

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in January 2015
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, who died from chronic obstructive pulmonary disease, in January 2015, while in the custody of HMP Parc. He was 71 years old. I offer my condolences to his family and friends.

A clinical review of the clinical care the man received at Parc was undertaken. The prison cooperated fully with the investigation.

The man was sentenced to 13 years imprisonment in 2010 and had been at Parc since October 2011. His health was very poor and he suffered from a number of long term conditions, including heart disease and chronic obstructive pulmonary disease. He saw healthcare staff frequently for shortness of breath and chest infections. His health gradually declined and, in 2014, his lung condition became progressively worse. He was admitted to hospital on 10 January 2015 and died a few days later.

I agree with Health Inspectorate Wales that overall the man received a good standard of care at Parc, equivalent to that he might have expected to receive in the community. However, I am concerned that, because of an inadequate risk assessment, an escort chain was used to restrain him when he went to hospital on 10 January, although I note that it was removed quickly after his admission.

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

June 2015

CONTENTS

Summary

The investigation process

HMP Exeter

Key events

Issues

Recommendation

Action Plan

SUMMARY

1. The man was serving a 13 year sentence. He had been in prison since July 2010 and at Parc since October 2011. He had a number of health problems, including heart disease, high blood pressure and chronic obstructive pulmonary disease (COPD). A stroke in November 2010 had reduced his mobility and he relied on a wheelchair. He lived in the assisted living unit at Parc.
2. The man was frequently short of breath, for which he received oxygen therapy. He suffered recurrent chest infections. Staff at the respiratory clinic at the hospital reviewed him frequently, but told him he was not suitable for active treatment for his lung disease because he refused to give up smoking. His condition gradually deteriorated. Nurses saw him every day and GPs reviewed his treatment frequently. His standard of care was good, but Health Inspectorate Wales noted he did not have a formal care plans and yearly reviews of his chronic conditions.
3. Towards the end of 2014, the man's condition deteriorated rapidly. On 10 January 2015 he was too short of breath to complete sentences and was too weak to sit up in bed. He was admitted to hospital that morning. Despite his very poor health and lack of mobility, prison staff assessed him as a medium risk of escape, hostage taking, and to the public and staff. A manager directed that he should be restrained by an escort chain. Shortly after he arrived at hospital, a doctor asked officers to remove the chain and a prison manager authorised this.
4. In hospital the man's condition continued to deteriorate. He became increasingly confused and then became unresponsive. He died a few days later.
5. We agree with Health Inspectorate Wales that the man received a good standard of care at Parc, which was equivalent to that he might have expected to receive in the community. While this did not affect the standard of his care, Health Inspectorate Wales noted that he did not have formal care plans or yearly chronic disease reviews and has made recommendations about this in the clinical review, which the prison will need to address. It is evident that the risk assessment for his hospital escort did not appropriately reflect his condition at the time. We make one recommendation.

THE INVESTIGATION PROCESS

6. The investigator issued notices to staff and prisoners at HMP Parc informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.
7. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. She and the clinical reviewer interviewed four members of staff at Parc on 4 March 2015. She interviewed one staff member by telephone.
8. Healthcare Inspectorate Wales reviewed the man's clinical care at Parc.
9. We informed HM Coroner for Bridgend and Glamorgan Valleys of the investigation, who provided the results of the post-mortem examination. We have sent the coroner a copy of this report.
10. One of the Ombudsman's family liaison officers contacted the man's next of kin about our investigation. His next of kin had no issues for the investigation to consider.
11. The draft report was shared with the Prison Service. There were no factual inaccuracies and the action plan has been added to the end of the report.

HMP & YOI PARC

12. HMP & YOI Parc is run by G4S and holds more than 1,400 convicted men 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 unit) for older prisoners with increased health needs.
13. 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

14. The most recent inspection of HMP Parc was in July 2013. Inspectors found that the prison was safe and, overall, prisoners received good care. Inspectors found the standard of health services good, with an impressive new healthcare unit. Prisoners had good access to mobility and health aids and there was very good care for prisoners with palliative and end of life needs.

Independent Monitoring Board

15. 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 February 2014, the IMB commented that the number of missed appointments and length of waiting times to see healthcare staff had reduced. However, the IMB was concerned that it received a disproportionate number of applications about healthcare at the prison.

Previous deaths at HMP Parc

16. The man was the fourth prisoner to die from natural causes at Parc since the beginning of 2014. We have made previous recommendations, about prisoners being restrained without comprehensive risk assessments to justify their use.

