Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jack Parfitt a prisoner at HMP Oakwood on 19 December 2017

A report by the Prisons and Probation Ombudsman

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

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 Jack Parfitt died on 19 December 2017 of heart failure, while a prisoner at HMP Oakwood. He was 81 years old. I offer my condolences to Mr Parfitt's family and friends.

Mr Parfitt had many chronic health conditions, which healthcare staff managed appropriately. We are satisfied that Mr Parfitt's care while at Oakwood was equivalent to that which he could have expected to receive in the community.

I am, however, concerned to see that, in the absence of medical information, Oakwood used a handcuff to restrain a very ill, elderly and immobile man who posed minimal risk when he was taken to hospital. I consider that this demonstrates narrow decision making and poor judgement.

Although I appreciate that this was an isolated instance where otherwise practice had been appropriate, this is the fourth time we have made had to make recommendations to Oakwood about the inappropriate use of restraints. On each occasion, our recommendations have been accepted and the prison has committed to act on them. The Head of Operational Contracts at Her Majesty's Prison and Probation Service will wish to satisfy himself that effective action will be taken.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **June 2018**

Contents

Summary

Events

1. Mr Parfitt was serving a five year sentence for fraud and had been at Oakwood since 7 April 2017. He was elderly and frail due to complex chronic conditions, including reduced kidney function, heart disease and type 2 diabetes for which he took medication. He also had reduced mobility, very reduced eyesight and needed full assistance with daily living.

2. Mr Parfitt was not always compliant with his medications but healthcare staff continued to encourage and support him. They informed him of the risks of not taking his medications, which he said he understood.

3. From June, Mr Parfitt began to show signs of fluid retention in his ankles. A blood test showed he had reduced kidney function and a prison GP referred him to the nephrology department at the hospital. Repeat blood tests showed that Mr Parfitt's kidney function was abnormal, but stable.

4. In October, Mr Parfitt's fluid retention had become worse and his abdomen was distended. He was admitted to hospital for two weeks for treatment. Mr Parfitt was sent to hospital on five more occasions between October and December for symptoms relevant to heart failure.

5. On 11 December, Mr Parfitt had decreased urine output and his genitalia were swelling. He was pale and dehydrated, although there was evidence he had been drinking fluids. Mr Parfitt said he did not want any further medical intervention and signed an order to that effect. A prison GP stopped the majority of his medications, and healthcare staff monitored him and kept him comfortable.

6. On 13 December, the prison made a referral for Mr Parfitt to move to a hospice for end of life care. He was transferred there two days later. Mr Parfitt died at 12.40pm on 19 December.

Findings

7. Healthcare staff reviewed Mr Parfitt appropriately and supported him daily with his complex clinical and physical needs. Additional resources were obtained to ensure Mr Parfitt could mobilise as much as possible. Appropriate referrals were made to hospital and prison GPs reviewed and amended his medications appropriately. Liaison with secondary services was good. We are satisfied that Mr Parfitt received a good standard of clinical care at Oakwood, equivalent to that which he could have expected to receive in the community.

8. HMP Oakwood was not an ideal location for Mr Parfitt because it did not have a 24-hour healthcare facility. However, we are satisfied that good efforts were made to find him appropriate accommodation and he was appropriately transferred to a hospice for end of life care.

9. Mr Parfitt attended external appointments unrestrained and with one officer for all but one appointment. On this occasion, the authorising prison manager felt that there was insufficient medical information to authorise no restraints and a single

cuff was applied. We consider this a poor decision given the wide range of non-medical evidence pointing to the very limited risk Mr Parfitt posed.

10. We make the following recommendations:

Recommendations

- 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 risk assessments show clear medical information and how their condition impacts their level of risk.
- The Head of Operational Contracts at Her Majesty's Prison and Probation Service should satisfy himself that the PPO's recommendations on restraints have been properly implemented at HMP Oakwood.

The Investigation Process

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

12. She obtained copies of relevant extracts from Mr Parfitt's prison and medical records.

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

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

15. The investigator wrote to Mr Parfitt's daughter to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.

16. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Oakwood

17. HMP Oakwood, which is near Wolverhampton opened in 2012. It is managed by G4S and provides places for up to 1,605 Category C male prisoners. Care UK provides the healthcare services, which includes a daily GP clinic, some specialist services and out-of-hours GPs. Healthcare staff are on duty from 7.00am to 8.00pm on weekdays and from 7.30am to 5.30pm on weekends.

