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 on 28 August 2013 while in the custody of HMP 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 man on 28 August 2013, while a prisoner at HMP Parc. A post-mortem examination showed that he died of heart disease. He was 78 years old. I offer my condolences to the man's family and friends.

Health Inspectorate Wales reviewed the clinical care that the man received at Parc. The prison cooperated fully with the investigation.

The man had been at Parc since April 2012, when he began an eight year sentence. He had a number of chronic health conditions and healthcare staff had frequent contact with him over the next nine months. In the early hours of 9 January 2013, he collapsed in his cell and was taken to the Princess of Wales Hospital, Bridgend. He was found to have suffered a severe stroke and remained in hospital until he died seven months later. Four months before he died, the hospital indicated that the man could be discharged to full time nursing care as active hospital treatment was no longer possible. Regrettably this was not achieved before his death.

Health Inspectorate Wales considers that the standard of healthcare the man received at Parc was equivalent to that he could have expected to receive in the community. While a more proactive approach by the prison might have helped speed up decisions about his ongoing care before his death, I am satisfied that this did not impact on his treatment and that, overall, he received appropriate care at Parc.

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 **March 2014**

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SUMMARY

1. On 11 April 2012 the man was sentenced to eight years in prison for sexual offences. He was sent to HMP Parc. A health screen when he arrived noted that he used a wheelchair and a walking stick, had asbestosis and tinnitus, which caused problems with his balance. A care plan was drawn up and the man was initially given a ground floor cell in the induction unit. At the end of April, he moved to a standard wing in the main prison and, in July, he was moved to a special wing for older prisoners with long term health needs.

2. Healthcare staff saw the man frequently and monitored his blood pressure. On 29 July, he was taken by ambulance to the Princess of Wales Hospital, Bridgend, because his blood pressure was very high and he was in pain. He was investigated for a heart attack, but the results were negative.

3. In November, the man was again investigated for a heart attack when he complained of chest pains, but the results were negative. On 22 December, he felt very unwell and healthcare staff monitored him every four hours. He was treated with antibiotics for a chest infection.

4. Early in the morning of 9 January an officer found the man slumped on the toilet, unable to move but conscious and breathing. The officer radioed an emergency code blue and two nurses attended with emergency kit. The man was taken to the Princess of Wales Hospital by emergency ambulance. He was not restrained on the way to hospital but an escort chain was applied at the hospital overnight. The next morning this was removed permanently. The hospital confirmed that he had suffered a severe stroke.

5. After the man's admission to hospital, the prison appointed a family liaison officer to ensure he and his wife were supported. The family liaison officer remained in contact with the man's wife throughout his time in hospital.

6. In the months that followed, he remained in hospital as he needed 24 hour care. In April, the hospital considered that the man was fit to be discharged, but only to a residential care home as the care he needed could not be provided in prison. The prison worked with outside agencies to find a suitable placement, but this had not been arranged before the man died in hospital on 28 August.

7. Health Inspectorate Wales consider that the man's care was equivalent to that he could have expected to receive in the community. We agree that Parc provided appropriate care, but consider the prison could have made more active attempts to pursue options for alternative care arrangements in the community after hospital care was no longer needed.

THE INVESTIGATION PROCESS

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

9. The investigator obtained copies of the man's relevant prison and prison medical records. She visited HMP Parc on 15 October and interviewed seven members of staff. She gave initial feedback about the preliminary findings of the investigation and followed this up in writing to the Director.

10. Health Inspectorate Wales (HIW) reviewed the clinical care the man received at the prison.

11. The investigator informed HM Coroner for Bridgend and Glamorgan Valleys District of the investigation and the Coroner 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 telephoned the man's wife to explain the purpose of the investigation and to invite her to outline any issues she wished the investigation to consider. His wife had the following questions about her husband's treatment at Parc:

    - Was his blood pressure managed appropriately?
    - How adequate and timely was the treatment for his chest infections?
    - Was access to the doctor equivalent to that in the community?
    - Were his chest pains investigated properly in Parc?
    - Should his cardiovascular condition have been identified earlier and treated in the prison?

13. The man's wife received a copy of the draft report and wrote to us in response. In her letter she clarified the reasons for some of her original questions and concerns, and explained reading the report had given her a clearer picture of his health while in prison. Her comments have not led to any factual changes in the report.

HMP & YOI PARC

14. HMP & YOI Parc, which opened in 1997, is run 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 around 60 young people under 18.

