PRISONS AND PROBATION
OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at hospital in February 2013 while in the custody of HMP/YOI Parc.

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the investigation report into the death of a prisoner at HMP Parc. He died at hospital in February 2013, of complications of heart disease and diabetes. He was 69 years old. I offer my condolences to his family and friends.

An investigator and Health Inspectorate Wales (HIC) conducted a review of the man's clinical care in custody.

The man was first remanded to Parc in April 2008. On his arrival, it was identified that he had a number of chronic conditions, including heart problems, arthritis, pancreatitis and diabetes. These conditions were kept under review during his time at Parc. In early January 2013, he began to experience severe health problems which culminated in him being admitted to hospital on 3 February for further assessment. Despite the hospital's attempts to find the underlying reason for his deteriorating health, no clear single cause was identified. Sadly, his condition continued to deteriorate and he died in hospital.

While the clinical review criticises the prison's use of some out of date medication, the overall standard of care healthcare received by the man at Parc was good and certainly equivalent to that he could have expected to receive in the community. However, it is unfortunate that the use of restraints when he was in hospital was at times poorly managed and communicated resulting in him being restrained unnecessarily.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **October 2013**

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SUMMARY

1. The man was remanded to HMP Parc in April 2008, when a health screen recorded that he suffered from heart problems, arthritis, diabetes and pancreatitis. He was sentenced to 11 years imprisonment at Crown Court on 13 May 2008. He had frequent contact with healthcare staff to help manage his chronic conditions.

2. In January 2012, a prison GP referred the man to hospital after he reported having stomach pain. He continued to suffer from stomach problems and in November 2012, the hospital informed him that tests had shown that scar tissue from a previous operation was causing his discomfort which would need to settle on its own.

3. In January 2013, the man reported feeling constantly short of breath. It was recorded that he had swollen hands and feet and that his blood sugar levels were erratic. He was prescribed diuretic medication to alleviate the swelling and healthcare staff saw him frequently throughout January. His condition did not improve and he said he had little appetite and was not sleeping well. A member of the mental health team saw him because of his low mood, and he was prescribed anti-depressant medication.

4. The man was taken to hospital on 3 February 2013, as he continued to be unwell. An emergency risk assessment was completed and he was restrained by an escort chain. He was admitted to the hospital for further tests. The next day, his risk assessment was reviewed and it was agreed that escort chain should be removed. This does not appear to have been communicated to the officers who were escorting him and he remained in restraints. A further review two days later indicated that the escort chain should be ‘reinstated’ (although it had never been removed), and the escort was reduced to one officer. Restraints were eventually removed on 12 February.

5. The hospital continued to carry out a range of tests on the man, but was unable to identify the cause of his deteriorating health. His family visited daily along with their parish priest. A member of the chaplaincy team at Parc also visited and met his wife on a number of occasions.

6. The man’s health continued to deteriorate and he died in hospital towards the end of February.

7. The investigation has found that, while the risk assessment process had taken account of the man’s medical condition and all parts of the documentation had been completed correctly, the decision to remove the restrains had not been communicated properly. The prison could not explain why it was decided that restraints should be reinstated and the decision appears to have been related to staffing levels rather than increased risk. HIW found that Parc had been using some out of date insulin which potentially can be less effective. We make two recommendations about these matters but generally he received a good standard of care at Parc.

THE INVESTIGATION PROCESS

8. The Ombudsman was notified of the man's death on 25 February 2012. The investigator issued notices to staff and prisoners at Parc informing them of the investigation and asking anyone with relevant information to contact him. No responses were received.

9. The investigator contacted Parc on 26 February and requested the man's records.

10. The Health Inspectorate of Wales (HIW) conducted a review of the man's clinical care and was provided with copies of his prison medical records.

11. On 1 May, the investigator interviewed six members of staff at Parc.

12. HM Coroner for Bridgend and Glamorgan Valleys District was informed of the investigation. A copy of this report has been sent to the Coroner.

