

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Scott a prisoner at HMP Holme House on 30 November 2018

A report by the Prisons and Probation Ombudsman

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 I oversee can improve their work in the future.

Mr John Scott died on 30 November 2018 at HMP Holme House. He died of bilateral pneumonia and a renal abscess, with an underlying condition of cerebrovascular disease and strokes. Mr Scott was 69 years old. I offer my condolences to Mr Scott's family and friends.

Mr Scott had been at Holme House since February 2018. He had a history of strokes and showed signs of confusion and memory loss, and was assessed as having a high risk of falling due to his poor health and mobility. Despite this, a falls assessment was not completed in a timely manner and, when it was done, it did not adequately manage Mr Scott's risks.

Mr Scott was admitted to hospital in May 2018 after suffering injuries in a fall in his cell (although I note that the pathologist did not consider that these injuries contributed to his death). His health deteriorated further and he remained in hospital. In early November 2018, he was transferred to the palliative care unit at Holme House, where he died about three weeks later.

The clinical reviewer concludes that the care Mr Scott received at Holme House was not equivalent to that he could have expected to receive in the community. I am concerned that this is the now third investigation my office has carried out into a death at Holme House in 2018 in which we have reached this conclusion. The Governor, the healthcare providers and the NHS Commissioners need to address this worrying situation as a matter of urgency.

I am also concerned that Mr Scott died before the compassionate release process was completed because of confusion about which agency was responsible for finding him suitable accommodation in the community.

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

July 2019

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Summary

Events

1. In December 2012, Mr John Scott was sentenced to seventeen years imprisonment. He spent time at a number of prisons.
2. Mr Scott had a history of transient ischaemic attacks (mini strokes), ischaemia (insufficient blood supply to the brain) and a stroke. He also had suspected early dementia and very poor mobility.
3. In January 2018, Mr Scott was admitted to hospital after falling in his cell at HMP Northumberland. He was treated for pneumonia and assessed as being at high risk of falls and requiring access to 24-hour healthcare.
4. In February 2018, he was transferred from hospital to the inpatient healthcare unit at HMP Holme House.
5. On 11 May, Mr Scott was found on the floor of his cell. He was confused, had burns to his arm, hand and back (caused by uncovered heating pipes) and bruising to his head. He was transferred to hospital by emergency ambulance. He was diagnosed with bruising of the brain tissue and bleeding over the surface of the brain. He was also treated for pneumonia. He remained in hospital and his health deteriorated further. His prognosis was considered poor.
6. On 6 November, Mr Scott was transferred from hospital to the palliative care suite at Holme House. He was unresponsive and required care to keep his airways clear. He was provided with continuous oxygen and was fed through a tube into his stomach. A Do Not Attempt Resuscitation (DNAR) order was put in place.
7. Mr Scott's health continued to deteriorate and he died on 30 November.
8. The post-mortem concluded that Mr Scott died of pneumonia and a renal abscess, with an underlying under-lying condition of cerebrovascular disease and strokes.

Findings

9. When Mr Scott arrived at Holme House in February 2018, healthcare staff failed to complete a transfer screening.
10. Although Mr Scott was at high risk of falls, an adequate falls risk assessment was not conducted.
11. He suffered a serious fall in May 2018 (although we note that the pathologist did not consider that the injuries he suffered in the fall had contributed to his death).
12. When Mr Scott was moved to the palliative care suite at Holme House in November, staff were not trained in all aspects of end-of-life care.
13. We are not satisfied that the healthcare Mr Scott received at Holme House was equivalent to that he could have expected to receive in the community. We are

concerned that this is the third death we have investigated at Holme House in 2018 in which we have reached that conclusion.

14. Although it was clear that Mr Scott had a very limited life expectancy, there was confusion about whose responsibility it was to find suitable accommodation for him in the community. As a result, his compassionate release application was not processed before he died.

