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 HMP & YOI Parc in December 2013

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 man who died from a stroke in December 2013 at HMP Parc. He was 84 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by an investigator. Healthcare Inspectorate Wales reviewed the clinical care the man received at Parc. The prison cooperated fully with the investigation.

The man was sentenced to nine years imprisonment in 2009 and sent to HMP Holme House. He transferred to Parc in November 2010. When the man suffered a stroke in October 2012, he refused all treatment. Although he continued to experience bouts of dizziness and high blood pressure, he still declined to take any medication. Despite this, with the help of healthcare staff at Parc, the man made a good recovery from the stroke and regained his mobility.

The man continued to refuse all medication and declined a move to an assisted living wing in the prison. On Christmas Day, in the afternoon, the man collapsed in his cell and staff attempted to resuscitate him. Shortly after paramedics arrived they confirmed his death.

The investigation found that, despite the man's frequent refusal to accept treatment, healthcare staff provided an excellent level of care throughout his time at Parc. This care and attention was at least as good as that which would have been available in the community and I agree with the clinical reviewer that healthcare staff deserve commendation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **June 2014**

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SUMMARY

1. The man was sentenced to nine years imprisonment in October 2009 and sent to HMP Holme House. He transferred to HMP Parc in November 2010. When he arrived at Parc a nurse assessed him as fit and well for his age and did not identify any concern about his physical or mental health. The man had no interaction with healthcare staff over the next 14 months.

2. A nurse examined the man on 12 February 2012 after he complained of having dizzy spells. His blood pressure was normal at this time, but he continued to suffer from bouts of dizziness when his blood pressure was raised. Despite advice he refused any medication or treatment.

3. On 14 October 2012, the man collapsed in his cell. He was admitted to the Princess of Wales Hospital, Bridgend, where a CT scan showed he had suffered a stroke. The hospital assessed that he needed to be admitted to hospital for medical treatment and stroke rehabilitation, but the man refused to be admitted and declined any medication. He was assessed to have mental capacity and confirmed that he understood the risks of discharging himself against medical advice. The man was taken back to prison that afternoon.

4. Over the next year, the man made a good recovery from the stroke and regained his mobility. Healthcare staff at Parc provided good care, but he continued to refuse any medication or formal rehabilitation. Doctors discussed the serious risks to his health with the man and it is clear he fully understood them, including that he might die.

5. On 22 October 2013, the man agreed to be prescribed ramipril, a medication to help reduce his high blood pressure. Three days later, he had a fall after he refused his morning medication. A GP reviewed him and offered a move to the prison's assisted living unit for older prisoners, but the man declined. He again decided not to take any medication. Healthcare staff continued to visit him regularly.

6. On 25 December 2013, a prisoner found the man collapsed in his cell. Staff attempted resuscitation, but the man did not respond. At 4.16pm, shortly after they had arrived, paramedics confirmed he had died. A post-mortem revealed that he had suffered a stroke.

7. The clinical reviewer found that the standard of healthcare the man received at Parc was better than he would have received in the community, and we agreed he was well cared for. However, we are concerned that prison staff were confused about the use of emergency medical codes. Although this did not affect the outcome for the man, in other circumstances it could be crucial. We make one recommendation about this.

THE INVESTIGATION PROCESS

8. The investigator issued notices to staff and prisoners at HMP Parc informing them of the investigation and inviting anyone who had relevant information to contact her. No one responded.

9. The investigator obtained copies of the man's prison medical records and relevant aspects of his prison records. She interviewed two members of staff and two prisoners at HMP Parc on 5 March 2014. The investigator gave initial feedback to the Head of Safer Custody, and followed this up in writing.

10. Healthcare Inspectorate Wales carried out a review of the man's clinical care at the prison.

11. We informed HM Coroner for Bridgend and Glamorgan Valleys District of the investigation who provided the post-mortem report. We have sent the Coroner a copy of this investigation report.

12. One of the Ombudsman's family liaison officers contacted the man's niece, his nominated next of kin, to explain the investigation. She had no concerns about his treatment at the prison.

HMP & YOI PARC

13. HMP & YOI Parc, which opened in 1997, is run by G4S. It holds more than 1,400 convicted male adults and young adults on remand or convicted. It also has a unit for around 60 young people under 18. There is a 14 bed unit (the assisted living wing) for older prisoners with increased health needs.

14. G4S provides 24 hour primary general and mental healthcare services at Parc and St John's Medical Practice provides 24 hour GP cover.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Parc was in July 2013. Inspectors found that the prison was safe and, overall, prisoners were well cared for. The standard of health services was assessed as good with an impressive new healthcare unit. There were some concerns about waiting times for hospital appointments.