13. One of the Ombudsman's family liaison officers contacted the man's next of kin to explain the purpose of the investigation. His family did not have any specific concerns relevant to his death for the investigation to consider other than a hospital doctor had mentioned that the insulin he had arrived with from Parc had been out of date. HIW has addressed this issue in its clinical review. It was also mentioned that they had contacted the prison in January by letter as they had concerns about his deteriorating health. The investigation did not have sight of this letter during the investigation. However, this was provided to the investigator, by the family on receipt of our draft report. We are satisfied that this correspondence was dealt with appropriately by HMP Parc.

14. The man's family received a copy of the investigation draft report as part of the consultation period. His family provided a copy of the letter and response from the prison that is mentioned in the paragraph above.

HMP PARC

15. HMP & YOI Parc, which opened in 1997, is privately managed by G4S. It holds more than 1,400 convicted male adult prisoners and young adults on remand or convicted. It also has a unit for up to 60 young people under 18.

16. There are 24 hour primary general and mental healthcare services at Parc provided by G4S. The healthcare centre has a 14 bed unit for older prisoners and those with increased health needs where the man lived when he was at the prison.

HM Inspectorate of Prisons (HMIP)

17. HMIP last completed a full unannounced inspection of Parc in September 2010. HMIP found that prisoners were mostly positive about their relationships with staff. However, support for prisoners with disabilities was weak, with no clear assessment of individual needs or care plans. HMIP reported that, at the time, healthcare services were not delivered to an acceptable standard. G4S was about to take over the provision of healthcare services when the inspection occurred. The prison has not been re-inspected since.

Independent Monitoring Board (IMB)

18. Each prison in England and Wales has an Independent Monitoring Board, made up of unpaid volunteers from the local community who monitor day-to-day life in the prison to help ensure that proper standards of care and decency are maintained. The last published IMB report for Parc noted that the prison was a well-run and safe prison. Some problems with prisoners being made aware of medical appointments were noted.

Previous deaths at Parc

19. There were six investigations completed into deaths at Parc in the year before the man died, all of which were due to natural causes. There were no direct similarities in the circumstances of these deaths, but we have previously identified the need for risk assessments for hospital escorts to take fully into account how a prisoner’s medical condition impacts on their risk.

KEY EVENTS

20. On 22 April 2008, the man appeared at Crown Court and was remanded to HMP Parc. He was convicted and sentenced to 11 years imprisonment on 13 May 2008.

21. The man was assessed by a nurse when he arrived at the prison who recorded that he had had previous heart problems and had undergone heart surgery. It was also noted that he suffered from arthritis, pancreatitis[1] and diabetes.

22. Due to his chronic health problems, and in particular his diabetes, the man had frequent contact with the healthcare team at Parc. He was seen regularly at a clinic for older prisoners to review the management of his chronic conditions.

23. On 24 April 2009, the man was taken by emergency ambulance to hospital after he told prison staff that he had taken a large number of paracetamol tablets. He was admitted to hospital for assessment and blood results indicated that his paracetamol levels were high. The hospital kept him under observation and he was discharged back to Parc on 28 April.

24. When he returned to the prison the man said that he had not intended self-harm or suicide but had taken the tablets due to the pain he was experiencing. Healthcare staff decided that, for his own safety, he should no longer be allowed to keep medication in his cell. Later, as his medical problems got worse, he was allowed to keep some medication to administer himself.

25. Throughout 2010 and 2011, healthcare staff frequently saw the man to monitor his conditions. On 27 March 2011, he was taken to hospital after he was found collapsed on his cell floor. Nurses suspected that he had suffered a stroke, but the hospital concluded that his collapse was caused by low blood pressure. He was discharged from hospital the next day. He was assessed when he returned to the prison and some of his medication was adjusted to help prevent a reoccurrence.

26. On 18 January 2012, a prison GP saw the man because he had reported low blood sugar readings in the mornings. He said that his appetite had been poor for a few months. The doctor recorded that he said he had lost weight, was finding eating difficult and was retching after meals. The doctor noted that there was no significant family history, but he had been a heavy drinker and smoker. The doctor recorded that he was slightly pale, his belly was soft and he had had operations in the past for pancreatic cysts. He referred him to the local hospital for further investigation.

27. The man refused to attend a hospital appointment on 26 January because he had a visit from his wife that day and a request for another appointment was made. On 7 February, he saw a prison GP, who noted that he was waiting for an appointment to investigate his stomach problems and asked nursed to chase this with the hospital. On 14 February, he initially refused to attend

[1] Inflammation of the pancreas

hospital again, but went after healthcare staff spoke to him about it. The results of initial hospital tests indicated no serious concerns.