HM Inspectorate of Prisons

18. The last inspection of HMP Oakwood was in December 2014. Inspectors reported that health services, including care for older prisoners had much improved since the last inspection. There were some chronic staff shortages in healthcare which had affected some areas of delivery and agency staff were used to fill the shortages. Care planning was well developed and clinical records were good.

Independent Monitoring Board

19. 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 their latest annual report, for the year to March 2017, the IMB reported that staff turnover was quite high with the number of officers under the age of 25 increasing. The change of healthcare provider in April 2016 went reasonably well but there was an ongoing problem with a shortage of nurses and a reliance on agency nurses. The number of hospital appointments that needed rearranging because of escort issues had decreased compared to the year before.

Previous deaths at HMP Oakwood

20. Mr Parfitt was the tenth prisoner to die of natural causes at Oakwood since January 2017. We have raised the issue of the inappropriate use of restraints four times before.

Key Events

21. On 7 February 2017, Mr Jack Parfitt was sentenced to five years imprisonment for fraud and was sent to HMP Bristol.

22. During his reception health screen, Mr Parfitt said he had reduced mobility, very reduced eyesight and needed full assistance with daily living. He had reduced kidney function, heart disease and type 2 diabetes for which he took medication.

23. On 20 February, Mr Parfitt had a social care assessment by a social worker. She said he required assistance with personal care three times a week. Bristol City Council was unable to facilitate this, so healthcare staff provided assistance. The prison ordered Mr Parfitt a wheelchair and healthcare staff would give him a bed wash if he did not feel up to having a shower.

24. On 23 February, a prison GP, stopped Mr Parfitt's metformin (diabetes medication) because a recent blood test had shown a deterioration in his kidney function.

25. On 27 March, the Healthcare Manager, spoke to the Head of Healthcare at HMP Oakwood to discuss transferring Mr Parfitt there. The move was approved and Mr Parfitt was transferred to Oakwood on 7 April. The prison had arranged for carers to see him three times a week and for a prison carer (another prisoner) to help him collect his meals and keep his cell clean.

26. On 18 and 19 April, Mr Parfitt refused to attend the medications hatch to receive his medications because his wheelchair was too small and his thighs had become sore. The nursing staff explained that they could not bring his medications to his cell. Mr Parfitt continued to refuse to attend, despite nursing staff saying they would see him first and his prison carer would assist him to walk over.

27. On 21 April, a nurse measured Mr Parfitt for a wheelchair. He signed a disclaimer stating he would not attend for his medications.

28. On 2 May, a nurse noted that Mr Parfitt had been collecting his medications again, although it is not clear when he started going to the medications hatch.

29. On 9 June, a prison GP, reviewed Mr Parfitt. He noted he had fluid retention to his ankles and encouraged him to move around more (he had support from the physiotherapist but was reluctant to engage and would not use a zimmer frame). He changed Mr Parfitt's paracetamol to soluble due to him choking and referred him for a blood test to monitor his kidney function.

30. On 19 July, Mr Parfitt had a blood test. The results were reviewed on 26 July, which showed he was low in vitamin D and had a low kidney function, which suggested stage four kidney failure. A prison GP referred Mr Parfitt to the nephrology department at hospital for review of his deteriorating kidney function.

31. On 27 September, Mr Parfitt had a repeat blood test. The results reviewed on 9 October, showed his kidney function remained abnormal, but was stable.

32. On 22 October, a nurse saw Mr Parfitt in his cell because he had been refusing all medications apart from his insulin. She wanted to assess his mental capacity but when she arrived at his cell he said he felt unwell and was short of breath. His stomach was distended and he had fluid retention to both legs and above his navel. She requested an emergency ambulance and Mr Parfitt was taken to hospital for review.

33. Mr Parfitt remained in hospital for treatment of ascites (accumulation of fluid in the abdomen). Hospital staff noted during his admission that his kidney function had deteriorated.

34. Mr Parfitt was discharged from hospital and was transferred back to Oakwood on 5 November. His medications had been amended and he needed a follow-up blood test. He had a review booked in the renal clinic. Mr Parfitt said he felt a lot better in himself and was able to breathe better.

