Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Booth, a prisoner at HMP Altcourse, on 6 October 2019

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 we oversee can improve their work in the future.

Mr Peter Booth died on 6 October 2019 of congestive cardiac failure caused by ischaemic heart disease while a prisoner at HMP Altcourse. He was 75 years old. I offer my condolences to Mr Booth's family and friends.

I am satisfied that the clinical care Mr Booth received at HMP Altcourse was of a good standard and equivalent to that which he could have expected to receive in the community.

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

Sue McAllister, CB
Prisons and Probation Ombudsman **May 2020**

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Summary

Events

1. On 11 April 2019, Mr Peter Booth was sentenced to seven years and four months in prison for sexual offences. He was sent to HMP Altcourse.

2. Mr Booth had a number of pre-existing medical conditions including a history of heart attacks, heart disease, heart failure, angina, ischemic cardiomyopathy and chronic kidney disease. He also had a defibrillator pacemaker, type 2 diabetes, glaucoma, anaemia and depression.

3. Mr Booth was a generally unwell man. Between May and August, he was admitted to hospital on three separate occasions with cardiac problems and pneumonia. A do not attempt cardiopulmonary resuscitation (DNACPR) order was put in place.

4. In September, Mr Booth's health deteriorated further but he refused to be admitted to hospital for further review. Healthcare staff arranged for emergency blood tests to be completed. The blood test results confirmed a decline in his kidney function. Mr Booth was sent to hospital for review and he was admitted as an inpatient.

5. Hospital staff told Mr Booth that his internal organs were beginning to shut down. The only treatment option available to him was palliative care.

6. Mr Booth's health continued to deteriorate and at 12.35am on 6 October it was confirmed that Mr Booth had died.

7. The coroner gave Mr Booth's cause of death as congestive cardiac failure caused by ischaemic heart disease.

Findings

8. The clinical reviewer concluded that the clinical care Mr Booth received at Altcourse was of a good standard and equivalent to that which he could have expected to receive in the community.

9. The clinical reviewer found that appropriate monitoring and assessment processes were in place to manage Mr Booth's long-term conditions. He received a good standard of medical and nursing care at Altcourse.

10. We make no recommendations.

The Investigation Process

11. 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.

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

13. NHS England commissioned an independent clinical reviewer to review Mr Booth's clinical care at the prison.

14. We informed HM Coroner for Liverpool and Wirral of the investigation. The coroner 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 Booth's next of kin, to explain the investigation and to ask whether he had any matters he wanted the investigation to consider. He did not raise any issues.

16. Mr Booth's family received a copy of the draft report. They did not make any comments.

17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed no factual inaccuracies.

Background Information

HMP Altcourse

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

HM Inspectorate of Prisons

19. The most recent inspection of HMP Altcourse was in November 2017. Inspectors reported that there was a range of appropriate primary care services, prisoners received responsive care and staffing levels were satisfactory. Continuity of care had been adversely affected after the termination of the previous GP contract and the use of locum cover, but this had recently improved with use of a regular agency. Care plans were in place for prisoners with long-term conditions, but they were sometimes inadequately reviewed. The inpatient unit required improvement.

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 June 2018, the IMB reported that a new GP contract had recently been agreed which they hoped would reduce the current eight week waiting time to see a doctor for non-urgent appointments. The IMB found that the waiting room for vulnerable prisoners was in poor condition, which they described as airless, cramped and generally unfit for purpose.

21. The board found a dramatic reduction in recent months of healthcare complaints together with the introduction of a healthcare 'forum' which gave prisoners the opportunity to raise concerns. They also noted the benefits of health promotion and prevention activity, including stress awareness, HIV, blood pressure, autism and mental health awareness and bowel cancer screening.

Previous deaths at HMP Altcourse

22. Mr Booth was the fourteenth prisoner to die at Altcourse since December 2016. Of the previous deaths, three were self-inflicted and nine were from natural causes and one death is currently unclassified. There are no similarities between our findings in the investigation of Mr Booth's death and the other deaths.

Key Events

23. On 11 April 2019, Mr Peter Booth was sentenced to seven years and four months in prison for sexual offences. He was sent to HMP Altcourse.

24. Mr Booth had a number of pre-existing medical conditions including heart disease, heart failure, angina (chest pain caused by reduced oxygen supply to heart), a history of heart attacks, ischemic cardiomyopathy (weakened heart muscle caused by heart attacks or coronary artery disease) and chronic kidney disease. He also had a defibrillator pacemaker, type 2 diabetes, glaucoma (where the optic nerve becomes damaged), anaemia and depression.