Recommendations

- The Governor and the Prisons Group Director for Tees and Wear should discuss healthcare provision at Holme House with the healthcare providers and the NHS England Commissioners and satisfy themselves that it is fit for purpose.
- The Head of Healthcare should ensure transfer reception screenings are completed when prisoners are admitted to healthcare.
- The Head of Healthcare should undertake a review of all long-term conditions care plans, nursing care plans and care processes to ensure care is in line with up-to-date guidance and best practice. Long-term condition management should incorporate a system of recall to ensure reviews take place at the desired frequency.
- The Head of Healthcare should ensure that a falls risk assessment for prisoners at risk of falling is completed in a timely manner, and that this takes into account the risks of the individual, equipment and his surroundings.
- The Governor and Head of Healthcare should ensure that a risk assessment of healthcare cells is carried out as a matter of urgency and that controls are put in place to minimise the risk from hot pipes and radiators.
- The Head of Healthcare should ensure that all staff are aware of their professional requirement to maintain clear, accurate, contemporaneous healthcare records. Late entries (after 24 hours) should include a rationale for delay.
- The Head of Healthcare should ensure that all staff have the necessary skills in end-of-life care to deliver high quality patient care, and that arrangements are in place to support staff to deliver the ambitions in the Dying Well in Custody Charter (2018).
- The Governor, the Head of Healthcare and the National Probation Service Divisional Director for the North-East should review the compassionate release process to ensure that information is provided in a timely manner and that all involved understand who is responsible for sourcing appropriate post-release accommodation.

The Investigation Process

15. The investigator issued notices to staff and prisoners at HMP Holme House informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
16. The investigator obtained copies of relevant extracts from Mr Scott's prison and medical records.
17. NHS England commissioned a clinical reviewer to review Mr Scott's clinical care at the prison.
18. We informed HM Coroner for Teesside of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.
19. The investigator wrote to Mr Scott's daughter to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. She asked the following questions, which have been answered in the main body of this report:
 - did Mr Scott have any mini strokes before he fell on 11 May 2018?
 - how was his health before this date?
 - did he have any fits before this date?
 - did he have brain disease?
 - was Mr Scott on any medication before 11 May?
 - was Mr Scott in the inpatient unit when he died?
 - did staff conduct frequent checks on him during the night?
 - when was he was last seen alive?
20. Mr Scott's family received a copy of the draft report. The solicitor representing Mr Scott's daughter wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.
21. The initial report was shared with HM Prison and Probation Service (HMPPS). There were no factual inaccuracies. The action plan has been annexed to this report.

Background Information

HMP Holme House

22. HMP Holme House is a medium security training prison holding over 1,200 men. Until May 2017, it was a local prison, holding men on remand or those who had recently been convicted by courts in the local area. G4S provides health services at the prison. There is a 24-hour healthcare unit with 16 beds and palliative care facilities.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Holme House was conducted in July 2017. It took place when Holme House was being transformed from a local prison (holding mainly prisoners on remand) to a training prison (for convicted prisoners). Inspectors reported that the healthcare interactions that they observed between staff and prisoners were very good, but they noted that chronic staff shortages in the primary care nursing team had affected service delivery. In their survey, only 22 per cent of prisoners said that the quality of health services was good. Many prisoners complained about long waiting times, and inspectors found that prisoners waited up to five weeks for routine doctor and nurse practitioner appointments. However, they found that patients with urgent needs were seen quickly.

Independent Monitoring Board

24. 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 31 December 2017, the IMB reported that plans were in place to restructure the delivery of primary care but that the plans had been compromised by significant staff shortages, including difficulties in the recruitment and retention of healthcare staff.

Previous deaths at HMP Holme House

25. Mr Scott's death was the fifth death from natural causes at Holme House since January 2018. In our investigations into two previous deaths (in January 2018 and October 2018) we found that healthcare was not equivalent to that which could be expected in the community, and in a third death (in May 2018) we found that some aspects of healthcare were not equivalent.

Key Events

26. Mr John Scott was sentenced to seventeen years imprisonment on 3 December 2012 for historic sex offences.

2012-2017

27. Mr Scott had a transient ischaemic attack (TIA, a 'mini stroke') in 2012, and in 2014, following a series of falls, he was diagnosed with ischaemia (insufficient blood supply to the brain) and a stroke. In 2015, he had further mini strokes, often resulting in falls, and in 2016 he was diagnosed with proximal atrial fibrillation (an intermittent irregular heartbeat) and suspected early dementia.