35. On 14 November, Mr Parfitt had a blood test. The results reviewed on 23 November showed no further action was needed.

36. On 19 November, Mr Parfitt fell in his cell. Wing officers assisted him to his chair. A nurse examined him and did not find any injuries, but he had a distended abdomen and she sent him to hospital in an ambulance. While in hospital, Mr Parfitt had an X-ray which showed a shadow on his lung, and a computerised tomography (CT) scan (an imaging procedure that uses special X-rays to create detailed scans of areas inside the body), which did not show any head injuries. A hospital doctor prescribed an antibiotic and he was returned to Oakwood on 22 November.

37. On 23 November, Mr Parfitt attended a review in the renal clinic. The consultant advised to increase his diuretic medication. Mr Parfitt was due for a review in three months time.

38. On 28 November, Mr Parfitt was taken to the Accident and Emergency (A&E) department at hospital with worsening shortness of breath. He was discharged and was returned to Oakwood later that evening after receiving verbal advice and intravenous diuretics to help reduce the fluid retention.

39. Mr Parfitt was sent to A&E again on 3 December, with shortness of breath and fluid retention. While in hospital, he had investigative tests and the discharge letter indicated he was suffering from heart failure. Again, hospital staff discharged Mr Parfitt later that evening and he was returned to Oakwood.

40. The following day, a prison paramedic, reviewed Mr Parfitt in his cell. He was still very unwell, so the paramedic requested an ambulance to take Mr Parfitt back to A&E. The paramedic and prison GP discussed Mr Parfitt's condition and amended his medications accordingly. Mr Parfitt was discharged from hospital and was returned to Oakwood the same day.

41. On 5 December, Mr Parfitt refused his medication. He said it made him feel worse. A nurse and the prison paramedic saw Mr Parfitt in his cell and explained his condition would deteriorate if he did not take his medications. Mr Parfitt said he was aware of this but still refused his medications. The nurse and the paramedic were satisfied that Mr Parfitt had the capacity to make this decision.

They helped Mr Parfitt have a wash and changed his clothes. Mr Parfitt was very unsteady on his feet and mainly bed-bound. He struggled to get up to go to the toilet, so healthcare staff inserted a catheter.

42. On 7 December, the Deputy Head of Healthcare, emailed the Head of Healthcare at HMP Birmingham about transferring Mr Parfitt there. Birmingham had 24-hour healthcare, which would have been better suited to his needs. A specialist nurse from Birmingham was due to assess Mr Parfitt in the following few days.

43. That morning, a locum GP reviewed Mr Parfitt. His condition was poor and he was refusing to have a catheter inserted. The GP felt that the prison was unable to meet his care needs and the prison paramedic arranged for him to go to A&E. A non-emergency ambulance took Mr Parfitt to hospital that evening. Mr Parfitt was discharged from hospital and was transferred back to Oakwood the following day. No changes were made to his medications, however he did not appear to be as short of breath.

44. On 11 December, the prison paramedic reviewed Mr Parfitt in his cell. He noted that Mr Parfitt had decreased urine output and his genitalia were swelling. He appeared pale and dehydrated, although there was evidence he had been drinking fluids. Healthcare staff monitored him and a prison GP reviewed him later that day. It was noted that Mr Parfitt did not want to go to hospital as he felt that they would just send him back to Oakwood. Mr Parfitt said he did not want any further medical intervention and signed an order to that effect.

45. On 13 December, Oakwood made a referral for Mr Parfitt to move to a hospice. That night, he fell out of bed three times. A hospital bed was too big to fit in his cell and he was too unwell to be moved to a disabled cell.

46. The following day, a specialist nurse from HMP Birmingham assessed Mr Parfitt but he was too unwell to transfer. He was in the final stages of end of life. A nurse sat with Mr Parfitt through the night.

47. On 15 December, Mr Parfitt was moved to a hospice for end of life care. He died at 12.40pm on 19 December.

Contact with Mr Parfitt's next of kin

48. On 29 November, the prison appointed a family liaison officer (FLO). Mr Parfitt had listed a family friend as the next of kin. The FLO contacted Mr Parfitt's friend later that day and explained that Mr Parfitt's condition had deteriorated and he was attending hospital regularly. Mr Parfitt's friend said she would pass this information on to his wife. The FLO left her contact details and said she would make contact again if Mr Parfitt's condition changed.

