control room called the emergency services as soon as he heard the code blue. He told the call handler that he was calling from HMP Stafford as a code blue had been called, but that was the only information he had. The call handler dispatched a category 1 ambulance (a category 1 ambulance is an immediate response to a life-threatening condition, such as cardiac or respiratory arrest). The OSG told the call handler that he would ring her back if he received any updates on Mr Haworth's condition.
39. At 9.23am, the OSG rang the emergency services to update them on Mr Haworth's condition. He told them that Mr Haworth was breathing and awake.
40. At 9.24am, the ambulance arrived at the prison and the paramedics were taken to Mr Haworth's cell.
41. At 10.12am, the ambulance left the prison and Mr Haworth was taken to a local hospital for further tests.
42. The next morning, while in hospital, Mr Haworth collapsed in the toilet. Hospital staff gave chest compressions to Mr Haworth and were able to stabilise him, however they said that he was not expected to recover. He died at 3.37pm.

Support for prisoners and staff

43. After Mr Haworth's death, a prison manager debriefed the staff involved in the emergency response and the staff present in hospital on the day of Mr Haworth's death. They were given an opportunity to discuss any issues arising and were offered support. The staff care team also offered support.

Cause of death

44. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was conducted. The doctor gave Mr Haworth's cause of death as pneumonia. They listed COPD as a contributing factor.

Findings

Clinical care

45. The clinical reviewer found that Mr Haworth received a good standard of care at Stafford which was equivalent to that which he could have expected to receive in the community.
46. However, she found that the nurse who saw Mr Haworth on 8 January did not calculate a NEWS2 score. She found that the clinical observations taken would have resulted in a medium risk score, which would have indicated that Mr Haworth needed an urgent review by a doctor. The Head of Healthcare told the clinical reviewer that she would expect a nurse to have calculated and documented the NEWS2 score on this occasion. We recommend:

The Head of Healthcare should ensure that all clinical staff are competent in the use of the NEWS2 assessment tool to identify and respond to potential acute illness.

47. We note that the action taken to a previous recommendation around the calculating and recording of NEWS2 scores has not been effective and we expect this to be reviewed and reflected in the prison's proposed action plan.

Other learning

Call to ambulance service

48. Prison Service Instruction (PSI) 03/2013, Medical Emergency Response Codes, says that the member of staff using the medical emergency code must also provide relevant information about the condition of the prisoner to the control room staff, so that they can pass it on to the ambulance service for use in the triage process.
49. We found that when the nurse called the code blue on 9 January, she did not provide relevant information about Mr Haworth's condition to the control room. The nurse was aware that Mr Haworth was conscious and breathing at the time she called the code blue, but she did not communicate this to the control room. As a result, the OSG was unable to relay this information to the emergency services on his first phone call. Although the lack of information did not affect Mr Haworth's care, we are concerned that if the control room cannot answer this question in the future, it could result in the wrong category of ambulance being sent to somebody in a more serious, life-threatening condition.

Inquest

50. At the inquest held on 30 November 2023, the coroner concluded that Mr Haworth died from natural causes.

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

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

T | 020 7633 4100