15. 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

16. The most recent inspection of HMP Parc was in July 2013. The prison was found to be safe and, overall, prisoners were well cared. Efforts to help prisoners sustain relationships with their families and work with the families themselves were regarded as outstanding. The standard of health services was judged to be good and the new health care unit was described as impressive. There were some concerns about access to hospital health appointments as there were no systems to monitor waiting times.

Independent Monitoring Board

17. 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 recent annual report for the year to May 2013, the IMB reported that there had been significant improvement in the appointment management system for prisoners to see GPs. They pointed out that the number of deaths in custody reflected an increasing older population and noted the provision of special accommodation and facilities for them at Parc.

Previous deaths at Parc

18. The man was the twelfth prisoner to die at Parc since the beginning of 2012. There has been one other death of a prisoner after a long stay in hospital. In a number of cases we made recommendations about the need to ensure that the use of restraints in hospital is justified by an individual risk assessment.

KEY EVENTS

19. On 11 April 2012, the man was sentenced to eight years imprisonment for sexual offences and was sent to HMP Parc. At his initial health screen, it was noted that the man had tinnitus causing balance problems, lung damage from asbestosis, and had recently collapsed at court and spent some time in hospital. He used a wheelchair or a stick and crutch to move around. The nurse reviewed his medication and referred him to the disability nurse. A supported living plan was drawn up to accommodate his needs. The man told the nurse he was breathless and had a history of chest pain. He initially stayed in a ground floor cell in the induction unit before moving to the main prison on 27 April. The prison received the man's community medical records on 12 April.

20. At a secondary health screen on 12 April, the man said he had COPD (chronic obstructive pulmonary disease – a term used to describe a number of lung diseases, including asbestosis). On 23 April, he asked to see a doctor as he was in a lot of pain. The next day, a doctor examined him and noted that the man was a long term sufferer of hyperhidrosis (excessive sweating) and had PMR (polymyalgia rheumatica –stiffness and inflammation of the muscles around the neck, shoulders and hips). The doctor prescribed omeprazole (to treat excess stomach acid) and naproxen (an anti-inflammatory).

21. On 8 May, a doctor took the man's blood pressure and general observations. His vital signs appeared normal. The man continued to be monitored by nurses and doctors.

22. The man did not attend a healthcare appointment on 26 June. He felt ill on 28 June and a doctor examined him on the wing. The doctor diagnosed an exacerbation of COPD and asked nurses to monitor the man every four hours and send him to hospital if his health deteriorated.

23. On 14 July, a doctor noted that the man's vital signs were normal except his blood pressure, which was raised (174/88). The doctor asked for observations to be repeated at 5.00pm and for nurses to phone through the results. At 5.00pm, the man's blood pressure was still raised (170/90). On 16 July, a doctor diagnosed an exacerbation of COPD. On 18 July, the man moved to another wing in the prison, for prisoners with long term health problems.

24. On 24 July, he complained of abdominal pain and a doctor took blood tests and clinical observations including blood pressure. His blood pressure was high (154/80) but the other results were normal. The doctor stopped his naproxen, as this medication is not advised for those at higher risk of a heart attack or stroke. The next day the man had an electrocardiogram (ECG) test (which records the rhythm and electrical activity in the heart) which ruled out a heart attack. His blood pressure was monitored every two hours and the nurses were told to call the GP if the man's blood pressure rose to over 200. At 7.30pm his blood pressure was 204/78 and he was feeling more pain. The nurses could not get through to the on call GP, so booked an urgent appointment for the next morning. They continued to take clinical observations every two hours.

25. The next day, 25 July, the man told a doctor he was in less pain. The doctor prescribed amlodipine for hypertension (high blood pressure), and continued with medicine for indigestion and pain relief for back pain. Two days later a doctor saw the man and prescribed further pain killers for back and abdomen pain. On 29 July, the man's blood pressure was high (202/82) and he was taken to the Princess of Wales Hospital by ambulance. He was investigated for a heart attack, but the results were negative. The hospital adjusted his medication and he returned to Parc the next day.

26. Over the next two months, he continued to be monitored by healthcare staff. On 10 October, he complained of chest pains. A doctor examined him and concluded the pain was unlikely to be caused by heart problems because the man's observations were normal and he was not sweaty or nauseous. The doctor thought the pain was muscular and added co-codamol (a pain killer) to the man's medication. He suffered from swollen ankles as a side affect of taking amlodipine, so the doctor stopped that. On 16 October, the man's blood pressure had improved and he said he felt better.