2018

28. On 16 January 2018, Mr Scott was admitted to hospital from HMP Northumberland after falling in his cell, and received treatment for pneumonia. He was diagnosed with postural hypotension (meaning his blood pressure dropped when he stood up) and was assessed being at high risk of falls as a result. He was also assessed as requiring prompting to eat and drink and help with getting in and out of bed. He needed to be in a prison with 24-hour healthcare.
29. On 1 February, he was discharged from hospital and transferred to the inpatient healthcare unit at HMP Holme House.
30. On arrival, he was seen by a nurse who noted his high risk of falls and took his physical observations. There is no evidence that a transfer reception screening was completed.
31. Later that day Mr Scott was seen by another nurse who calculated his Malnutrition Universal Screening Tool (MUST) score as '3', meaning his dietary intake should be monitored, he should have weekly weight checks and he should be considered for referral to a dietician. (A further MUST score was calculated on 16 February, but there is no evidence that it was done after that, and no evidence that his dietary intake was monitored or that he was weighed regularly.)
32. The nurse also recorded that Mr Scott used a Zimmer frame to move around, that he should be supported by nurses when standing up from a sitting or lying position, and that they should ensure the environment was free of objects that could create a risk of falls. There is no evidence that a falls risk assessment was conducted.
33. Mr Scott presented as having memory loss and confusion and was referred to the mental health team.
34. On 2 February, a blood pressure care plan was put into place. It stated that Mr Scott required daily blood pressure readings. However, over the next few months, blood pressure readings were only taken every one to four days.
35. Also on 2 February, a mental health nurse saw Mr Scott in his cell. She was unable to complete an assessment as no room was available. The appointment was rearranged. Mr Scott was assessed on 15 and 28 February. He appeared

confused on both occasions and was unable to understand the questions. Mr Scott was discharged from the mental health team and referred to speech and language therapy due to his frustration at his word-finding skills, a result of his stroke.

36. On 3 February, it was decided to remove Mr Scott's Zimmer frame to minimise his risk of falling until he could be seen by occupational therapy specialists. On 10 February, occupational therapy and the mental health team were unable to visit Mr Scott. This appointment was not rearranged. Mr Scott was moved in a wheelchair and there is no record of whether his Zimmer frame was returned to him.
37. On 11 March, Mr Scott had a fall in his cell. A nurse requested that the bed in his cell be changed as his current one could not be adjusted. She noted that this would assist Mr Scott to mobilise safely.
38. On 22 March, Mr Scott was reviewed by a mental health support worker. He was confused about why he was taking medications and still had memory loss. The mental health support worker supported Mr Scott over the next few weeks with his speech programme but no formal assessment of his memory took place.
39. On 10 April, a nurse completed a falls assessment, but the level of risk to Mr Scott and his surrounding area was not determined and his number of falls over the previous year was incorrectly recorded as zero, although Mr Scott had fallen on several occasions at Northumberland and once at Holme House.

Events of 11 May 2018

40. On the morning of 11 May at 6am, a nurse found Mr Scott on the floor of his cell. He was confused and agitated. He had bruising to his head and burns to his right arm, right hand and back, from falling against uncovered heating pipes. His burns were dressed and at 7.20am the paramedics arrived. They administered oxygen and took Mr Scott to hospital by emergency ambulance. (The nurse told the investigator that Mr Scott was subject to routine four-hourly observations by healthcare staff on the night of his fall.)
41. Mr Scott was admitted to the neurosurgery ward at James Cook Hospital, Middlesbrough, where he was treated for pneumonia and received conservative management (no direct medical intervention, just monitoring and care) for bruising to the brain and bleeding in the membranes of the brain. He remained in hospital, where his condition was stable, but he did not recover to his previous state. He was unresponsive and required assistance to feed and with his personal care. Prison healthcare staff contacted the hospital regularly for updates.
42. On 13 September, a Macmillan nurse and a palliative care consultant visited Mr Scott in hospital to assess his needs. The nurse noted that Mr Scott showed no signs of recognition and did not have any capacity to make decisions. Several meetings of the multi-disciplinary team (MDT) took place at Holme House between September and November to determine the best care for Mr Scott.