28. The man continued to experience stomach problems and on 1 May a doctor arranged for further blood tests. The same day he again refused to attend a hospital appointment as he did not want to be handcuffed. He subsequently attended an appointment at the end of May when further tests indicated no mass in his stomach or serious health concerns.

29. The man's stomach problems continued and he often saw doctors for medication to alleviate his symptoms. He also regularly attended a diabetic clinic and disability clinic to review his care plans.

30. On 29 July, wing staff asked a mental health nurse to see the man on the wing as he appeared low in mood. He told her that he felt as though his 'skin was crawling' and he was on the verge of a nervous breakdown. He said he had no thoughts of self-harm and would speak to the GP the next day as he had an appointment. He saw a doctor on 31 July, who prescribed citalopram for depression and referred him to the mental health in-reach team for further assessment.

31. A nurse assessed the man on 8 August. They discussed issues in his past that had caused him problems which he said he was now over. He told the nurse that he felt he no longer required assistance from the mental health team and said he had no thoughts of self-harm.

32. The man's stomach problems continued over the next few months and he was seen frequently by healthcare staff, although he often refused to attend routine appointments, saying that he was too unwell. At those times nurses went to see him on the wing. In November, he was sent to the local hospital as an emergency after complaining of pain radiating from his front to his back. The hospital carried out a Computerised Tomography (CT) scan[2] which indicated that he had scar tissue from a previous operation, which was shrinking and causing his discomfort. He was told that he would have to allow this to take its course.

33. A doctor assessed the man on 12 January 2013, and recorded that he felt short of breath all the time. The doctor noted that his feet and hands appeared swollen and that recently his diabetic blood tests had been erratic. He told the doctor that he felt exhausted and had occasional chest pain. He said that he had been waking at night short of breath and had recently given up smoking. The doctor prescribed diuretic medication to alleviate the swelling, checked his weight and planned to see him again in one week. From 12 January, he was assessed by healthcare staff almost weekly as he continued to feel unwell, was short of breath and had swollen feet and hands.

34. The man did not attend a GP appointment on 21 January and also missed an appointment with a nurse on 22 January. On 23 January, a nurse manager visited him in his cell. He was in bed and said that he had not been feeling well for a few days, which was why he had missed his GP appointment. A senior nurse went to see him later that day to assess him and recorded that

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[2] A scan that uses X-rays and a computer to create detailed images of the inside of the body

he was low in mood, tearful, had a poor appetite and had not been sleeping well. He said he had no thoughts of self-harm. The nurse noted that he had history of heart problems, but his chest was clear, and he had mild swelling to his hands and feet. It was planned to start him on medication to help with his mood and to review this in six weeks. He was also encouraged to continue with his other medications as he had not collected them the previous days. He was referred to be assessed by a mental health nurse.

35. A nurse saw the man on 27 January and recorded that he was isolating himself on the wing. Staff were collecting his meals for him. He was noted to be unsteady on his feet even when using a walking aid and his personal hygiene was suffering. The nurse said that he would benefit from support with all aspects of daily living as his mobility was quite restricted.

36. On 29 January, a doctor saw the man. He noted that he had a history of major ischaemic heart disease and had previously had heart surgery. Since the operation, he said that he had not had problems with angina, but continued to take aspirin regularly. His recent health issues had been in relation to his stomach problems, but tests had confirmed that there were no serious problems such as cancer and he had been discharged from the care of the hospital gastroenterology. The doctor noted that he had been suffering from depression which was related to his physical state but he had also suffered from this for a number of years. It was planned for him to be assessed again by a GP in seven days.

Transfer to hospital

37. On the evening of Sunday 3 February, a nurse assessed the man after he became unwell. His blood sugar was low and, as a precaution, it was decided that he should go to hospital for further assessment.

38. An emergency escort risk assessment was completed which indicated that, due to his ill health, only an escort chain would be used by the escorting staff. (An escort chain is a length of chain with a single handcuff attached to either end, one attached to the prisoner and the other to a prison officer.)

