Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Denis Parker, a prisoner at HMP Bullingdon on 16 February 2016

A report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

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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*

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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 Denis Parker died of respiratory failure and chronic obstructive pulmonary disease while a prisoner at HMP Moorland on 17 May 2015. He was 82 years old. I offer my condolences to Mr Parker's family and friends.

I am satisfied that Mr Parker received a generally good standard of care at Moorland. Healthcare staff managed his chronic illnesses well and reviewed him frequently. A prisoner helper supported him effectively with daily tasks. Staff treated Mr Parker with care and respect. However, in the weeks before he died, it appears that Mr Parker began to give up eating and drinking and not enough was done to monitor and address this. Mr Parker's end of life care would have been improved with a formal care plan, including ensuring he received adequate nutrition and hydration.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **September 2016**

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Summary

Events

1. In 2007, Mr Denis Parker was sentenced to fifteen years in prison. In March 2011, Mr Parker moved to HMP Long Lartin before moving to HMP Bullingdon in May 2015.

2. Mr Parker gave up smoking in 2014 after smoking for over fifty years. He suffered from chronic obstructive pulmonary disease (COPD) and used an inhaler and oral steroids to ease his symptoms.

3. On 14 April 2015, Mr Parker went from Long Lartin to Alexandra Hospital after his COPD deteriorated. Hospital doctors diagnosed advanced COPD and treated Mr Parker with non-invasive ventilation therapy (NIV).

4. On1 May, hospital doctors decided Mr Parker was fit for discharge. Prison managers arranged to move Mr Parker to the inpatients unit at Bullingdon, where healthcare staff could safely managed his NIV therapy.

5. Prison nurses created a care plan to manage Mr Parker's COPD and referred him to a respiratory specialist nurse who first saw him on 14 May. Nurse saw Mr Parker daily to monitor his COPD and use of oxygen therapy. The respiratory nurse assessed Mr Parker regularly and noted that he did not always comply with the agreed oxygen therapy regime.

6. On 27 August, the respiratory nurse agreed a strict oxygen therapy regime with Mr Parker. However, Mr Parker continued to use his oxygen therapy for longer periods than necessary, which increased his oxygen saturation level above the recommended level of 85%.

7. Nurses continued to see Mr Parker daily. On 30 December, he went to John Radcliffe Hospital after he stopped using his oxygen therapy, which caused his oxygen saturation levels to drop. The hospital admitted Mr Parker and treated him for advanced COPD. A hospital doctor noted that Mr Parker's COPD was at a terminal stage.

8. On 31 December, Mr Parker returned to Bullingdon to receive palliative care. A community palliative care nurse visited him and gave nurses advice to ensure Mr Parker remained comfortable and pain free.

9. Mr Parker continued to decline and he died in the inpatients unit on 16 February 2016.

Findings

10. The clinical reviewer found that healthcare staff managed Mr Parker's chronic illnesses very well. They reviewed him frequently and monitored his conditions well. A prisoner helper gave him good support with day to day living tasks. However, we are concerned that healthcare staff did not implement a coordinated care plan to monitor and manage Mr Parker's care and nutrition.

The Investigation Process

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

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

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

14. We informed HM Coroner for Oxfordshire of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.

15. One of the Ombudsman's family liaison officers contacted Mr Parker's ex partner, his next of kin, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Parker's ex partner did not have any specific concerns for the investigation to consider.

16. Mr Parker's ex partner received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.

17. The initial report was shared with the Prison Service. The Prison Service pointed out a factual inaccuracy and this report has been amended accordingly.

Background Information

HMP Woodhill

18. HMP Bullingdon is a training and local prison, serving the courts of Oxfordshire and Berkshire. It holds up to 1,114 men. Virgin Care provided healthcare services at the time of Mr Parker's death. There is 24-hour healthcare cover with 21 in-patient beds.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Bullingdon was in June 2015. The inspectorate noted that healthcare services had improved from a relatively low base and was now reasonably good. Support for those with lifelong conditions was good. Inpatients received good GP, mental health and nursing input.

Independent Monitoring Board

20. 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 July 2015, the IMB noted there had been improvements in healthcare; recruitment was more effective, waiting lists had reduced and patient attendance rates had increased. Following implementation of the Care Act 2014, staff from the community based Adult Health and Social Care Team were now assessing and providing targeted personal care for prisoners on all wings.

Previous deaths at HMP Moorland

21. Mr Parker was the sixth prisoner at Bullingdon to die of natural causes since 2013. There were no significant similarities with the circumstances of the previous deaths.

Key Events

22. On 23 August 2007, Mr Denis Parker was sentenced to 15 years in prison. He spent time in a number of different prisons before moving to HMP Long Lartin in March 2011. Mr Parker had been at HMP Bullingdon since 1 May 2015.

23. Mr Parker had a history of chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases such as chronic bronchitis and emphysema). He had smoked for over 50 years and gave up in 2014. While he was at Long Lartin he was admitted to hospital on several occasions for COPD. Prison GPs prescribed an inhaler and oral steroids to ease his COPD symptoms.