Independent Monitoring Board

16. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recently published annual report for the year to May 2013, the IMB commented that the number of recent deaths in custody reflected an increasing older population. They said that, the prison was to be complimented for the way it cared for prisoners with complex health and mental health problems and their families.

Previous deaths at HMP Parc

17. The man was the 14th prisoner to die at Parc since the beginning of 2012, the second as a result of a stroke. We identified issues about emergency response procedures in two previous investigation reports.

KEY EVENTS

18. The man was convicted of sexual offences on 12 October 2009. He was sentenced to 12 years imprisonment on 5 November 2009 and sent to HMP Holme House. In April 2010, this was reduced to nine years on appeal.

19. A nurse saw the man when he arrived at Holme House and noted that he was generally fit for his age and had lived independently in the community. The nurse noted the man's blood pressure was raised, at 183/89. His body mass index indicated he was in the obese range, he smoked on average 20 cigarettes a day and was slightly deaf in his left ear. He refused any advice about giving up smoking. A prison GP reviewed the man the next day and noted that the man's blood pressure was now normal and that he had never taken any regular medication for his blood pressure.

20. During his time at Holme House, the man had two episodes of dizziness. The doctor diagnosed possible viral labyrinthitis (inflammation of the inner ear causing dizziness) for which he received appropriate medication.

21. The man moved to HMP Rye Hill on 9 July 2010, and then to HMP Parc on 30 November. Records show he had no significant interaction with healthcare staff at Rye Hill. When he arrived at Parc, a nurse recorded that he was fit and well for his age and there were no concerns about his physical or mental health.

22. For the next 14 months, the man did not have any healthcare appointments or interaction with healthcare staff.

2012

23. A nurse saw the man on 12 February 2012, after he had complained of dizzy spells. The man refused to see the doctor. After some persuasion the nurse was able to take his blood pressure, which was raised at 158/78. She made an appointment for a doctor to review the man two days later, on 14 February. There is no further record of this in his medical notes.

24. A prison GP saw the man on 27 March after he complained of a number of dizzy spells. The GP examined him and noted his dizziness was linked to when he stood up from a sitting position. The doctor noted that the man suffered no loss of control, was a little unsteady on his feet and had an occasional headache. The man explained that if he had a lie down for 30 minutes after an incident, his symptoms disappeared. His blood pressure was raised at 151/78. He told the GP that he did not wish to take any medication.

25. Another prison GP saw the man on 24 April. The GP reviewed his symptoms and told him he thought he had benign positional vertigo. (A disorder arising in the inner ear.) He advised the man to follow a low salt diet to help lower his blood pressure and said that he would review his blood pressure in six to eight weeks. The man still refused to take any medication.

26. On 2 May a healthcare assistant saw the man on the wing after he complained of dizziness. His blood pressure was very high at 181/94. The GP reviewed the man later that day and noted his blood pressure had reduced to 166/86. The GP prescribed amlodipine (to lower blood pressure).

27. Three days later, on 5 May, the man said that he no longer wanted to take his blood pressure medication as he believed there were too many side effects. The GP saw the man on 8 May, noted his blood pressure was high at 200/65 and discussed his reluctance to take medication. The doctor told him that if his blood pressure remained high and he continued to refuse to take his medication he was at risk of a stroke. He recorded that the man had the capacity to refuse treatment.

28. The man's blood pressure remained high but, contrary to advice, he continued to refuse to take any medication to regulate it. He was made aware of the risks and benefits related to his medication, but assessed as mentally competent to decide.

29. On 14 October at 11.50am, the man collapsed in his cell. Officers called a code blue emergency which indicates a prisoner is unconscious or has breathing problems. A nurse attended and examined him. The man said that he had fallen from his chair but had not lost consciousness. His blood pressure was raised at 185/78. The nurse noted that he was unable to do basic functions that he was able to do before he fell, such as zip up his fleece or roll a cigarette.

30. Another prison GP examined the man later the same day. She noted he had left sided weakness, had lost some vision in his left eye and was unsteady on his feet. His vision and speech were normal and he remained alert. The GP told the man that she thought he had suffered a small stroke. After discussion with the specialist registrar at the Princess of Wales Hospital, the GP asked that the man be observed every four hours and then to be admitted to the hospital the next morning for a CT scan and assessment.

31. On 15 October, the man had a scan at the Princess of Wales Hospital which confirmed that he had suffered a stroke. Hospital staff advised the man that he would need to be admitted for medical treatment and therapy to reduce the risk of another stroke. However, he refused to be admitted to hospital or take any medication. He was assessed to have capacity and confirmed that he understood the risks of discharging himself against medical advice. The man went back to the prison later that day.