27. On 29 November, prison healthcare staff carried out a test for heart damage after the man complained of chest pains again. The results were normal. He had two further ECGs and a blood test, and all results were normal. His blood pressure was high (180/85 and later 150/70) and he continued to be monitored. A doctor again diagnosed the pain as musculoskeletal.

28. A nurse took the man's observations at 11.00am on 22 December, which were normal. At 12.30pm, a doctor saw the man urgently on the wing because he had stabbing pains in the right side of his chest. The doctor noted that the man's chest was clear, but his blood pressure was high (150/94). His pulse was normal (91bpm). The doctor diagnosed a possible exacerbation of COPD and prescribed antibiotics. He also asked for the man to be monitored every four hours. His condition remained stable.

29. At 5.46am on 9 January, while carrying out a morning roll check, an officer found the man slumped on the toilet in his cell. The officer radioed a code blue (indicating a life-threatening emergency due to loss of consciousness or difficulty breathing). Two nurses responded with emergency kit. The man was conscious, so they moved him to his bed, and sat him up.

30. A nurse told the investigator that she had thought that the man had suffered a stroke because the left side of his face appeared drooped, his left side was weak and his speech was slurred. She radioed for an ambulance which was called at 5.56am. Once the man was on the bed, the nurses took his blood pressure which was high at 176/95, his pulse rate was also high but his oxygen levels at 72% were low. The man was given oxygen and his level rose to 98%. The ambulance arrived at 6.15am and he was taken to hospital. No restraints were used.

31. At hospital the man tried to take his clothes off and exposed himself. It is not clear from the records whether his behaviour was a result of his medical condition. A risk assessment was completed at 10.40am that morning and, as a result, an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer) was applied.

There was no medical input recorded on the risk assessment, or any security reasons noted, but the escort chain was removed at 10.15am the next morning after a risk assessment indicated no need for restraints. A nurse from Parc contacted the Princess of Wales Hospital for an update and was told that the man had suffered a severe stroke.

32. A family liaison officer was appointed on 9 January at 8.30am. She spoke to the man's wife that morning and explained what had happened and the arrangements for visiting him in hospital.

33. On 15 January, hospital staff told Parc that the man was not expected to live more than a few weeks. He was released on temporary licence (ROTL) on 17 January. On 6 February, the licence was revoked as hospital staff requested support from the prison because the man began to behave aggressively. He then had an officer escort but was not restrained. It is not clear if his behaviour was a result of his condition. He was released on temporary licence again, without an escort, on 27 February when his risk was considered to have reduced again.

34. On 8 February, the prison applied for release on compassionate grounds on the man's behalf. The application was refused because he had been in a wheelchair when he had committed the offences for which he was convicted so it was not apparent that his condition at the time sufficiently reduced his risk. In addition there was no clear prognosis. A second application was submitted on 27 February after the man had contracted an infection and needed full nursing care. The application was returned as it had not been fully completed. It does not appear to have been re-submitted.

35. On 4 April, the man's wife, prison staff, a social worker and hospital staff attended a meeting and agreed that the man was not capable of looking after himself and needed 24 hour nursing care. It was agreed that the level of care he needed could not be provided at the prison. The hospital considered the man was fit to be moved on 23 April. The prison began to plan to move him to suitable accommodation and made a further application for release on compassionate grounds in May 2013. This application was also refused, because the man had no clear prognosis. (A life expectancy of less than three months is usually expected.)

36. On 30 May, it was noted that the man had pneumonia. A doctor and the prison nurse manager drew up a care plan to transfer the man to a full time nursing home once his condition was stable. A social worker was contacted about arranging a place for the man in a nursing home. The social worker was organising the healthcare part of funding and researching local homes to see if they would accept him. (On 4 July, a multi-disciplinary team meeting was held at the hospital to plan his discharge but records indicate some concerns were raised about the vulnerability of other patients in a local nursing home should he be sent there. The prison agreed to assess the suitability of the placement while funding was agreed. There are no further prison notes about this and funding had not been agreed for a nursing home before the man died.)

37. At the beginning of June, the man suffered seizures and his health deteriorated. He became abusive towards hospital staff at the end of June

and at the hospital's request prison officers came back to the hospital to sit with him, although restraints were not used. It is not clear from the records how long the officers remained with him.

38. The man's wife had visited him throughout his time in hospital and had been with him earlier in the day on 28 August. Hospital staff had told her he was not expected to live for more than a couple of days. The man died at 4.50pm on 28 August and the hospital informed his wife by telephone. The family liaison officer telephoned his wife and arranged to visit her at her home the next day with a colleague. The prison offered funeral expenses in line with national guidance.