25. On his arrival at Altcourse, a nurse completed Mr Booth's initial health screen. She noted his pre-existing medical conditions and medications, and considered that given his cardiac history he should be located in the prison's healthcare unit until he was reviewed by a prison GP. His second health screen was completed on 12 April in line with national guidelines.

26. Mr Booth was a frail and generally unwell man. Between May and July, he was admitted to hospital with chest pain on three occasions and was treated for pneumonia and cardiac problems.

27. On 11 August, Mr Booth was reviewed by a nurse after he complained of intermittent chest pain which radiated from his chest to his jaw. The nurse took Mr Booth's observations and calculated his National Early Warning Score (NEWS - a tool used to help clinicians to respond to clinical deterioration in adult patients). Mr Booth scored one which indicated that he needed to be monitored regularly.

28. Later the same day, Mr Booth complained of chest pain and he was sent to hospital for further review. Mr Booth was admitted to hospital as an inpatient and treated for a heart attack, anaemia, haematuria (presence of blood in urine), heart failure and cardiomyopathy.

29. On 21 August, a do not attempt cardiopulmonary resuscitation (DNACPR) order (which means that, in the event of cardiac or respiratory arrest, no attempt at resuscitation will be made; all other appropriate treatment and care will continue to be provided) was discussed with Mr Booth and put in place.

30. On 28 August, Mr Booth was discharged from hospital after receiving treatment and was transferred back to Altcourse.

Events of 19 - 23 September

31. On 19 September, a prison GP reviewed Mr Booth after he complained of having difficulty breathing and abnormal chest sounds. Mr Booth felt generally unwell and he experienced pain when moving. The prison GP decided to send Mr Booth to hospital for further review. Mr Booth was treated at hospital for a chest infection and was discharged back to the prison the following day.

32. On 22 September, a prison GP reviewed Mr Booth after he had vomited overnight, was dehydrated and had mild jaundice (yellow discoloration of the skin). The prison GP told Mr Booth that he wanted to send him to hospital for

further assessment. Mr Booth declined the offer and told the prison GP that he wanted to be treated in prison. The prison GP explained to Mr Booth the risks of refusing to go to hospital and confirmed that Mr Booth had the mental capacity to make decisions about his care and treatment. The prison GP requested urgent blood tests and made an appointment to see Mr Booth again the following day.

33. On 23 September, the blood test results showed that there was a decline in Mr Booth's kidney function. A prison GP discussed the results with Mr Booth and he agreed to go to hospital for further review.

34. Mr Booth was admitted as an inpatient at hospital. A hospital consultant told him that his internal organs were beginning to shut down and that there was nothing more that could be done for him. The only treatment option available to him was palliative care. Hospital staff updated prison healthcare staff regularly about Mr Booth's condition.

35. Mr Booth's health deteriorated rapidly and at 12.35pm on 6 October, it was confirmed that Mr Booth had died.

Post-mortem report

36. The coroner gave Mr Booth's cause of death as congestive cardiac failure (a chronic progressive condition that affects the pumping power of the heart muscles) as a result of ischaemic heart disease (the reduction of blood flow to the heart muscle due to build-up of plaque in the arteries of the heart).

Contact with Mr Booth's family

37. On 22 August, the prison appointed a Prison Custody Officer (PCO) as the family liaison officer (FLO). The FLO supported the family during Mr Booth's hospital admission. The hospital informed Mr Booth's next of kin that Mr Booth had died and the FLO met her at the hospital to offer his condolences and support. On 7 October, the FLO contacted Mr Booth's next of kin to discuss the coronial process and to offer support.

38. Mr Booth's funeral was held on the 30 October. In line with Prison Service instructions, the prison contributed to the costs of the funeral.

Support for prisoners and staff

39. The Duty Director held a hot debrief after Mr Booth's death. Staff were given the opportunity to discuss the incident and any issues arising and were offered support.

40. The prison posted notices informing staff and prisoners of Mr Booth's death, and offering support.

Findings

Clinical care

41. The clinical reviewer concluded that the clinical care Mr Booth received at Altcourse was of a very good standard and equivalent to that which he could have expected to receive in the community.

42. Mr Booth had a number of pre-existing medical conditions. He underwent a thorough routine health screen which noted his past medical history and current medical state. The clinical reviewer considered that Mr Booth received appropriate care for his medical conditions, most significantly for his cardiac history, and that his nursing care was appropriate, compassionate and responsive. There is good evidence that comprehensive care plans were put in place to manage his care in line with national guidance.

43. We make no recommendations.

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