Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Parker a prisoner at HMP Altcourse on 1 June 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*

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.

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

Mr John Parker died in hospital on 1 June 2016 from chronic obstructive pulmonary disease (COPD) while a prisoner at HMP Altcourse. He was 61 years old. I offer my condolences to Mr Parker's family and friends.

The clinical reviewer concluded that during his short time at Altcourse, Mr Parker's clinical care was not of the standard he could have expected in the community, as healthcare staff did not follow the national clinical guidelines for the management of his chronic disease or use formal assessment tools to assess any deterioration.

Mr Parker's death was sudden and unexpected. I am satisfied that the emergency response was prompt and that staff did their best to try to resuscitate him.

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

Richard Pickering
Deputy Prisons and Probation Ombudsman **December 2016**

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Summary

Events

1. Mr John Parker was remanded to HMP Altcourse on 30 April 2016 charged with violent offences.

2. At his initial health screen, a nurse noted that Mr Parker had chronic obstructive pulmonary disease (COPD – the name of a collection of lung diseases including chronic bronchitis and emphysema) which had been diagnosed in 2007, asthma and heart disease. Mr Parker declined help to stop smoking and continued to smoke throughout his time in prison.

3. On 21 May, Mr Parker was suffering with shortness of breath, wheezing and producing green sputum (phlegm). A nurse diagnosed a possible chest infection and transferred him to the inpatient unit. As Mr Parker's condition did not improve, the nurse sent him to hospital where he was diagnosed with exacerbation of COPD and treated with antibiotics and nebulisers. He was discharged back to the prison six days later and returned to the inpatient unit.

4. On 1 June at 4.45am, a nurse responded to Mr Parker's cell call bell. She saw that Mr Parker was struggling to breathe and could not walk or talk. At that time the nurse did not consider it an emergency, so she telephoned a senior manager and asked an officer to unlock Mr Parker's cell. At 4.55am, the nurse entered Mr Parker's cell to assess him. She decided to give him the nebulisers due later that morning. In spite of using the nebulisers, Mr Parker's oxygen saturation levels continually decreased. Having tried and failed to contact an on-call prison GP, at 5.15am, the nurse requested an emergency ambulance. The nurse then gave Mr Parker oxygen but his breathing became shallower. She called a medical emergency code blue (used to indicate a prisoner has difficulty breathing or is unconscious) and carried out CPR until paramedics arrived at 5.30am.

5. Mr Parker was taken to hospital and died at 10.45am.

Findings

6. Healthcare staff did not put in place appropriate care plans in line with the National Institute for Health and Care Excellence (NICE) guidelines for the management of COPD. For this reason, we agree with the clinical reviewer that the standard of care Mr Parker received at Altcourse was not equivalent to that he could have expected in the community.

7. We are concerned that the National Early Warning Score (NEWS – a tool for the assessment and response to acute illness) and NICE guidelines were not implemented. Although this may not have affected the outcome for Mr Parker, it could be vital to the outcome for other prisoners in the future.

8. Mr Parker's death was sudden and unexpected. We are satisfied that staff followed the emergency response procedures and that the resuscitation attempts at the prison were managed effectively.

Recommendations

- The Head of Healthcare should ensure that healthcare staff manage prisoners with complex and chronic medical conditions in line with NICE guidance including implementing detailed care plans appropriate to their needs, regular planned reviews and accessible management plans to manage deterioration of their condition.
- The Head of Healthcare should ensure that staff understand and use the NEWS tool to assess, monitor and respond to acute illness.

The Investigation Process

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

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

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

12. We informed HM Coroner for Merseyside of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

13. One of the Ombudsman's family liaison officers contacted Mr Parker's daughter to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She asked us to consider and explain the following:

    - Whether Mr Parker's cell bell was easily accessible and whether he had pressed it for assistance.
    - Details of how Mr Parker's chronic obstructive pulmonary disorder (COPD) was managed and whether he had access to a nebuliser.
    - Whether Mr Parker had used his nebuliser in the time leading up to his deterioration.
    - Details of the emergency response.

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

15. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP Altcourse

16. HMP Altcourse is a local prison in Liverpool, which takes prisoners from the courts in Merseyside, Cheshire and North Wales. It holds up to 1,324 sentenced and remanded adult and young adult men. G4S manage the prison and provide primary healthcare services. There is an inpatient unit with 12 beds and 24-hour healthcare cover.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Altcourse was in June 2014. Inspectors reported that prisoners had satisfactory access to most health services. There was a good range of clinical and screening services. Prisoners were generally positive about the care provided, especially in the inpatient unit. There were good arrangements for palliative and end of life procedures.