Events from 6 to 30 November 2018

43. Mr Scott was discharged back to the palliative care suite at Holme House on 6 November with a DNAR in place. (A Do Not Attempt Resuscitation Order is a formal clinical document, informing a medical team not to attempt resuscitation.) This accompanied an emergency healthcare plan, specifying what should happen in response to a deterioration in Mr Scott's health.
44. On readmission to Holme House, Mr Scott was seen by a prison GP and prescribed anticipatory medications. He was unresponsive, in a fixed position, required regular suctioning to clear secretions from his airways, required continuous oxygen and was fed by means of a percutaneous endoscopic gastrostomy (PEG) tube into his stomach. A nurse told the investigator that healthcare staff at Holme House received in-house training on administering PEG feeds and effective suction, and were made aware of the correct position in which to nurse Mr Scott.
45. On 7 November, urine tests showed signs that Mr Scott had developed an infection. On 9 November, a nurse recorded retrospectively that she asked, "staff nurse X to collect a sample for Culture and Sensitivity". There is no evidence that any urine sample was collected or sent to the lab for further testing. Mr Scott was considered as being at a high risk of infection because of his catheter. There are no recorded temperature checks during this period.
46. Mr Scott frequently vomited his PEG feeds up. On 13 November, a prison GP prescribed hyoscine to reduce Mr Scott's respiratory secretions. This was given by injection, as staff were not trained in the use of a syringe-driver (a device which administers medication continuously via a needle which sits under the skin).
47. Later that day, Mr Scott began taking an antibiotic for PEG site infection. There is no evidence that his observations were taken for signs of deterioration.
48. On 20 November, Mr Scott had three consecutive seizures and was given a drug to stop seizures. Again, no clinical observations were recorded.
49. On 27 November, Mr Scott was prescribed a course of antibiotics and steroids for pneumonia, but his health continued to deteriorate. As Mr Scott did not have capacity, a 'best interest decision' had been made by the hospital that he should not be readmitted to hospital, but should receive care to alleviate treatable ill health/alleviate symptoms. Clinical observations were recorded on this occasion, to aid clinical decision making. The Macmillan nurse visited Mr Scott and assessed that he was in the final days of his life. Mr Scott was monitored by healthcare every two hours.
50. On 30 November, at 1.54am, Mr Scott was observed sleeping. At 2.55am, staff confirmed Mr Scott had died.

Liaison with Mr Scott's daughter

51. Mr Scott did not have a recorded next of kin at the time of his death. The prison's family liaison officer (FLO) made every attempt to locate Mr Scott's family but was unsuccessful.

52. On 13 December, the FLO was contacted by the community probation team with the details of Mr Scott's daughter. The FLO contacted her and arranged to visit her at her home address. She supported her and enabled her to attend her father's funeral.
53. In line with national guidance, the prison made a financial contribution to Mr Scott's funeral, which was held on 14 December.

Post-mortem

54. The pathologist concluded that the cause of Mr Scott's death was severe pneumonia, probably with a significant contribution from an abscess in the right kidney. General debility as a result of cerebrovascular disease and strokes would have increased the risk of pneumonia and death.
55. The pathologist said that the injuries Mr Scott suffered in his fall on 11 May had resulted in only minor lasting changes and, in his opinion, would not have accounted for or contributed significantly to Mr Scott's death.

Findings

Clinical care

56. The clinical reviewer concluded that “the level of care Mr Scott received was not of an acceptable standard and not equivalent to that which would have been received in the wider community”. She added that there was an absence of risk assessment and management, and that care was not in line with NICE guidelines or expected nursing practice. She identified a number of specific concerns, including:

- There is no evidence that a transfer reception screen was completed when Mr Scott was transferred to Holme House on 1 February 2018.
- The assessment and management of falls was not in line with NICE guidelines. Falls reduction was limited to statements that trip hazards had been removed, that he should be moved in a wheelchair and that he should be supervised for sit to stand.
- Although Mr Scott had a history of mini strokes, stroke, suspected dementia and postural hypotension (which made him vulnerable to a fall), no action was taken to protect him from the risk of burns from uncovered radiators and pipes.
- Although Mr. Scott’s blood pressure was monitored (a risk factor for stroke), there was no care plan in place in relation to stroke/TIA to identify risk factors, rehabilitation and management. Review screening for stroke and TIA should take place annually as a minimum.
- Although Mr. Scott was at high risk of malnutrition due to stroke, the care and monitoring he received was not in line with NICE guidelines. The intended dietary intake monitoring was ad hoc with no regular weight monitoring, and there was no consideration of referral onto a dietician.
- Although night healthcare staff made entries about checking Mr Scott overnight, the frequency of checks was not specified in his medical record.
- The mental health care was not of an acceptable standard, no formal assessment of cognition was attempted, and cognitive assessment scales for stroke patients were not used.
- After Mr Scott returned to Holme House on 6 November for end-of-life care, he developed pressure sores. Although ad hoc skin inspections took place, there was no formal skin integrity risk assessment to determine risk and the response required.

57. We agree with the clinical reviewer that Mr Scott’s clinical and mental health care at Holme House was not equivalent to that he could have expected to receive in the community. We make the following recommendations:

The Head of Healthcare at should ensure transfer reception screenings are completed when prisoners are admitted to healthcare.