39. At the hospital, doctors decided the man should be admitted for further tests to try to identify the cause of his health problems. Two officers remained with him (this is known as bedwatch). The escort risk assessment was reviewed the next morning, 4 February. The revised risk assessment took into account further medical information and the Head of Security concluded that, in view of his ill health and lack of identified risks, restraints were not required. However, this decision does not appear to have been passed to the escort staff and he remained in restraints.

40. The man's family were informed that he had been admitted to hospital and they were able to visit him. He had further tests in an attempt to identify the cause of his health problems, but no definitive cause was found.

41. On 6 February, the Head of Security agreed another revised risk assessment and this time indicated that an escort chain should be used, despite having concluded on 4 February that restrains were not necessary. He specified on the risk assessment that the staffing of the escort would be reduced to one

officer, with the second officer moving between the man and another prisoner who was at the hospital.

42. The man continued to be escorted by a single officer with an escort chain until 12 February when nurses spoke to healthcare staff at Parc and asked if the restraints could be removed as they were rubbing on his skin, making it sore. A further revision of the risk assessment agreed that restraints were no longer needed. This was conveyed to the escort staff who then removed the chain.

43. Despite further tests, the hospital was still unable to identify a cause for the man's deteriorating health. His family visited daily. A member of Parc's chaplaincy team visited him and met his wife a number of times.

44. The man remained very unwell and was not eating or drinking. His insulin was stopped and he was fed by nasogastric tube. He was also treated with antibiotics for pneumonia. On 22 February, his condition deteriorated even further and he was treated palliatively.

45. One morning a few days later, the escorting officer noticed that the man appeared to have stopped breathing and notified a nurse who assessed that he had died. His death was confirmed at 3.15am. The hospital informed his family. The chaplain was notified and went to the hospital where he met the family and spent some time with them and their parish priest at the bedside.

46. After the man's death the chaplain kept in contact with his family and advised them about the formalities. In line with national guidance, the prison offered financial support towards funeral costs.

Post-mortem

47. A post-mortem examination was carried out and recorded the man's cause of death as Ischaemic heart disease, coronary atheroma (narrowing of the coronary arteries with fatty deposits) and ketoacidosis (build up of acid in the blood).

ISSUES

Clinical care

48. The man arrived at Parc with multiple chronic health problems including ischemic heart disease, pancreatitis, osteoarthritis and diabetes. He was prescribed medication for all these conditions and needed continuous monitoring.

49. HIW note that the man was regularly reviewed at the diabetic clinic and his diabetic control and renal functions were monitored. He was also seen at the coronary heart disease clinic. His mental health was assessed and he was treated for depression. Any symptoms he developed were treated promptly. When he overdosed on paracetamol, he was quickly transferred to hospital and referred for appropriate tests. He was promptly sent to hospital when he collapsed with low blood pressure and when he was found to be unwell on 3 February he was properly assessed, treated and transferred to hospital.

50. HIW conclude that the man received good quality care and frequent medical input while in custody, and this was of a standard equivalent to that which he could have expected to receive in the community. He died from complications of ischaemic heart disease and diabetes, both chronic diseases with known significant morbidity and mortality, but HIW state there was no indication before his final admission to hospital that such a rapid deterioration was likely.

The man's insulin

51. During the investigation, the man's family told the investigator that, while he had been in hospital, the doctor treating him had told them that insulin provided at Parc had been out of date. HIW considered this as part of their review.

52. In their report, HIW say that the man managed his diabetes himself and that his diabetic control was acceptable. He was competent in dealing with his insulin and therefore there was reliance on him to take it appropriately and for him to inform staff if there were any concerns. He kept one insulin pen and one needle at a time and was issued with a new pen and needle when he needed more insulin.

53. The prison pharmacy said that they checked the dates on medication as it arrived and again when it was dispensed. They said that there was also a monthly check of stock to ensure that any out of date medication was destroyed. Data from the pharmacy indicated that wing nurses had ordered no new insulin for the man for some time because there was sufficient stock in the wing medication fridge. HIW concluded that, because of the pharmacy systems, it was unlikely that he had received out of date medication directly from the pharmacy, but out of date medication could have been given from stock on the wing.