Independent Monitoring Board

18. 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 June 2015, the IMB reported that the inpatient unit continued to manage and care for a diverse range of men. The healthcare management structure had been reformed and a new triage system had been introduced to reduce the length of waiting lists. Following the introduction of the Care Act 2014, the prison's links with the Local Authority had improved, although prison staff recognised that better links with Macmillan Nursing was required to enhance palliative care.

Previous deaths at HMP Altcourse

19. Mr Parker was the ninth prisoner to die of natural causes at Altcourse since May 2014. There have been two subsequent deaths. There were no significant similarities with the circumstances of the previous deaths.

Key Events

20. On 30 April 2016, Mr John Parker was remanded to HMP Altcourse charged with violent offences. It was not his first time in prison and he had been at Altcourse before.

21. At his reception health screening, Mr Parker told a nurse that he had longstanding COPD (diagnosed in 2007) and asthma and used a seretide accuhaler (breathing device), and salbutomol (medication to open the airways). He also had heart disease and had suffered an asthma attack at Altcourse in December 2015. She assessed Mr Parker as a heavy drinker and moderate smoker of up to twenty cigarettes per day. Mr Parker declined the offer of help to stop smoking.

22. On the same day, a prison GP assessed Mr Parker and noted that he drank five bottles of sherry daily. The GP prescribed two inhalers and tiotropium for his COPD and vitamins. There was no existing care plan to manage Mr Parker's COPD and no evidence that healthcare staff created a care plan when he arrived at Altcourse. A drug treatment nurse reviewed Mr Parker and noted no problems.

23. On 21 May, a nurse examined Mr Parker, who was short of breath, wheezing and producing green sputum (phlegm). She diagnosed a possible chest infection and transferred him to the healthcare inpatient unit for closer monitoring. His condition did not improve and she requested an ambulance to take him to hospital. In Mr Parker's escort risk assessment, a healthcare assistant stated that there were no medical objections to restraints. A senior manager authorised the use of an escort chain, which remained in place until Mr Parker was discharged back to prison.

24. Hospital doctors diagnosed a worsening of Mr Parker's COPD. They treated him with antibiotics and a nebuliser and he remained in a stable condition. On 27 May, the hospital discharged Mr Parker with nebulisers and inhalers.

25. Mr Parker returned to the prison's inpatient unit. A prison GP reviewed him and prescribed carbocisteine to treat respiratory tract problems, ipratropium and salbutomol, to open up the airways in the lungs, and paracetamol.

26. A nurse observed Mr Parker that evening. He appeared settled and slept well that night. She recorded how to manage Mr Parker's condition within his medial record, but a formal management plan was not created. Healthcare staff continued to monitor Mr Parker daily.

27. On 30 May, a prison GP examined Mr Parker. He noted Mr Parker was still smoking up to 12 cigarettes per day and had a mild scattered wheeze. The GP added that he was waiting for some information from the hospital and that if Mr Parker required the ongoing use of nebulisers a management plan would need to be created.

28. During the evening of 31 May, Mr Parker told a nurse that the heat was making him feel unwell. She noted at 8.03pm that Mr Parker had remained settled for the rest of her shift.

1 June

29. On 1 June at 4.45am, Mr Parker pressed his cell buzzer to get assistance. A nurse went to Mr Parker's cell. He was having difficulty breathing so she went to get his nebulisers, which he was due to receive at approximately 7.00am. When she returned, Mr Parker could not walk to the cell door, he was on his bed and struggling to breath or talk. Although there was a key in a sealed pouch for use in an emergency, she considered it was not an emergency at that time so she telephoned a senior manager and asked him to send an officer with a key. At 4.55am, an officer opened Mr Parker's cell. A healthcare assistant was also there.

30. The nurse gave Mr Parker salbutamol and ipratropium nebulisers and recorded an oxygen saturation level of 78%. She then went to check Mr Parker's normal oxygen level in his medical record and found that it was normally 95%. When she returned to his cell, his saturation level had dropped to 66% and Mr Parker told her that the nebulisers were not having any effect.

31. Due to Mr Parker's COPD, the nurse wanted to check with a doctor if it was appropriate to administer oxygen. She tried to call the out of hours GP service, provided by Gables Medical Offender Health Ltd, but the number they had provided was incorrect. She decided to administer oxygen. She returned to Mr Parker's cell and took his temperature and blood pressure, which were normal. She asked him if he had received oxygen before and he said he had. At 5.15am, she called the control room and requested an emergency ambulance. She then applied an oxygen mask to allow a higher flow of oxygen. Mr Parker's saturation level had dropped to 49% and he appeared grey and clammy. He slumped back on the bed, but remained conscious.

