

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Llywarch a prisoner at HMP Stafford on 28 September 2017

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*



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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.

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 Llywarch died in hospital on 28 September 2017 of congestive cardiac failure and chronic obstructive pulmonary disease (COPD) while a prisoner at HMP Stafford. He was 74 years old. We offer our condolences to his family and friends.

Mr Llywarch received appropriate care for his COPD, and was managed in line with the National Institute for Health and Care Excellence guidelines. Mr Llywarch was not diagnosed with cardiac failure until he was admitted to hospital, but the clinical reviewer found no fault with the prison that this diagnosis was not made earlier.

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

March 2018

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Summary

Events

1. On 20 June 2001, Mr John Llywarch was sentenced to life in prison, with a minimum tariff of 9 years for historic sexual offences.
2. In July 2011, he was diagnosed with chronic obstructive pulmonary disease (COPD - a progressive respiratory condition caused by smoking). Between 2010 and 2015, Mr Llywarch's COPD worsened despite his regular attempts to stop smoking, with the support and treatment from the healthcare teams in the prisons in which he served his sentence.
3. In October 2015, Mr Llywarch was transferred to HMP Stafford, where healthcare staff continued to manage his COPD appropriately.
4. On 24 January 2017, Mr Llywarch complained of difficulty breathing, and staff radioed a medical emergency code for healthcare staff to attend his wing. A nurse who responded, noted that he was short of breath, but was not otherwise concerned.
5. Staff raised two further emergencies for Mr Llywarch within a week. On both occasions, his observations were taken and were within the normal range. Mr Llywarch was referred to see a doctor who recorded that his COPD was worsening and diagnosed him with a respiratory tract infection.
6. Healthcare staff continued to monitor Mr Llywarch. On 21 July, he was prescribed furosemide (a diuretic) for his swollen ankles.
7. Mr Llywarch's health declined. On 18 September he was admitted to hospital after his blood pressure and pulse were found to be outside the normal range. He was treated for a respiratory tract infection and poor kidney function which was caused by the furosemide. On 20 September, he was discharged to HMP Stafford, with antibiotics.
8. On 21 September, Stafford sent Mr Llywarch back to hospital. While an inpatient, Mr Llywarch's haemoglobin dropped. (Low haemoglobin means that oxygen is not effectively being carried around the body.) On 24 September, doctors confirmed that Mr Llywarch had an infection in his lungs which was causing a decline in his health.
9. Mr Llywarch did not respond to treatment. On 28 September, all active treatment was stopped. He died of heart failure and COPD at 11.50pm that night.

Findings

10. We are satisfied that Mr Llywarch's COPD was effectively managed in line with National Institute for Health and Care Excellence (NICE) guidelines following his diagnosis in 2011.
11. Mr Llywarch was not diagnosed with congestive heart failure until his final admission to hospital, but there is no evidence that healthcare staff missed an opportunity to diagnose him sooner.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Stafford informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
13. The investigator obtained copies of relevant extracts from Mr Llywarch's prison and medical records.
14. NHS England commissioned a clinical reviewer to review Mr Llywarch's clinical care at the prison.
15. We informed HM Coroner for South Staffordshire District of the investigation who gave us the cause of death. We have sent the Coroner a copy of this report.
16. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found three factual inaccuracies.

Background Information

HMP Stafford

17. HMP Stafford is a medium security prison for adult sex offenders. It holds more than 700 prisoners across seven wings. Care UK has provided healthcare services since April 2016. There are no inpatient facilities. Nurses are on duty daily between 7.30am and 5.30pm and there is a weekday GP service, with on-call GPs outside these hours.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Stafford was conducted in February 2016. Inspectors considered that the range of primary care services was reasonable, with good access to nurses and GPs available. They found that wing-based nurses provided consistent care, treatment and review.

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 its latest annual report for the year to April 2017, the IMB reported that healthcare had improved substantially since its last report, with a reduction in waiting lists for internal services, and fewer cancelled escorts for external appointments. The IMB acknowledged the exceptional care shown by staff and prisoner carers towards very frail and terminally ill prisoners

Previous deaths at HMP Stafford

20. Mr Llywarch was the eighth prisoner to die at HMP Stafford since January 2016 which is not remarkable, given the prison's role. There were no similarities between Mr Llywarch's death and the previous deaths

Key Events

21. On 20 June 2001, Mr John Llywarch was sentenced to life in prison, with a minimum tariff of 9 years for historic sexual offences. He spent time in a number of prisons.
22. An x-ray in July 2010 showed signs of chronic obstructive pulmonary disease (COPD). After his diagnosis, Mr Llywarch started but did not complete a smoking cessation programme, and was treated for COPD. In 2013, he was recorded as having moderate COPD.

