Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr George Carr, a prisoner at HMP Preston on 13 March 2015

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr George Carr died of chronic obstructive airways disease at HMP Preston, on 13 March 2015. He was 64 years old. I offer my condolences to Mr Carr's family and friends.

Mr Carr had already been diagnosed with chronic obstructive pulmonary disease, when he was sentenced to prison in February 2015. The clinical reviewer suggested some improvements in prescribing arrangements for prisoners with chronic lung disease, but, overall, considered that Mr Carr had received appropriate treatment for his health conditions. I am satisfied that Mr Carr received an appropriate standard of care at Preston.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **October 2015**

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Summary

Events

1. On 24 February 2015, Mr George Carr was sentenced to five and a half years in prison and was sent to HMP Preston.

2. Mr Carr had chronic obstructive pulmonary disease for which doctors prescribed appropriate inhaler medication to manage his condition. Shortly after he arrived at Preston, Mr Carr's condition deteriorated and he suffered from shortness of breath and was coughing up phlegm. Doctors prescribed antibiotics and referred him for an X-ray. (The X-ray appointment was scheduled for a date after his death.) He was briefly admitted to the prison's healthcare unit for observations, which were in the normal range.

3. In the early hours of 13 March, Mr Carr's cellmate covered him with a blanket after Mr Carr fell asleep in his chair. When his cellmate woke up in the morning, he discovered Mr Carr cold and unresponsive on the floor. Nurses arrived quickly and assessed Mr Carr. It was apparent that Mr Carr had been dead for some time and resuscitation would not be possible.

Findings

4. The clinical reviewer concluded that Mr Carr received satisfactory treatment for his lung disease, but in her review has made recommendations about prescribing practice, which the Head of Healthcare will need to address. Overall, we are satisfied that Mr Carr received an appropriate standard of care at Preston. We make no recommendations.

The Investigation Process

5. The investigator issued notices to staff and prisoners at HMP Preston informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

6. The investigator obtained copies of relevant extracts from Mr Carr's prison and medical records.

7. NHS England commissioned a clinical reviewer to review Mr Carr's clinical care at the prison.

8. We informed HM Coroner for Preston and West Lancashire District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

9. One of the Ombudsman's family liaison officers contacted Mr Carr's daughter, to explain the investigation. Mr Carr's daughter did not have any specific matters she wanted the investigation to take into account. She received a copy of the draft report but did not make any comments. The prison also considered our draft report and did not raise any factual inaccuracies.

Background Information

HM Prison

10. HMP Preston is a local prison holding up to 842 adult men. Lancashire Care Foundation Trust provides healthcare services at the prison. There is an inpatient unit for up to 30 prisoners, which is used as a regional facility, including for end of life care.

HM Inspectorate of Prisons

11. The most recent inspection of HMP Preston was in April 2014. Inspectors reported that healthcare, overall, was safe and decent. The inpatient unit provided patients with complex needs good support. However, some aspects of the environment and regime needed improvement.

Independent Monitoring Board

12. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to March 2014, the IMB reported that the primary care team at Preston provided a wide range of services and care.

Previous deaths at HMP Hull

13. Mr Carr was the twelfth person to die of natural causes at Preston. There were no significant similarities with the circumstances of the other deaths.

Key Events

14. On 24 February 2015, Mr George Carr was convicted of drug offences and sentenced to 5 years and 6 months in prison. He was sent to HMP Preston.

15. At an initial health screen, a nurse noted he had chronic obstructive pulmonary disease (COPD) the name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease. He had been prescribed two types of inhalers, salbutamol and titropium to help manage his condition. A prison doctor prescribed the same medication and Mr Carr collected it that day. Mr Carr was a heroin user and was referred to substance misuse services. He was prescribed methadone to treat symptoms of withdrawal.

16. On 25 February, a nurse saw Mr Carr for a second health screen. She noted his diagnosis of COPD and that he smoked approximately ten cigarettes a day. Mr Carr said he did not want help to give up. The nurse took a number of clinical observations, including his oxygen saturation levels and respiration rate, which were all within the normal range. Later that day, Mr Carr declined to have a Wellman assessment, which includes health screenings to help identify early signs of degenerative illness and risk factors.