The Head of Healthcare should undertake a review of all long-term conditions care plans, nursing care plans and care processes to ensure care is in line with up-to-date guidance and best practice. Long-term condition management should incorporate a system of recall to ensure reviews take place at the desired frequency.

The Head of Healthcare should ensure that all staff are aware of their professional requirement to maintain clear, accurate, contemporaneous healthcare records. Late entries (after 24 hours) should include a rationale for delay.

The Head of Healthcare should ensure that all staff have the necessary skills in end-of-life care to deliver high quality patient care and that arrangements are in place to support staff to deliver the ambitions outlined in the Dying Well in Custody Charter (2018).

58. The clinical reviewer had also made a number of other recommendations which the head of Healthcare will need to address.
59. We are concerned that this is the third death at Holme House in 2018 in which our investigation has found that healthcare was not equivalent to what could be expected in the community. This is a worrying state of affairs and we, therefore, make the following recommendation:

The Governor and the Prisons Group Director for Tees and Wear should discuss healthcare provision at Holme House with the healthcare providers and the NHS England Commissioners and satisfy themselves that it is fit for purpose.

Mr Scott's location

60. Mr Scott was accommodated in the healthcare unit at Holme House due to his high risk of falling. A falls care plan was put in place when he arrived in February 2018, but it was very limited in scope and his risk of falling was not assessed. Although he had access to a cell bell and extra support from staff to mobilise, he had a fixed bed which could not be adjusted. This was only changed after he was found on the floor on 11 March. A falls risk assessment was completed on 10 April but this was inadequate, incorrectly stating that Mr Scott had not had any previous falls and failing to address key risks.
61. Mr Scott had poor mobility and his many health conditions meant he became easily confused. He was at a high risk of falling and was too frail to stand on his own. The single cell in which Mr Scott was accommodated had several exposed heating pipes and, given his high risk of falling, every effort should have been made to move him to an appropriate cell or to cover the pipes. Unfortunately, the cell was not properly risk-assessed and this resulted in unnecessary suffering for Mr Scott.
62. When Mr Scott returned from hospital in November 2018, he was placed in the palliative care suite which had a hospital bed. There was an open-door policy in

place and staff observations were increased to every two hours. This accommodation was appropriate for Mr Scott's needs.

63. We recommend:

The Head of Healthcare should ensure that a falls risk assessment is completed for prisoners at risk of falling in a timely manner and that this takes into account the risks of the individual, equipment and his surroundings.

The Governor and Head of Healthcare should ensure that a risk assessment of healthcare cells is carried out as a matter of urgency and that controls are put in place to minimise the risk from hot pipes and radiators.

Compassionate release

64. Release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months, can be permanently released from custody before their sentence has expired. A clear medical opinion of life expectancy is required.

65. The criteria for early release for prisoners with a determinate sentence are set out in Prison Service Order (PSO) 6000. Among the criteria is that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of the Her Majesty's Prison and Probation Service (HMPPS).

66. On 9 October 2018 (while Mr Scott was still in hospital), a prison GP completed the compassionate release form for Mr Scott and sent this to the Governor for consideration. Mr Scott's release was supported by the Governor on 29 October and sent to PPCS of HMPPS the following day.

67. PPCS responded the same day with several questions about Mr Scott's risk and planned accommodation in a nursing home in the community. The prison's offender management hub manager requested the information from a senior probation officer. He responded on 5 November but the PPCS requested further information. On 16 November, PPCS contacted the offender management hub manager to explain that the delay was due to difficulties in getting information from the community probation team.

68. On 19 November, the offender management hub manager emailed a nurse and a prison manager about an address for the nursing home. She received a reply from the prison manager the same day stating her belief that it was up to the Probation Service to find accommodation, and not healthcare.

69. On 20 November, the offender management hub manager spoke to a senior probation officer seeking further advice. On 23 November, the senior probation officer informed her that Mr Scott would need a high dependency nursing home and believed that the local authority would source this. Mr Scott died before the

offender management hub manager could determine which agency was responsible for finding a suitable nursing home.

70. We are concerned at the length of time taken for the information to be passed to PPCS by the Probation Service and by the lack of knowledge between agencies about who had responsibility for identifying suitable accommodation. This caused unnecessary delays and Mr Scott was unable to transfer to a nursing home which would have been better equipped to manage his needs before his death. We recommend:

The Governor, the Head of Healthcare and the National Probation Service Divisional Director for the North East should review the compassionate release process to ensure that information is provided in a timely manner and that all involved understand the responsibility of sourcing appropriate post-release accommodation.

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