HMP Stafford

23. On 1 October 2015, Mr Llywarch was transferred to HMP Stafford. At his initial health screen that day, a nurse noted his history of COPD and recorded that he had smoked cigarettes since the age of 10. He declined smoking cessation advice. She referred Mr Llywarch to a prison GP who prescribed him a continuation of his medication.
24. There are no significant entries in Mr Llywarch's medical records until 21 March 2016 when a prison GP reviewed his COPD symptoms and inhaler use as Mr Llywarch said that the inhaler had given him a sore throat and he had stopped using it. He prescribed Mr Llywarch an alternative inhaler, and advised him how often it should be administered.
25. He was next seen in the healthcare department on 26 April when a nurse recorded that Mr Llywarch had fallen after feeling dizzy but that no intervention was needed. Mr Llywarch had further symptoms of dizziness on 9 and 14 June. A prison GP referred him for an echocardiogram (ECG – a scan of the heart) which was completed on 24 June. No concerns were recorded.
26. On 6 July, a nurse completed a COPD review. Mr Llywarch again declined smoking cessation advice. His weight was recorded at 56kg, a loss of 3.5kg since five months earlier. She put a COPD care plan in place and noted that he should be reviewed in six months. She referred him to see a GP about his weight loss.
27. On 11 July, a prison GP saw Mr Llywarch. He arranged for Mr Llywarch to have blood tests and a chest x-ray under the two-week rule. The test results showed signs of COPD but no cause for concern. Mr Llywarch was prescribed fortisip (a nutritional drink) to manage his continued weight loss.
28. The healthcare department continued to monitor Mr Llywarch. On 23 September, he agreed to go to smoking cessation appointments, and was prescribed a nicotine inhaler and patches.
29. Between September 2016 and January 2017, Mr Llywarch had blood tests, the results of which were normal. His weight loss stabilised.
30. On 24 January, a member of prison staff noticed that Mr Llywarch appeared unwell and called a medical emergency code blue (which indicated breathing difficulties). A nurse responded. She noted that Mr Llywarch was breathless but that all his observations were in the normal range. She recorded that an

emergency code blue had not been necessary and advised that Mr Llywarch should use his inhaler. He was taken to the healthcare department for further assessment.

31. On 31 January and 4 February, staff called code blue emergencies for Mr Llywarch. On each occasion, healthcare staff recorded that his observations were in the normal range, and administered oxygen therapy. On 4 February, a nurse noted that this was the third time that a code blue had been called for Mr Llywarch in a week, and arranged for him to see a doctor.
32. On 7 February, a prison GP reviewed Mr Llywarch and diagnosed that his COPD had got worse. He prescribed antibiotics and arranged for him to use a nebuliser immediately. He advised Mr Llywarch to report to the healthcare department if he had any further concerns about his health.
33. In February, Mr Llywarch twice saw a member of the healthcare team because he was short of breath. On 3 March, a prison GP reviewed a self management plan with Mr Llywarch as his COPD was worsening. He diagnosed a respiratory tract infection and prescribed antibiotics.
34. On 27 March, a prison GP reviewed Mr Llywarch and noted that his chest was clearer than during the last two examinations. He recorded that Mr Llywarch would benefit from a spirometry (a test used to help diagnose and monitor certain lung conditions) and on 25 April, a nurse carried out this test. The results showed a severe obstruction of his airways, which prevented air getting to his lungs. His COPD care plan was updated and it was noted that he had to use a wheelchair for long distances. Mr Llywarch continued to smoke and declined smoking cessation advice.
35. Between April and July, Mr Llywarch was monitored regularly, and it was noted that his weight had increased and was stable at 71.8kg.
36. On 21 July, Mr Llywarch saw a prison GP as he had swollen ankles. He found no other abnormalities, diagnosed him with oedema to the ankles and prescribed him with furosemide to reduce swelling.
37. Over the next month, the healthcare team monitored Mr Llywarch's COPD. On 7 September, a nurse recorded that he was using his inhalers at a fast rate, indicating that he was increasingly breathless.
38. On 14 September, a prison GP arranged for blood tests for Mr Llywarch. He noted that the results showed that Mr Llywarch's sodium, potassium and estimated glomerular filtration rate (eGFR which was used to test renal function) were low because of the furosemide.
39. On 18 September, a prison GP saw Mr Llywarch to review his blood test results. Mr Llywarch complained of feeling light headed. A prison GP took his observations and noted his blood pressure was low at 80/44. His pulse was elevated at 112 bpm. (A person in good health tends to have a pulse rate between 60-80bpm.) Mr Llywarch was sent to hospital that day because of his blood test results and observations. Due to Mr Llywarch's presentation, he was not restrained as he was considered too unwell but was escorted by two officers. Mr Llywarch was treated as an inpatient for a lower respiratory tract infection and