49. On 14 December, the FLO arranged for Mr Parfitt to speak to his daughter on the telephone. The Head of Healthcare also spoke to his daughter and explained Mr Parfitt's condition and prognosis. Mr Parfitt asked for his daughter to be his next of kin going forward.

50. The FLO arranged for Mr Parfitt's daughter to visit him on 15 December. She offered support and explained the processes that would take place after Mr

Parfitt died. She also facilitated a telephone call to Mr Parfitt's wife while their daughter was visiting.

51. The FLO arranged for Mr Parfitt's wife to visit him in the hospice. She attended the hospice and provided support. She provided on-going support to Mr Parfitt's wife and daughter after his death.

52. Mr Parfitt's funeral was held on 15 January 2018. The prison made a financial contribution towards the cost of the funeral in line with national guidance.

Support for prisoners and staff

53. After Mr Parfitt's death, a prison manager debriefed the staff who were on the escort to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

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

Cause of death

55. The Coroner listed Mr Parfitt's cause of death as heart failure and ischaemic heart disease; contributory factors not directly linked to his death, were diabetes and kidney failure.

Findings

Clinical care

56. Mr Parfitt was an elderly man and very unwell. He had complex medical conditions including diabetes, kidney disease and heart disease. He needed assistance when mobilising. Mr Parfitt's condition steadily deteriorated and he was admitted to hospital on six occasions with symptoms of heart failure.

57. The clinical reviewer found that healthcare staff were compassionate and liaison with secondary services was well documented. We are satisfied that the clinical care Mr Parfitt received while at HMP Oakwood was equivalent to that which he could have expected to receive in the community

58. The clinical reviewer makes one recommendation, which we do not repeat in this report, but which the Head of Healthcare will wish to consider.

Mr Parfitt's location

59. As Mr Parfitt's condition deteriorated healthcare staff catered to his needs and made him comfortable as much as possible. The prison appropriately sourced Mr Parfitt additional resources. Carers assisted him three times per week and a disability orderly assisted with his daily tasks.

60. HMP Oakwood was not an ideal location for Mr Parfitt as his condition deteriorated, because it did not have a 24-hour healthcare facility. However, we are satisfied that good efforts were made to find him appropriate accommodation. Healthcare staff made efforts to secure a bed place at HMP Birmingham but there were no spaces available. When a space did become available, Mr Parfitt was, by this time, too ill to travel. Mr Parfitt expressed his wish to stay at Oakwood among his friends and peers. He was transferred to a hospice for the last few days of his life.

61. We are satisfied that Mr Parfitt's needs were met in line with his wishes.

Restraints

62. When prisoners have to travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a 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 medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

63. For Mr Parfitt's hospital escorts, his risk assessments showed him to be a low risk and record that he had limited mobility. He was not restrained for the majority of his appointments and it was usual practice for just one officer to accompany him. However, on one occasion, 23 November, Mr Parfitt was

restrained using a single cuff. The authorising manager, told the investigator that he had not met Mr Parfitt and had no knowledge of his medical conditions. There was limited medical information in the risk assessment and it had been stated that Mr Parfitt was fully mobile, which indicated that he was capable of escape. He also said that Mr Parfitt's file showed him to be a tall and large man, which helped to inform his decision. Had he known Mr Parfitt struggled with his mobility, he would have reconsidered the use of restraints.

64. The decision to use restraints was made narrowly, without sufficient medical input from healthcare staff. Had the medical section have been more comprehensive, the level of restraint might well have been different. More broadly, we feel that, even with the limited information available – most obviously Mr Parfitt's evident limited mobility, advanced age, very poor condition and history of no restraints being used, the decision to use restraints showed poor judgement.

65. It is the Governor's responsibility to ensure that the process is managed properly, but the Head of Healthcare also needs to satisfy themselves that healthcare staff know the importance of showing clear relevant medical information when carrying out the risk assessment. We are concerned that this is the fourth time we have expressed concern about the inappropriate use of restraints on prisoners at Oakwood. We make the following recommendations:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that risk assessments show clear medical information and how their condition impacts their level of risk.

The Head of Operational Contracts at Her Majesty's Prison and Probation Service should satisfy himself that the PPO's recommendations on restraints have been properly implemented at HMP Oakwood.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141