17. On 26 February, a nurse examined Mr Carr, who was short of breath and coughing up phlegm, a symptom of COPD exacerbation. His respiration rate was quicker than normal and his temperature was slightly raised. His blood pressure and oxygen saturation levels were within the normal range and his NEWS score (National Early Warning Score, which helps identify the severity of an acute illness) was four, which was in the low range. She discussed her findings with the prison GP who saw Mr Carr later that day.

18. The GP noted that Mr Carr was no longer short of breath and examined his chest. He could not hear any crackles, but referred Mr Carr for a routine chest X-ray and prescribed a course of antibiotics. The X-ray referral was sent on 27 February, booked for 18 March, and subsequently rearranged for the 23 March.

19. On 27 February, Mr Carr was producing yellow sputum. His community health records arrived and confirmed that his community GP had prescribed a course of antibiotics from 6 February for an exacerbation of COPD. The GP admitted Mr Carr to the healthcare inpatient unit and took his clinical observations every four hours to check for signs of infection. All observations were within normal ranges. The GP assessed him the next day. As he had not reported any further chest problems, he moved to the prison's substance misuse unit.

20. On 10 March, Mr Carr submitted a complaint saying that he needed his inhalers. Records show that doctors had prescribed an adequate supply and Mr Carr had collected them on 24 February and 11 March.

21. On the evening of 12 March, Mr Carr's cellmate said that they chatted until approximately midnight. Mr Carr slept sitting up in a chair to help his breathing. His cellmate said that Mr Carr did not seem well but not any different from usual.

He woke up at approximately 1.00am and put a blanket over Mr Carr. He put another blanket over him at 2.00am and Mr Carr acknowledged him.

22. At approximately 7.10am, on the morning of 13 March, the cellmate woke and found Mr Carr on the floor with the blankets over him. His inhaler was on the floor next to him. He touched Mr Carr's back and noted he was cold and not breathing. At 7.15am, he pressed the cell bell and shouted for help.

23. A custodial manager, one officer and two nurses all went to the cell immediately. The nurses were already on the wing and did not have a defibrillator with them but shouted for an officer to bring one from the wing treatment room. However, once they assessed Mr Carr they realised that he had died and it would not be possible to resuscitate him.

24. In the meantime, at 7.18am, the duty governor had asked an officer in the communications room to call an ambulance. Paramedics arrived at the prison at 7.22am and confirmed Mr Carr's death. (The coroner subsequently gave the cause of death as acute chronic obstructive airways disease.)

Contact with the family.

25. On the morning of Mr Carr's death, the Governor established that Mr Carr's daughter lived in Bristol. He contacted HMP Bristol who arranged for a family liaison officer to break the news of Mr Carr's death to his daughter in person. The family liaison officer had great difficulty contacting Mr Carr's daughter and asked the police to help. Eventually, on 15 March, the police informed her that Mr Carr had died. The prison contributed to the costs of the funeral, in line with Prison Service instructions.

Support for prisoners and staff

26. After Mr Carr's death, the duty governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and for managers to offer support. The staff care team also offered support.

27. The prison posted notices informing prisoners of Mr Carr's death, and offering support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case Mr Carr's death had adversely affected them. Staff spoke to Mr Carr's cellmate separately in the Listener's care suite and offered support.

Findings

Clinical care

28. When Mr Carr arrived at Preston, a nurse quickly identified he had COPD and arranged to continue the medication he had been receiving before he was sent to prison. He also began a methadone programme to treat symptoms of drug withdrawal. The clinical reviewer concluded that the management of his conditions was equivalent to that he would have received in the community.

29. The clinical reviewer was satisfied that Mr Carr had received sufficient supplies of appropriate medication for COPD, but he appeared to be using it very quickly and this might have been a sign that his condition was deteriorating more rapidly than staff thought. The prison GP's assessment and prescription of antibiotics on 26 February was appropriate and timely, although it is not recorded whether he also considered steroid treatment at the time. The clinical reviewer has made recommendations about these issues in her review, which we do not repeat here, but which the Head of Healthcare will need to address.

30. Overall, we are satisfied that Mr Carr received an appropriate standard of care at Preston, for his COPD and substance misuse problems, and there was nothing healthcare staff could have done to prevent his death.

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