54. Out of date insulin is not harmful but can lose potency very gradually over time if it is not stored in optimum conditions. HIW have concluded that the man did receive some out of date insulin but it is not possible to know for how long or how far out of date it was and what, if any, impact this had. His blood

tests indicate that his diabetic control had been reasonable We make the following recommendation:

The Head of Healthcare should implement a system to check stocks of medication on wings to ensure that out of date medication is not issued.

Restraints, security and bed watch

55. The Prison Service has a duty to protect the public when escorting prisoners to hospital and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. 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 which also takes into account factors such as the prisoner's health and mobility. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion regarding the prisoner's ability to escape must be considered as part of the assessment process. It deemed that handcuffing a prisoner receiving chemotherapy (and, by implication, other life saving treatment) was degrading and that such restraint would be likely also to be regarded as inhumane unless justified by other relevant considerations.

56. When the man was taken to hospital on 3 February, the risk assessment indicated that an escort chain would be used. After his admission, the risk assessment was appropriately revised on 4 February and, based on information which included healthcare input, it was decided that restraints were not required. However, it does not appear that this decision was verbally communicated to the escort staff although it was in the escort records. He therefore remained restrained.

57. On 6 February, a further risk assessment was completed and it is not clear what prompted this. There is nothing to suggest any increase in the level of risk the man posed, his health and mobility had not improved and, as far as the security department at Parc were aware, he was not in restraints. However, this time the security manager decided that the escort chain should be used, but the number of staff escorting him would be reduced to one.

58. We asked Parc's Head of Security for the reasoning behind this decision. He said that he believed that the other member of staff was to be used to go between the man and a second prisoner who was on the same ward. Therefore, he would have been in sight of the officer escorting him. However, the investigator examined the records which clearly state that he was on ward 2 and the other prisoner was on ward 20. The two wards are at different ends of the hospital.

59. The Head of Security was asked whether the decision to reinstate the escort chain was taken based on staffing levels rather than an increased risk in the man's behaviour. He said that such a decision would not have been based on staffing, but accepted that the risk assessment indicated no change in his risk and that in fact the records indicated that his health continued to deteriorate. He could not give us a clear reason why the escort chain was reinstated. It is

contrary to Prison Service guidance to have just one officer escorting a prisoner using restraints and it appears that this decision was made on the basis of staffing rather than any increased risk posed by him.

60. The investigator raised the issues of restraints and quality of the risk assessment process with the Director of HMP Parc, who said that these issues had been identified by the prison management team in a review after the man's death. The Director said that the prison was in the process of looking at the way risk assessments were being completed and communicated. The evidence we saw indicated that an appropriate risk assessment had been made taking account of healthcare advice which concluded that restraints were not necessary. Although restraints were finally removed at the request of hospital staff on 12 February, on the basis of the risk assessment of 4 February, we do not consider their use was justified at any time. We make the following recommendation:

    The Director should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances, including their health and mobility, are based on the actual risk the prisoner presents at the time and that managers communicate decisions to appropriately staffed escorts.

RECOMMENDATIONS

1. The Head of Healthcare should implement a system to check stocks of medication on wings to ensure that out of date medication is not issued.

   In response to our draft report the following action was taken:

   A weekly date check of all stock medication has now been introduced.

2. The Director should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances, including their health and mobility, are based on the actual risk the prisoner presents at the time and that managers communicate decisions to appropriately staffed escorts.

   In response to our draft report the following action was taken:

   A review has been undertaken of how Healthcare Medical Services accurately stipulate how a prisoner's physical condition affects his mobility and as such his level of risk whilst on escort. Changes have been made to the Escort Risk Assessment Form to provide better quality information, which covers the individual factors listed and takes into account individual circumstances of the prisoner. A meeting has taken place between the Head of Healthcare, Head of Security and the Director to ensure that risk levels are informed by healthcare assessments. Escorts are only authorised by the Director, Deputy Director or Head of Security or person designated as in charge. Each risk assessment has sections for medical assessment, completed by a nurse, and a security assessment completed by the security department prior to the risk assessment being presented for authorisation. Without this information being available the escort is not authorised. In the event of an emergency escort out of hours, the Orderly Officer contacts the Duty Director giving full details of the Security and Medical assessments.