Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Barry Park a prisoner at HMP Winchester on 26 April 2018

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 I oversee can improve their work in the future.

Mr Barry Park died on 26 April 2018 of metastatic pancreatic cancer while a prisoner at HMP Winchester. He was 56 years old. I offer my condolences to Mr Park's family and friends.

Mr Park entered custody with several serious health conditions and a long-term addiction to heroin. I am satisfied that Mr Park's condition was diagnosed appropriately and he received care equivalent to that he could have expected to receive in the community. I commend the prison for facilitating a move to the hospice shortly after his diagnosis for optimum palliative care, but consider that they should have started a compassionate release application.

I consider the security risk assessment when Mr Park was taken to hospital was inadequate and that the use of double handcuffs was excessive.

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
Deputy Prisons and Probation Ombudsman **November 2018**

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Summary

Events

1. On 17 February 2018, Mr Park arrived at HMP Winchester awaiting sentence for possession of a weapon. He had a long history of substance misuse and was diagnosed with asthma, epilepsy, osteomyelitis (bone infection) and hepatitis C. He also had a diagnosis of schizophrenia and a personality disorder.

2. Mr Park began a methadone (heroin substitute) maintenance programme and had his dose increased when he felt that it was not controlling his withdrawal symptoms.

3. Mr Park first reported abdominal problems on 25 March 2018. These were diagnosed as constipation caused by his long-term substance abuse. He complained to nurses in early April of bowel problems and pain in his abdomen. They advised measures to relieve constipation. On 17 April, a doctor was concerned that Mr Park might have a bowel obstruction and sent him to hospital for assessment the same day.

4. On 18 April, Mr Park was diagnosed with metastatic pancreatic cancer. He was told that it was inoperable and that palliative care would be provided. Mr Park was transferred to a hospice on 20 April and was escorted by a single officer in plain clothes. He died on 26 April.

Findings

5. We are satisfied that Mr Park received a good standard of care at Winchester and commend the prison for facilitating an immediate transfer to a hospice from hospital. However, we consider the use of double cuffs when Mr Park was taken to hospital to have been excessive and that a compassionate release application should have been started when he went into the hospice.

Recommendations

- The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints 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.
- The Governor should ensure that compassionate release processes are started without delay for terminally ill prisoners.

The Investigation Process

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

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

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

9. We informed HM Coroner for Hampshire of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.

10. The investigator wrote to Mr Park's ex-wife to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. She did not respond to our letter.

11. The investigation has assessed the main issues involved in Mr Park's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.

12. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Winchester

13. HMP Winchester is a local prison, serving courts in Hampshire. It holds around 700 adult remanded and sentenced men. It includes a separate lower security unit for up to 129 sentenced men nearing the end of their sentence, known as West Hill. Central and North-West London NHS Foundation Trust provides healthcare at the prison and 24-hour healthcare cover.

HM Inspectorate of Prisons

14. The most recent inspection of HMP Winchester was conducted in July 2016. Inspectors found the quality of health services to be good overall. There was an appropriate range of primary care services, with reasonable waiting times. The management of long-term conditions had improved, with an increase in the number of nurse-led clinics, regular reviews and a more systematic approach.

Independent Monitoring Board

15. 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, covering June 2016 to May 2017, the IMB reported that healthcare services at the prison had been barely adequate the previous year but were now failing to safeguard the basic needs of prisoners. The Board found that in common with the rest of the prison, the fabric and facilities of the Healthcare wing did not offer an appropriate environment for recuperation or palliative care.

Previous deaths at HMP Winchester

16. Including Mr Park, we have investigated 13 deaths at Winchester since April 2015. Of the other deaths, six were natural causes and six were self-inflicted. There are no similarities in this report to previous deaths at the prison.

Findings

The diagnosis of Mr Park's terminal illness and informing him of his condition

17. Mr Park was awaiting sentence for the possession of a weapon in a public place. He had been in prison many times before and had been at HMP Winchester since 17 February 2018. Mr Park had several serious health conditions, including asthma, epilepsy, osteomyelitis (bone infection) and hepatitis C. He was diagnosed with paranoid schizophrenia and a personality disorder. Mr Park had a long history of substance misuse including heroin, crack cocaine and alcohol.

18. On arrival at Winchester, a nurse prescriber prescribed methadone (a heroin substitute) and Mr Park began a stabilisation programme. He was also seen by a mental health worker, who noted he had a personality disorder but did not have any current concerns about Mr Park.

19. On 13 March, a prison GP agreed to increase Mr Park's methadone from 20mls to 40mls after he had complained that it was too low. Mr Park said he had not been sleeping or feeling well. On 16 March, a nurse saw Mr Park for the 28-day review of his stabilisation process. He found him to be stable and planned to complete a follow up review a month later.