32. After he returned, healthcare staff took medical observations every four hours. On 16 October, the GP examined the man who again refused to be admitted to hospital for assessment. He was still unsteady on his feet and was using a zimmer frame to get about. The director offered him a move to U wing, the assisted living wing (where he would have received a higher level of monitoring) but the man declined. The GP prescribed him aspirin (to help thin the blood) with the plan to change this to clopidogrel (to prevent blood clotting) at the end of a two week period.

33. At 2.00pm the same day, a mental health nurse visited the man in his cell. She noted there was no decline in his mental health. He again refused a move to U wing where he could be more closely monitored and said that he was happy where he was. He agreed to take aspirin. His blood pressure was now reduced at 130/60.

34. At the request of the healthcare manager, a locum doctor saw the man on 17 October to assess his mobility and the safety of him remaining in his current cell. The doctor noted that the man had reduced mobility, coordination and balance which affected his left side. He was able to get about in his cell with his zimmer frame and said he was quite comfortable and well supported by officers and other prisoners. The locum requested ongoing physiotherapy to help improve the man's mobility, coordination and balance in order to improve his safety.

35. Later that afternoon, the GP discussed the man's health with him and the risk that he might die if he had another stroke. The man again refused to be admitted to hospital for stroke rehabilitation and said that he was happy with the care he was receiving in prison. He said that he did not want to go back to hospital and wanted no further treatment, saying "if the big man decides it's my time, then it's my time".

36. The man confirmed that he understood all the risks and accepted that he might die in prison. The GP asked if he wanted his family to be contacted so he could discuss this further. The man refused and said that he had written to his niece to tell her he had been unwell and this was sufficient. He said that in the event of another stroke he did not want assistance and did not wish to be resuscitated in the event of a cardiac arrest. The GP noted that he considered the man was of sound mind and was able to retain information and make decisions about his care.

37. On 18 October, two doctors and a mental health nurse saw the man to assess his mental health. They concluded that there was no evidence of depression or dementia. They discussed that he had discharged himself from the hospital and his preference not to be resuscitated. The man said that he did not like being at the hospital because he had had to wait a long time to be seen. After some persuasion he agreed that he would go to hospital for care and treatment in an emergency.

38. A physiotherapist also assessed the man that day. He recorded that after his stroke the man had reduced mobility, coordination and balance and was unsafe to mobilise independently. He made arrangements for the man to receive physiotherapy.

39. On 22 October, the man agreed with the GP that he would take ramipril, a medication to help reduce his high blood pressure. Over the following days the man had two physiotherapy sessions. His mobility had significantly improved and he was now able, with close supervision, to get about without his zimmer frame.

40. On 25 October, a nurse saw the man because he had a fall after refusing his morning medication of ramipril. She referred him to the GP and the GP saw him later that morning. Against advice, the man still refused to take his medication. The GP asked healthcare staff to monitor the man closely.

41. On 26 October, the GP, the older prisoners' manager and the clinical lead nurse discussed the man who was still refusing to take medication. They decided that, although the man did not require palliative care at this time, he should be added to the palliative care register due to the unpredictability of his condition and his refusal of medical treatment. This would ensure appropriate monitoring and a mental health nurse would see him routinely every six weeks.

42. The man signed a medical disclaimer declining any further hospital treatment on 27 October. On 19 November, a mental health nurse assessed the man and noted no decline in his mental health.

43. On 21 November, a doctor spoke to the man about him refusing to take his medication. The man confirmed that he was aware of his poor prognosis and the risk of death if he did not take medication or have any further treatment. He asked again that he should not be resuscitated in the event of a cardiac arrest. The doctor was satisfied that the man was mentally competent and completed a do not attempt cardiopulmonary resuscitation order.

2013

44. The GP spoke to the man on 27 February 2013 to review his decision about resuscitation. The man explained that he was not bothered and did not want to take part in the decision making process. He asked that healthcare staff should make the decision about resuscitation. The GP considered that, as the man had made a good recovery from his stroke and in his current state of health resuscitation would be appropriate, the earlier order should be withdrawn. (The man subsequently indicated that he agreed with this.)

45. On 21 March, the man attended the Princess of Wales Hospital for an outpatient appointment. A hospital consultant reviewed the partial loss of sight in his left eye after his stroke and concluded that the damage to his eye was likely to be permanent.

46. Healthcare staff visited the man in his cell each day, but he complained saying he was getting tired of people disturbing him. After discussing this with him, it was agreed to reduce healthcare visits to twice a week

47. Mental health nurses reviewed the man, on 25 April, 12 June, 16 July, 27 August and 10 October. On each occasion it was noted there was no decline in his mental health.

48. On 14 December, a healthcare assistant visited the man in his cell. She noted his blood pressure was raised at 173/83. However the man said he felt well and did not wish to see a doctor.