KEY EVENTS

17. On 26 July 2010, the man was convicted of sexual offences and sentenced to 13 years imprisonment. He initially went to HMP Bullingdon and moved to Parc on 24 October 2011. He lived in the assisted living unit at Parc and was reliant on a wheelchair to get about, but was able to transfer himself to his chair and bed independently.
18. The man had a medical history of strokes, which affected his mobility. He had heart disease, high blood pressure and chronic obstructive pulmonary disease (COPD - lung disease), and had suffered a heart attack. He smoked heavily and refused to give up, although prison GPs and nurses often discussed this with him and pointed out the risks.
19. When the man arrived at Parc, staff began an assisted living plan. Such plans are used for prisoners who have additional needs, which prison and healthcare staff need to be aware of. Once the prisoner is settled and the points on the plan have been met, the plan is closed. He had an asthma care plan opened, but this did not continue. There is no record of other care plans for his long-term conditions.
20. Nurses saw the man every day, for medication or as part of the daily routine in the assisted living unit. Although nurses reviewed him when they saw him and noted any deterioration or changes in his medical record and referred him to the GP when indicated, he did not have formal chronic disease management reviews.
21. The man mostly saw healthcare staff when he was short of breath or had chest infections. In 2012 a consultant at the respiratory clinic at the hospital reviewed him several times. The consultant told him that there were treatments to help relieve his shortness of breath, but he would first need to stop smoking. He was adamant that he would not stop smoking and said he knew that it would reduce his life expectancy.
22. On 6 February 2013, the consultant at the respiratory clinic told the man that there was nothing that could be done to treat his condition and he would not get better. The prison mental health in-reach team supported him and he appeared to accept his position.
23. On 22 March, an entry in the man's medical record noted that an application for compassionate release had been considered, but the prison's offender management unit advised that he did not meet the criteria (a life expectancy of three months or under). The offender management unit asked to be kept up to date with his condition. There is no record that this was done. However, we note that until the very end of his life, he had no clear prognosis.
24. The man's condition remained relatively stable until 2014, when he started to experience increased shortness of breath, recurrent chest infections and to lose weight. He had an oxygen tank and mask in his cell to use as needed and, in September, doctors prescribed high calorie supplement drinks to help maintain his weight.

25. On 12 December, a doctor reviewed the man and again advised him to stop smoking. However, he said it was his only pleasure and he would not stop. The doctor explained his lung function was now very poor and referred him to the community palliative care team, in case his condition became worse.
26. On 2 January 2015, the doctor saw the man again and noted that he was gradually worsening. He wrote to a respiratory consultant at the hospital to see if there was anything else that could be done. The man said he knew he was in respiratory failure and did not appear distressed. On 9 January, the doctor spoke to the consultant. They agreed that the man's prognosis was very poor and oxygen therapy would not help. They considered that he might soon need palliative care and this would be kept under review.
27. At about 8.00am on 10 January a healthcare assistant went to see the man at the request of an officer. He looked grey and clammy and was finding it difficult to breathe. She said she spent some time talking to him and took his basic observations, including his blood pressure and temperature. His blood pressure was low and his oxygen saturations were very good, which in a patient with such poor lung function can indicate something is wrong. She left an officer with him and went to the healthcare centre to get advice from the doctor. (The healthcare centre is near to the assisted living unit.)
28. The doctor asked the healthcare assistant to go back to the man's cell and see if he was able to sit up on the edge of the bed. When she got back, he was too weak to sit up. She took his observations again and reported back to the doctor, who came to examine him. The doctor decided he needed to go to hospital for further assessment, and the healthcare assistant brought a larger, more powerful oxygen therapy unit from the healthcare centre while they waited for an ambulance, which was called at 11.35am. An ambulance arrived at the prison at 12.02pm. Paramedics assessed him and took him to hospital at around 12.30pm.
29. Security staff assessed the man's risk for going to hospital and indicated that he was a medium risk to the public, hospital staff, of escape and hostage taking. The risk assessment did not include any details of his medical condition or mobility. A manager decided that he should be escorted by two escort officers using an escort chain. (An escort chain is a long chain with a handcuff at each end, one attached to an officer and one to the prisoner.) At 1.11pm, a hospital consultant asked officers to remove the escort chain, because of his very poor condition. Escort officers sought permission from the duty prison manager who authorised this.
30. The man's condition continued to deteriorate over the next few days. He became confused and his breathing became worse. He was unresponsive and his breathing was very slow. A hospital doctor certified his death.