Support for prisoners and staff

39. A notice from the director informed prisoners and staff of the man's death and support was offered if they had been affected by his death.

40. The officer who found the man collapsed, is a permanent night officer and was not kept informed about what had happened to the man. This has been drawn to the Director's attention. Other staff said they had felt supported and were aware that the man was not likely to return to the prison.

Post-mortem report

41. The post-mortem concluded that the man died of ischaemic heart disease and coronary atheroma.

ISSUES

Clinical Care

42. HIW considers the man's care at the prison was equivalent to that which he could have expected to receive in the community.

43. While in prison, he was diagnosed with high blood pressure. Healthcare staff monitored his blood pressure frequently, especially when he complained of chest pains. His blood pressure was often noted as high but not excessively so and, other than medication, no specific action was taken. HIW states:

> "On average his blood pressure was on the high side of normal and would not have warranted further intervention."

44. HIW concludes that the man's abdominal and chest pains were dealt with appropriately and appeared to be a result of asbestosis and not heart damage. HIW reports that the man did not have typical symptoms of heart disease (breathlessness or central pain on exercise) and concludes it was not possible for his heart condition to be diagnosed before he died.

The man's location

45. The hospital originally considered that the man would be able to be discharged to full time nursing care in April 2013, yet he was still in hospital when he died four months later. Finding appropriate accommodation and the funding for it was not a straightforward matter. There is evidence of some discussion between Social Services, the hospital and the prison, but it seems to have taken a long time to resolve the issue. This appears to have been because funding had not been secured by Social Services and because decisions had not yet been taken about the suitability of available accommodation and the man's perceived risks.

46. There is limited evidence to indicate that the prison was proactive in finding a suitable nursing home, although ultimately this depended on funding being provided. We draw this to the Director's attention. Nevertheless, as the man needed full-time nursing care, which he received in hospital, we do not conclude that the hospital was an inappropriate location for him or that his care was compromised in any way because of the delay.

Release on Compassionate Grounds

47. Release on compassionate grounds is a means by which prisoners who are seriously ill can be permanently released from custody before their sentence has expired. The criteria for early release for determinate sentenced prisoners are set out in Prison Service Order (PSO) 6000 and prisoners are usually expected to have less than three months to live. The criteria include 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 National Offender Management Service (NOMS).

48. An initial application for release on compassionate grounds was completed on 8 February 2013 and refused because the man's prognosis was not clear and his level of risk had not reduced. On 27 February, a second application was started. It was returned for a section of the form to be completed but there is no evidence this was done. The next application was completed on 2 May and refused because there was still no clear prognosis.

49. Although we consider that the second application should have been properly completed and progressed, we accept that the prison made active efforts to pursue the possibility of compassionate release. There was no clear prognosis and the man did not have an agreed release plan or release address as a residential home had not yet been secured. It therefore appears unlikely that any application for compassionate release would have been agreed.

Emergency Response

50. The man was discovered collapsed at 5.46am on 9 January and an emergency code was called, but an ambulance was not called for ten minutes until a nurse had assessed him. Guidance to prisons at that time was in a letter from the Department of Health and National Offender Management Service (NOMS) of February 2011 and reiterated previous guidance about the importance of calling an ambulance as soon as possible in an emergency and that it should not be necessary for prison healthcare staff to attend first. While this did not affect the outcome for the man, an ambulance should have been called as soon as the officer radioed a code blue to indicate that there was a life-threatening emergency.

51. In February 2013, NOMS issued Prison Service Instruction (PSI) 03/2013 about medical emergency response codes, requiring all prisons to implement a protocol which amongst other things, ensures an ambulance is called by the control room automatically as soon as an emergency code is used. We are satisfied that Parc now has such a protocol and therefore do not make a recommendation.

Restraints

52. 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.

53. When the man was taken to hospital on 9 January 2013, he was not restrained, but an escort chain was applied once he was in hospital, after a

risk assessment. There was no recorded medical input to the risk assessment, and no security information noted. Although there were some concerns about his behaviour, at the time, the man was suspected to have suffered a severe stroke which had significantly impeded his already limited mobility. We are pleased to note that the restraints were removed after another risk assessment the next morning.

54. It was acknowledged by the prison that the man was not an escape risk due to his physical condition when he was taken out to hospital and it does not appear that the subsequent decision to use an escort chain was fully justified by a risk assessment which took into account all appropriate factors. Nevertheless, we recognise that the decision was quickly reversed and apart from this short time, restraints were never used again during his lengthy hospital stay.