49. At around 3.50pm on 25 December, Christmas Day, a prisoner found the man collapsed on the floor next to his toilet. The prisoner called for assistance and an officer closely followed by another officer, went to check him. The officer was unable to find a pulse, and at 3.54pm he called a code blue emergency. (Prisons are required to have a two level code system that differentiates between a blood injury and all other injuries. Code red is usually used for blood injuries and code blue indicates a prisoner with symptoms such as breathing difficulties and collapses.)

50. A nurse and healthcare assistant were already on the wing dispensing medication when they heard the emergency call and went to assist. The nurse noted that the man looked grey and she was unable to find a pulse. After discussion with two officers called a code red as they believed this would escalate the incident. Two nurses arrived, in response to the original code blue and brought a defibrillator (a machine that gives an electric shock to try and restart the heart). The defibrillator was used, but no shockable rhythm was detected. The staff began cardiopulmonary resuscitation and an ambulance arrived at 4.03pm. The paramedics continued the resuscitation attempt, but the man could not be revived and they confirmed his death at 4.16pm.

51. A Director's notice informed staff and prisoners about the man's death. Staff involved in the emergency response had an appropriate debrief and staff and prisoners were offered support if they needed it.

52. The man's niece, his next of kin, lived over 300 miles away from the prison. The prison family liaison officer contacted HMP Holme House to see if they would be able to send someone to inform his niece of the man's death. Holme House were unable to assist, so Parc asked the local police to inform the man's niece. At 6.00pm, when the police confirmed that this had been done, the family liaison officer telephoned the man's niece to offer her condolences and support.

53. The man's funeral was on 16 January 2014. In line with national guidance the prison contributed towards funeral costs.

54. The post-mortem report showed that the man died from a right cerebral infarct (a stroke), resulting from a blockage in the blood vessels supplying blood to his brain.

ISSUES

Clinical care

55. The man had high blood pressure throughout his time in prison and suffered a stroke in October 2012. It is well documented that he consistently refused almost all medication. It is clear that he fully understood the consequences of his refusal and that his mental capacity to take such decisions was frequently reviewed.

56. Although the man refused to take medication, it is apparent that healthcare staff at Parc looked after him well. Nurses checked him regularly and doctors and mental health nurses also frequently reviewed him. Healthcare staff discussed the implications of him refusing medication many times and he always made it clear that he did not want any treatment. At first he indicated he did not wish to be resuscitated in the event of a cardiac or respiratory arrest but he later changed his mind. When staff found the man collapsed they appropriately attempted resuscitation.

57. The clinical reviewer commented that, had the man's blood pressure been better controlled both before and after he went to prison his stroke might have been prevented. However, this was not possible because he refused treatment. We agree with the clinical reviewer that the standard of healthcare the man received in prison was at least as good, and likely to have been better, than he would have received in the community.

58. We agree with the clinical reviewer, that healthcare staff at Parc should be commended for the excellent care and attention they gave the man.

The emergency response

59. When the man was found collapsed in his cell on 25 December, a code blue emergency was correctly called. A code blue means that a prisoner has symptoms such as chest pain, breathing difficulties or is unconscious. However, the two officers both believed that by calling a code red it would increase the urgency of response. In fact a code red is issued to indicate that a prisoner is bleeding. The reason for different codes is to ensure healthcare staff and others are forewarned about the type of incident they are attending and bring the correct equipment. Both codes should result in an emergency being called immediately.

60. The nurses responded to the original code blue and brought the correct equipment and an ambulance was called and attended without delay, so this did not impact on the emergency response. However, it is a concern that officers were unsure about the emergency code system.

61. Prison Service Order 03/2013 required governors to have a medical emergency response code protocol based on the instruction and we are satisfied that Parc has an appropriate local protocol. The Head of Safer Custody reminded staff by email on 14 August 2013 of the emergency codes

and when to use them. However, the response to this incident indicates that not all staff fully understand the emergency code system. We make the following recommendation:

The Director should ensure that all prison staff are made aware of and understand the prisons protocol in respect of PSI 03/2013 and their responsibilities during medical emergencies including appropriate use of emergency codes.

RECOMMENDATION

The Director should ensure that all prison staff are made aware of and understand the prisons protocol in respect of PSI 03/2013 and their responsibilities during medical emergencies including appropriate use of emergency codes.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and Function Responsible	Progress (to be updated after 6 months)
1	The Director should ensure that all prison staff are made aware of and understand the prisons protocol in respect of PSI 03/2013 and their responsibilities during medical emergencies including appropriate use of emergency codes.	Accepted	The Director's Order has been re-published to remind staff of the emergency code system at Parc. Staff have also been issued with individual cards with codes for ease of reference. The clinical lead of healthcare liaises directly with the Head Of Safer Custody following any medical emergency to ensure the correct code was used.	Director Completed	