

**Prisons &
Probation**

Ombudsman
Independent Investigations

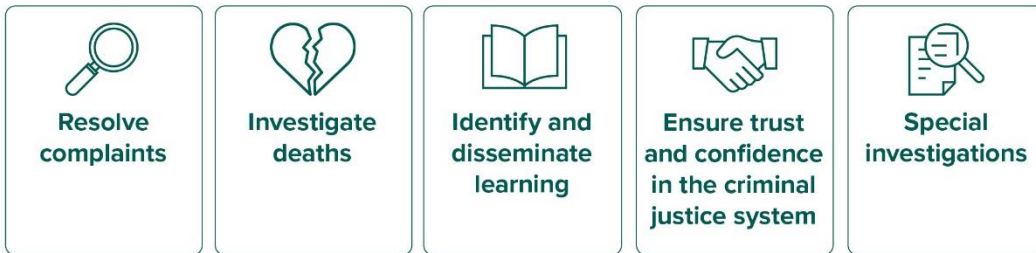
Independent investigation into the death of Mr John Francis, a prisoner at HMP Littlehey, on 14 March 2022

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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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 Francis, who was 75 years old, died of heart failure at HMP Littlehey. We offer our condolences to his family and friends.
4. The clinical reviewer concluded that the care Mr Francis received at HMP Littlehey was equivalent to that which he could have expected to receive in the community. She made several recommendations about the use of the National Early Warning Score and formal incident reporting, which we do not repeat in this report but which the Head of Healthcare will need to address.
5. We did not find any non-clinical issues of concern.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Francis' clinical care at HMP Littlehey.
7. The PPO investigator has investigated non-clinical issues, including Mr Francis' location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. One of the PPO's family liaison officers wrote to Mr Francis' wife, to explain the investigation. She did not respond to our letter.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS identified some factual inaccuracies, which have been addressed in this report and the clinical review.

Previous deaths at HMP Littlehey

10. Mr Francis was the thirty third prisoner to die at Littlehey since March 2020. Of the previous deaths, thirty one were from natural causes and one was self-inflicted.
11. There are no similarities between our findings in the investigation of Mr Francis' death and the previous deaths.

Key Events

12. On 7 August 2019, Mr John Francis was sentenced to 12 years imprisonment for historic sex offences against children. He was sent to HMP Wormwood Scrubs.
13. Mr Francis had several pre-existing medical conditions, including asthma, type 2 diabetes, left ventricular heart disease (for which he had had two stents and a pacemaker fitted) and hypertension (raised blood pressure) and COPD (chronic obstructive pulmonary disease, the term used for a variety of respiratory conditions). He used a zimmer frame to move around and a wheelchair for longer distances.

HMP Wormwood Scrubs

14. Following his initial health screen, healthcare staff referred Mr Francis to the prison's long-term condition clinics, and they created care plans to manage his medical conditions. They also referred him to secondary care providers to ensure continuity of his care.
15. Between 7 August 2019 and 20 May 2021, Mr Francis was taken to hospital by emergency ambulance on eleven occasions for his heart disease and COPD. Hospital staff considered that there were no active treatment options open to him and that his prognosis was poor. They did not expect him to survive more than a year.
16. On 20 July, a prison GP completed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order on Mr Francis' behalf, meaning that, in the event his heart or breathing stopped, he would not be resuscitated. Healthcare staff continued to conduct daily reviews and social care staff provided additional support.
17. On 8 September, Mr Francis' condition had deteriorated, and he was referred to his local Specialist Palliative Care team. The following week, a Consultant in Palliative Medicine and a nurse from the local hospice visited Mr Francis to assess his palliative care needs for his possible transfer to Littlehey.

HMP Littlehey

18. On 2 November, Mr Francis transferred to Littlehey.
19. A nurse carried out an initial health screen and noted Mr Francis' pre-existing medical conditions. She reviewed and updated his care plans and made referrals to the prison's long-term condition clinics and secondary care providers to ensure continuity of his care.
20. On 8 November, a prison GP reviewed and updated Mr Francis' DNACPR order. Mr Francis confirmed that he did not wish to be resuscitated in the event of a cardiopulmonary arrest. Healthcare staff continued to conduct daily reviews and the prison's mental health in-reach team supported him.
21. On 30 November, two nurses saw Mr Francis after he reported difficulty breathing. They took a note of his observations, which were all within a normal range. There is

no evidence that the NEWS2 tool was used (National Early Warning Score is a scoring system used to identify acutely ill patients).

22. On 22 December, a psychologist working with Littlehey carried out a MMSE test (mini mental state exam, a thirty-point questionnaire that is used to identify signs of dementia). Mr Francis scored eighteen points indicating a mild level of dementia.
23. On 19 January 2022, Mr Francis refused to attend a secondary care cardiology review because he felt too unwell. Mr Francis signed a medical disclaimer, and the appointment was rearranged for 31 January.
24. At 4.40pm on 14 March, an officer was unlocking prisoners for their evening meal. When she got to Mr Francis' cell, she saw him lying on the floor. She called his name, but he did not respond. She entered his cell and checked for a pulse but found none. She immediately radioed a code blue (indicating a prisoner is unconscious or is having breathing difficulties) and control room staff telephoned for an ambulance.
25. Two nurses responded, taking with them an emergency grab bag containing lifesaving equipment. A senior officer and a custodial manager also responded and brought a defibrillator.
26. One nurse reviewed Mr Francis and noted that he felt cold to the touch and that his skin was mottled. She was aware that he had a DNACPR in place and that any attempt at resuscitation would not be appropriate. The other nurse contacted the prison control room to cancel the emergency ambulance.
27. At 5.12pm, a prison GP confirmed that Mr Francis had died.

Post-mortem report

The post-mortem report concluded that Mr Francis died from decompensated heart failure caused by hypertensive heart disease. He also had chronic obstructive pulmonary disease which did not cause but contributed to his death.

Lisa Burrell
Assistant Ombudsman

November 2023

Inquest

The inquest, held on 1 November 2022, concluded that Mr Francis 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