24. On 14 April 2015, Mr Parker was admitted from Long Lartin to hospital. Hospital doctors diagnosed advanced COPD and treated Mr Parker with non-invasive ventilation therapy (NIV). This is a form of pressurised oxygen therapy given to patients with chronic respiratory failure and attempts to slow further deterioration and complications of COPD. When Mr Parker was ready to leave hospital, prison managers decided that he was no longer suitable for Long Lartin due to the severity of his COPD. Prison managers arranged to move Mr Parker to the inpatients unit at Bullingdon where healthcare staff could manage his NIV therapy safely.

25. On 1 May, Mr Parker moved to Bullingdon. A prison nurse noted that he used oxygen due to his COPD and would be located on the inpatients unit. The next day a prison GP reviewed Mr Parker's medication.

26. On 4 May, a nurse created a care plan to manage Mr Parker's COPD and an inpatients care plan to manage his daily living needs. The nurse also made a referral to a respiratory specialist nurse. Nurses provided Mr Parker with a NIV machine and a continuous positive airway pressure (CPAP) machine to provide his oxygen therapy during the night.

27. On 14 May, the respiratory specialist nurse assessed Mr Parker on the inpatients unit. Mr Parker said he was not using his CPAP machine due to the lack of plug sockets in his cell. The respiratory nurse gave Mr Parker an extension lead and asked nurses to monitor his use of the machine during the night,

28. Nurses saw Mr Parker daily to monitor his COPD. On 25 May, Mr Parker complained of breathlessness. His oxygen saturation level was low (85%). The nurse increased the oxygen delivery (5 litres per min) which maintained Mr Parker's saturation level at 97-98%.

29. On 31 May, Mr Parker complained again of breathlessness. A nurse increased the oxygen delivery (5 litres per min) which increased his saturation level to 98%.

30. On 18 June, a nurse increased the oxygen delivery to raise Mr Parker's saturation level from 83% to 97%. The same day the respiratory nurse saw Mr Parker. She noted that the oxygen delivery was set at 5 litres per min. This was despite the advice of hospital doctors who set the oxygen delivery 0.5 litres per minute. The respiratory nurse told Mr Parker the oxygen therapy was limited to 15 to 18 hours a day. She advised him to do some light exercise in his cell. The nurse advised Mr Parker that the CPAP machine was for use overnight while he

was asleep and should not be used during the day. She noted that Mr Parker was very dismissive of her advice about the use of oxygen therapy.

31. On 30 June, Mr Parker went to the respiratory clinic at hospital. Hospital doctors noted that his COPD was very severe and Mr Parker should use the NIV machine overnight and have supplementary oxygen for two hours a day. When he returned to Bullingdon, a prison nurse amended Mr Parker's COPD care plan to reflect the hospital doctor's instructions.

32. On 13 July, the respiratory nurse assessed Mr Parker and noted that he was not using his NIV machine for the full eight hours.

33. On 25 August, nurses discussed Mr Parker's oxygen therapy in the weekly nursing meeting and noted he was using oxygen continuously. Mr Parker's oxygen saturation levels were much higher than the hospital doctors' recommended level of 85%. The same day, a prison doctor noted that Mr Parker's ankles were very swollen. He prescribed medication to reduce the swelling.

34. On 27 August, the respiratory nurse agreed a strict oxygen therapy regime with Mr Parker. Mr Parker agreed to use oxygen therapy for a maximum of two hours a day and have continuous oxygen therapy during the night. The respiratory nurse amended Mr Parker's COPD care plan to reflect these changes.

35. Nurses saw Mr Parker daily to monitor his COPD and use of oxygen therapy. The respiratory nurse assessed Mr Parker regularly and noted that he did not always comply with the agreed oxygen therapy regime.

36. On 5 November, a nurse noted that Mr Parker's oxygen saturation level was too high (97%) due to his use of a high flow nasal cannula rather than the lower flow facemask. Mr Parker agreed to use his facemask to administer oxygen to ensure his saturation level did not increase to a dangerous level.

37. On 12 November, a nurse noted that Mr Parker's oxygen saturation level was above the recommended 85%. Mr Parker refused to allow the nurse to turn down the NIV machine. The nurse asked the respiratory nurse to visit Mr Parker to discuss his reluctance to comply with the agreed oxygen therapy regime. The next day Mr Parker told the respiratory nurse he would continue to use the nasal cannula because he found it more comfortable.

38. On 5 December, a nurse noted that Mr Parker was managing his breathing well and had reported less incidents of breathlessness. Nurses continued to record his oxygen saturation level twice daily in accordance with his COPD care plan.

39. On 18 December, Mr Parker went to the respiratory clinic at hospital. A hospital consultant said that prison healthcare were managing Mr Parker's COPD through ongoing excellent joint care. The consultant said it was important to avoid higher oxygen saturation levels because this would put Mr Parker at risk of worsening ventilatory failure. Mr Parker's oxygen therapy was limited to a maximum of 2 litres per minute through nasal cannula and he no longer needed to use a facemask. During the night, Mr Parker would receive oxygen therapy at 4 litres per minute using a NIV machine. Prison nurses amended Mr Parker's COPD care plan to reflect these changes.