Liaison with the man's next of kin

31. On 10 January, one of the prison chaplains tried to contact the man's named next of kin, his ex-wife, to tell her he was very ill in hospital. She was unable to speak to her and left a voicemail message for her to contact the prison. The chaplain also contacted a friend, who had been visiting the man and explained he was unwell in hospital. The man's ex-wife spoke to the chaplain later that

day. She said that she did not want to visit him but would like to be informed by telephone when he died. The chaplain also informed the man's adult son.

32. When the man died, the chaplain informed the man's son. His son said he would let his mother know, but they did not want to be involved in his funeral. The prison arranged the funeral and the chaplain conducted the service on 2 February. A prison manager attended.

Support for prisoners and staff

33. A Governor's notice informed staff and prisoners of the man's death. The post incident care team offered the escort staff support.
34. A prison manager spoke to all residents on the assisted living unit and offered them support. Staff checked prisoners assessed as at risk of suicide or self-harm, in case they had been adversely affected by the news of the man's death.

Post-mortem

35. A post-mortem examination found that the man died from respiratory failure, as a result of chronic obstructive pulmonary disease.

ISSUES

Clinical care

36. The man had a number of complex chronic conditions. Healthcare staff saw him frequently, usually for shortness of breath and chest infections related to his chronic lung disease. He was a heavy smoker, which exacerbated his symptoms, but despite regular encouragement from prison GP's and nursing staff, he refused to stop. He had capacity to take decisions about his health and was aware of the serious implications of continuing to smoke.
37. Healthcare Inspectorate Wales noted that the man did not have any care plans to manage his conditions. While this did not affect his standard of care, care plans are a useful tool for monitoring conditions. In the community a patient with such conditions would have yearly checks with a nurse for chronic disease management. Healthcare Inspectorate Wales has made recommendations about these matters, which the Head of Healthcare will need to address. We do not repeat them in this report as we are satisfied, as was Healthcare Inspectorate Wales that overall he received a good standard of clinical care at the prison which was equivalent to that he might have expected to receive in the community. He was seen every day by prison and nursing staff and a GP reviewed him when needed.

Escort risk assessment

38. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. 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 takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between the prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that prison staff must take into account medical opinion about the prisoner's ability to escape and keep this under review as circumstances change.
39. When the man was taken to hospital on 10 January, he was in the final stages of a chronic condition. He was completely immobile and struggling for breath. A nurse completed the medical section of the risk assessment for the escort and noted that he used a wheelchair, but did not give any other information about how his condition affected his level of risk. She noted that he would have had the ability to escape unaided, which is difficult to understand. The security section assessed him as a medium risk to the public and hospital staff and of escape and hostage taking. Again, it is difficult to see how this conclusion was reached: he had been convicted of offences committed 30 years previously and was now seriously ill and immobile. A manager authorised that officers should use an escort chain to restrain him. This was removed not long after his admission to hospital, but only because a doctor considered its use was inappropriate.
40. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances, which must be fully considered, taken into

account and balanced against the security risks. We do not consider that staff appropriately assessed the man's risk, or took fully into account his condition at the time. We make the following recommendation:

The Director and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

RECOMMENDATION

The Director and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

ACTION PLAN

No	Recommendation	Accepted/ Not accepted	Response	Target date for completion and Function Responsible
1	<p>The Director and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.</p>	Accepted	<p>Guidance will be sent to Duty Directors in regards to handcuffing arrangements and staff made aware of the need to take the medical condition and mobility at the time into account when considering the level of risk.</p> <p>All prisoners / circumstances will be risk assessed on an individual basis.</p> <p>In addition a list of prisoners with medical needs that negate the requirement for handcuffs on escort will be published to all duty managers and duty Directors and recorded on the prisoner's SystemOne record and any risk of death in custody paperwork.</p> <p>The list will be reviewed weekly at the Clinically and Older Vulnerable Prisoners meetings and updates fed back into the Senior Managers morning meetings weekly.</p> <p>A risk assessment for all those prisoners who medically do not require handcuffs will be completed in readiness for any transfer/escort. This assessment will be reviewed and updated should there be any change in health and prior to any escort.</p>	<p>Head of Security</p> <p>Head of Safer Custody</p> <p>Head of Healthcare</p> <p>June 2015</p>