20. On 25 March, Mr Park told a nurse that he had had an upset stomach for two weeks and that it was swollen and sore to touch. On 27 March, a prison GP reviewed his condition and examined his stomach. She diagnosed Mr Park with constipation and he asked her to contact the drug treatment team as he felt the methadone he was prescribed was not sufficient.

21. On 1, 8 and 13 April, Mr Park told different nurses he had had no bowel movements since he had last seen a doctor and that he had abdominal pain. They all encouraged him to increase his fluid intake to help the symptoms of constipation. On 17 April, a prison GP reviewed Mr Park and found him to have a distended abdomen. He considered that he might have a bowel obstruction and requested that Mr Park be checked at hospital. He was escorted there later that day.

22. On 18 April, Mr Park received a diagnosis of metastatic pancreatic cancer at hospital (advanced pancreatic cancer that had spread to other parts of the body). The clinical reviewer concluded that although Mr Park had seen several health professionals for his abdominal symptoms, the assumption that the cause was due to long term substance abuse was reasonable. He further commented that pancreatic cancer is well known for presenting with symptoms late on in the disease. We agree with the clinical reviewer that Mr Park's condition was diagnosed and treated appropriately.

Mr Park's clinical care

23. Mr Park was told that his cancer inoperable and that he would receive palliative care. A hospital consultant said that he only had a few months to live and arranged a place at a hospice for optimal palliative care. Mr Park transferred to the hospice on 20 April.

24. Mr Park said he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect before going to the hospice.

25. Prison staff maintained daily contact with the hospice, where Mr Park died on 26 April at 2.10am.

26. We agree with the clinical reviewer that the clinical care that Mr Park received was equivalent to that which he could have expected to receive in the community.

Mr Park's location

27. Mr Park lived on the vulnerable prisoner unit and moved there ten days after he arrived at Winchester. While in prison his presentation and symptoms were appropriately managed. On 17 April, Mr Park's health deteriorated and he was taken to hospital. He was moved to a hospice three days later for palliative care. The prison provided travel arrangements to the hospice and ensured that escort staff were dressed in plain clothes which was suitable to the setting.

Restraints, security and escorts

28. 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 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.

29. On 17 April, when Mr Park went to hospital, an Escort Risk Assessment was completed. The risk assessment form completed by the prison had been adapted from the standard form used by prisons. Mr Park was assessed as being a risk to the public and to hospital staff, and posing a risk of violence, but there was no indication as to whether these risks were low, medium or high. There was no medical information included to inform the risk assessment. All of these are necessary to comply with the provisions set out in the High Court judgement.

30. Despite an absence of information about how his health impacted on his ability to escape, Mr Park was restrained with double cuffs. (This is when a prisoner's hands are handcuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs.) It is usually required for moving category A or category B prisoners in good health. Although Mr Park was a category B prisoner, there is no written evidence to support the decision to use double cuffs and, given his age and condition, we can see no reason why it would be justified. The risk assessment used was based entirely on the prison's view of his security risk with little evidence that there was any consideration of how his health condition impacted on this risk, as the 2007 High Court judgement requires.

31. On 19 April, an operational manager reviewed Mr Park's risk assessment and decided his restraints could be removed. His restraints were not removed until 20 April. The manager could not remember why the restraints were not removed immediately once the decision had been made.

32. To make an appropriate decision on the use of restraints prison managers need up to date and detailed information. They should consider the nature and seriousness of the prisoner's risks of escape or harm to others, and medical information about a prisoner's condition and how it impacts on their risk is vital. We make the following recommendation:

The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints 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.

Liaison with Mr Park's family

33. On 20 April, an operational manager was appointed as Family Liaison Officer (FLO) and visited Mr Park at the hospice the same day. Mr Park had opted not to provide any next of kin details when he came to prison, but said he would like his former wife to be told that he was there. The FLO asked the police to contact Mr Park's former wife because the prison did not have any address details and also because a restraining order was in place. The police were not able to establish contact with her before Mr Park died. They broke the news of his death on 27 April and gave her the FLO's contact details.

34. Once Mr Park's former wife had contacted the FLO, they remained in regular contact and the FLO offered support in making funeral arrangements. The funeral took place on 15 May. The prison contributed to funeral costs in line with national policy. We are satisfied that the prison liaised with the family appropriately.

Compassionate release

35. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months. Mr Park died nine days after his terminal illness was discovered. His care was transferred from hospital to a hospice with a plain-clothed officer escort. We commend the prison for a seamless transfer from prison to hospice, to allow decent end of life care for Mr Park.

36. No compassionate release application was started for Mr Park and with his prognosis unclear at the time of transfer to a hospice, it was a missed opportunity to give Mr Park the chance to have a more dignified death. We make the following recommendation:

The Governor should ensure that compassionate release processes are started without delay for terminally ill prisoners.

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