40. On 30 December, a nurse saw Mr Parker and noted that his condition had deteriorated. Mr Parker had removed his nasal cannula and his oxygen saturation level was between 75% and 79%. The nurse arranged for Mr Parker to go to hospital by ambulance. Two officers accompanied Mr Parker, but did not use restraints.

41. On 31 December, a hospital doctor told a prison GP that Mr Parker's COPD was at a terminal stage and he was suitable for palliative care only. Mr Parker returned to Bullingdon the same day. A prison manager said Mr Parker's cell door could remain open to allow nurses to observe him constantly. The GP discussed a Do Not Resuscitate Order with Mr Parker, which he signed on 31 December. Nurses sought advice from a community palliative care nurse at a hospice.

42. On 7 January 2016, the respiratory nurse saw Mr Parker in his cell. Mr Parker said he was no longer using the NIV machine. He told the respiratory nurse that he wanted to be left in peace. Nurses continued to advise Mr Parker to use his NIV machine without success.

43. On 11 January, a community palliative care nurse visited Mr Parker. She advised the use of oromorph (liquid morphine) if Mr Parker was in pain. Nurses created an end of life care plan to ensure Mr Parker remained pain free and comfortable.

44. On 10 February 2016, a prison GP assessed Mr Parker after his condition significantly deteriorated. Mr Parker was drowsy and his breathing rapid. The GP said it was still appropriate for Mr Parker to receive care at Bullingdon. He gave Mr Parker oromorph for pain relief.

45. On 16 February, a prison GP assessed Mr Parker and noted that he was less responsive. Mr Parker was lying in bed receiving oxygen therapy through a nasal cannula. The GP was satisfied that Mr Parker was comfortable and pain free. The prison chaplain also visited Mr Parker in his cell.

46. Nurses continued to regularly monitor Mr Parker throughout the day to ensure that he was comfortable. At approximately 7.45pm, a nurse went to Mr Parker's cell and said he appeared not to be breathing. The nurse sought immediate assistance from a prison GP, who came to Mr Parker's cell and confirmed that he had died.

Contact with Mr Parker's family

47. On 31 December 2015, the prison appointed the Head of Reducing Reoffending as family liaison officer (FLO). Mr Parker had named his ex partner as his next of kin. Due to the nature of Mr Parker's offence, the FLO contacted the victim liaison service before contacting Mr Parker's ex partner. The victim liaison service said Mr Parker's ex partner did not wish to be contacted until after Mr Parker had died. The FLO visited Mr Parker on the inpatients unit on a weekly basis.

48. At 1.10pm on 17 February, the FLP and the deputy family liaison officer visited Mr Parker's ex partner at home. Mr Parker's ex partner was not in so they

returned to the house approximately one hour later. Mr Parker's ex partner had not returned home by this time.

49. As Mr Parker's ex partner lived a considerable distance from Bullingdon, the FLO asked the local police to inform her of Mr Parker's death. At 4.30pm, a police officer visited Mr Parker's ex partner and told her Mr Parker had died. The police officer also passed on the FLO's contact details.

50. At 10.40am on 18 February, the FLO spoke to Mr Parker's ex partner on the telephone and offered her condolences and support. She asked the FLO to arrange the funeral. Mr Parker's funeral was on 9 March and the prison contributed to the costs in line with national instructions.

Support for prisoners and staff

51. After Mr Parker's death, the prison's care team offered staff support.

52. The prison posted notices informing staff and prisoners of Mr Parker's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Parker's death.

Cause of death

53. The coroner concluded that the cause of death was cor pulmonale which is the abnormal enlargement of the right side of the heart as a result of chronic obstructive pulmonary disease. Mr Parker also suffered from left ventricular hypertrophy (enlargement and thickening of the heart's left pumping chamber).

Findings

Clinical care

54. Mr Parker's COPD required complex and specialist oxygen therapy**.** The clinical reviewer noted that during the first four months of his stay at Bullingdon, Mr Parker's oxygen therapy lacked a robust management framework. The inpatients unit did not receive specific guidance from hospital doctors regarding his oxygen therapy and use of the NIV machine. This meant prison nurses were uncertain about best practice when treating a patient with a complex medical condition.

55. The clinical reviewer commented that the oxygen saturation level in healthy adults is 97% to 98%. In COPD sufferers, the normal level is usually about 88% to 92%. There are several incidents recorded in Mr Parker's medical record where he administered his oxygen therapy at levels not recommended in COPD treatment. On occasions, nurses also increased his oxygen therapy above the hospital doctor's recommended level of 85%.

56. The clinical reviewer considered that when Mr Parker arrived at Bullingdon, the inpatient unit needed a clear oxygen therapy protocol to manage his breathlessness and encourage the best care. Nurses did not create a robust COPD care plan until 27 August. We make the following recommendation:

    The Head of Healthcare should ensure that prisoners who require oxygen therapy are assessed on arrival by a respiratory specialist nurse and an appropriate care plan is created to mange their treatment.

    The clinical reviewer concluded that Mr Parker's care was equivalent to what he could have expected to receive in the community. Throughout the final palliative care of his condition, Mr Parker's care was comprehensive and nurses supported him compassionately**.**

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