poor renal (kidney) function. He refused further management of his condition and, on 20 September, was discharged to the prison, with antibiotics.

40. At 8.47am on 21 September, an unknown officer on E Wing radioed a medical emergency code blue as Mr Llywarch had difficulty breathing. Nurses A and B and a healthcare assistant responded. Mr Llywarch was sitting on the bed in his cell. He was talking coherently and in full sentences. Nurse A recorded that he appeared slightly out of breath. She arranged for blood tests to be taken, reassured Mr Llywarch and advised him to speak to a member of staff if his health declined.
41. On the afternoon of 21 September, further blood tests were arranged, and while the results showed that his sodium and potassium levels had risen, his eGFR remained low. Nurse B contacted the blood chemistry department at the hospital, and Mr Llywarch was admitted to hospital later that day (as there was no doctor available in prison).
42. Nurse A called the hospital on 23 September and a hospital nurse confirmed that he was taking antibiotics and that his haemoglobin level had dropped. (Haemoglobin allows the red blood cells to bond with oxygen in the lungs and carry that oxygen to tissues and organs throughout the body.) The hospital was investigating why this had occurred.
43. On 24 September, a nurse spoke to a sister in charge of Mr Llywarch's care. She said that the doctors had reviewed him, and diagnosed that his decline in health was due to a chest infection. Mr Llywarch remained in hospital. On 28 September, the hospital contacted a nurse at the prison to say that Mr Llywarch had not responded to treatment.
44. A document to say that Mr Llywarch would not be resuscitated if he had sudden cardiac arrest or died was put in place. All treatment was stopped and Mr Llywarch was placed on the end of life care pathway. Mr Llywarch died at approximately 11.50pm on 28 September.

Contact with Mr Llywarch's family

45. After Mr Llywarch's death, the prison appointed a Senior Officer (SO) as the family liaison officer. At 10.20am on 29 September, she contacted his community Probation Officer whom Mr Llywarch had appointed as his next of kin, and told him of his death.
46. The SO contacted a victim liaison officer to see if Stafford should make contact with Mr Llywarch's family. A victim support officer contacted Mr Llywarch's family, and told the prison that they did not wish to be involved. His brother asked to attend the funeral.
47. Stafford arranged Mr Llywarch's funeral which was held on 1 November 2017, and paid the cost of the funeral in line with national standards.

Support for prisoners and staff

48. After Mr Llywarch's death, the Head of Safety, Equalities and Admissions, debriefed the staff who were on duty as Mr Llywarch's bedwatch officers in

hospital to ensure that they had the opportunity to discuss any issues arising, and to offer support.

49. The prison posted notices informing other prisoners of Mr Llywarch's death, and offering support.

Cause of death

50. The Coroner informed us that Mr Llywarch died from congestive cardiac failure (heart failure) and COPD.

Findings

Clinical care

51. Mr Llywarch's diagnosis of COPD was made in 2011, and the clinical reviewer said that throughout his time in prison, it had been treated in line with NICE guidelines. He noted that Mr Llywarch was not diagnosed with congestive cardiac failure until his final admission to hospital. He found no failings in the care Mr Llywarch received from Stafford's healthcare team before his death.
52. Although the clinical reviewer noted that it did not contribute to Mr Llywarch's death, the use of furosemide without appropriate blood tests led to physical symptoms and an unnecessary admission to hospital. He made two further recommendations about healthcare issues that the Head of Healthcare will need to address.

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