32. The nurse told the officer to get the defibrillator. Mr Parker's breathing slowed down and she changed the oxygen mask to an ambu bag (an ambu bag helps open the airway for the oxygen to get through). She cut Mr Parker's clothes and applied the defibrillator pads to his chest. Mr Parker's breathing became more shallow until she could not see his chest rising. She called a code blue, turned on the defibrillator and she and the officer placed Mr Parker on the floor. She started cardiopulmonary resuscitation (CPR), at approximately 5.20am, though the defibrillator twice advised not to shock. She continued CPR until the paramedics arrived at 5.30am. The paramedics put an airway device in Mr Parker's throat and she continued CPR, at their instruction. Mr Parker left the prison at 6.20am for hospital. He was not restrained.

33. When Mr Parker arrived at the hospital, he was due to have a CT scan to assess whether he had brain damage. He remained in a critical condition and died at 10.45am.

Contact with Mr Parker's family

34. On 1 June at 8.10am, the prison appointed an officer as the family liaison officer. At 9.00am, she visited Mr Parker in hospital and a nurse told her that the life support machines were keeping Mr Parker alive.

35. Mr Parker's nominated next of kin was a friend who was staying in his house while he was in prison. The officer had an address but no telephone number. Mr Parker's ex-partner lived in the house next door. However, his ex-partner was the victim of his crime so she was not allowed to have contact with his next of kin.

36. A senior manager decided that Mr Parker's ex-partner should be told that Mr Parker was critically ill. The officer telephoned her at 9.40am and arranged to pick her up from her home and take her to the hospital.

37. The officer and the prison chaplain left the prison at 10.25am and arrived at the home of Mr Parker's next of kin at 11.40am. When they arrived, the prison told the officer that Mr Parker had died. She told Mr Parker's friend of his death and offered her condolences. Mr Parker's friend gave them the contact details of one of Mr Parker's daughters and said that she should be the next of kin.

38. The officer knocked on the door of Mr Parker's ex-partner and telephoned her in the afternoon but there was no response either time.

39. The officer then telephoned Mr Parker's daughter and told her of his death. She visited the prison at 3.40pm and the officer helped to arrange a visit to her father. There is no record of further support from the prison to Mr Parker's family.

40. Mr Parker's family arranged his funeral, which took place on 17 June. The prison contributed to the costs in line with national policy.

Support for prisoners and staff

41. After Mr Parker's death a senior manager posted a notice to staff informing them of Mr Parker's death and directing to them to the staff care team, human resources and their line manager if they required support.

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

Post-mortem report

43. The post-mortem concluded that Mr Parker died from infective exacerbation of severe chronic obstructive pulmonary disorder (a sudden and sustained worsening of COPD symptoms) with acute asthma. Coronary artery disease was a contributing factor.

Findings

Clinical care

44. When Mr Parker arrived at Altcourse, healthcare staff assessed him appropriately and they promptly referred him to hospital when he became unwell on 21 May. He returned to Altcourse on 27 May and died five days later.

45. The clinical reviewer stated that Mr Parker's COPD was not managed in line with NICE guidance, as there was no care plan in place. The clinical reviewer requested information from the head of healthcare about Mr Parker's COPD care plan and was sent a document which consisted of only one line of information. The management plan was inadequate and did not reflect the hospital's discharge advice recorded in the systmone notes about Mr Parker's care. (In spite of this, he was monitored as advised by the hospital.) The absence of a care plan meant that on the morning of 1 June, the responding nurse had to go through Mr Parker's medical notes and attempt to seek the advice of an out of hours GP. Although she was aware of his nebuliser frequency, she did not know his COPD history. Additionally, the responding nurse had been unable to contact the on-call doctor because the rota was not up to date and contained incorrect contact details. Following Mr Parker's death, the prison immediately replaced the rota with the correct contact details.

46. The clinical reviewer also commented that the responding nurse should have used the National Early Warning Score (NEWS – a tool for the assessment and response to acute illness) to assess Mr Parker. This would have provided earlier relief of his respiratory distress and given him more comfort. The clinical reviewer concluded that the standard of care Mr Parker received was not equivalent to that he could have expected in the community. We make the following recommendations:

The Head of Healthcare should ensure that healthcare staff manage prisoners with complex and chronic medical conditions in line with NICE guidance including implementing detailed care plans appropriate to their needs, regular planned reviews and accessible management plans to manage deterioration of their condition.

The Head of Healthcare should ensure that staff understand and use the NEWS tool to assess, monitor and respond to acute illness.

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