Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Frederick Lawlor, a prisoner at HMP Parc, on 7 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 Frederick Lawlor died of septic shock as a result of a bowel obstruction on 7 October 2019 while a prisoner at HMP Parc. He was 66 years old. I offer my condolences to his family and friends.

The clinical reviewer was satisfied that the standard of healthcare that Mr Lawlor received was good and equivalent to that which he could have expected to receive in the community.

We have made no recommendations.

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 **April 2020**

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Summary

Events

1. On 30 October 2007, Mr Frederick Lawlor received a life sentence for murder. On 24 February 2015, he was transferred to HMP Parc.

2. At his initial health screen, a nurse noted that Mr Lawlor appeared fit and well but that he had had a mini-stroke in 2007. At his second health screen, a nurse noted that he had also had two hernias in 2007.

3. On 22 November 2017, Mr Lawlor saw a prison GP because he had had diarrhoea for four to five weeks. The GP told him that altered bowel habits could be a sign of bowel cancer, but Mr Lawlor declined to be referred to hospital for investigations. The GP prescribed him medication to treat diarrhoea.

4. Mr Lawlor continued to have diarrhoea. He said that he had irritable bowel syndrome caused by his anxiety. A pharmacist saw Mr Lawlor in January and March 2018 and again prescribed medication for diarrhoea.

5. In June, Mr Lawlor saw the GP again because he still had diarrhoea. He declined a referral to hospital and refused to have blood tests.

6. In February 2019, he was sent a bowel cancer screening kit, but he did not complete it.

7. On 30 September, Mr Lawlor told a nurse that he had a swollen abdomen, that he was not eating, only drinking small amounts of fluid and passing small amounts of watery stool. A prison GP saw Mr Lawlor later that day. She noted that Mr Lawlor's abdomen was swollen but soft and not tender. Mr Lawlor refused to allow further examinations of his bowel and abdomen but agreed to take a laxative for constipation.

8. At 6.20pm on 3 October, an officer called a medical emergency code blue because Mr Lawlor was short of breath and struggling to breathe. A nurse saw him and took his observations. He had very low blood oxygen levels and a swollen stomach. She gave him oxygen. Mr Lawlor did not want to go to hospital and the nurse told him that she was concerned about his health. Healthcare staff continued to monitor him.

9. At 9.00pm, paramedics arrived at Parc and took him to hospital, where he was diagnosed with a twisted bowel. Mr Lawlor initially refused treatment. However, on 4 October, he agreed to surgery. His condition subsequently deteriorated.

10. On 7 October, Mr Lawlor died of septic shock as a result of a bowel obstruction.

Findings

Clinical care

11. The clinical reviewer found that the care that Mr Lawlor received at Parc was equivalent to that which he could have expected to receive in the community. He

said that there was no clear relationship between Mr Lawlor's ongoing symptoms of diarrhoea and a twisted bowel.

12. Mr Lawlor refused to go to hospital for assessment of his medical condition despite staff telling him the risks of not doing so. He refused blood tests and other investigations at the prison.

Use of restraints

13. When Mr Lawlor went to hospital on 3 October, prison staff completed an escort risk assessment which followed the correct process and a senior manager decided that he should be restrained with a single cuff. This was reduced to an escort chain in hospital and appropriately removed before he had surgery.

14. We make no recommendations.

The Investigation Process

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

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

17. Healthcare Inspectorate Wales (HIW) commissioned a clinical reviewer to review Mr Lawlor's clinical care at the prison.

18. We informed HM Coroner for South Wales Central of the investigation. He gave us the cause of death. We have sent the Coroner a copy of this report.

19. The Ombudsman's family liaison officer wrote to Mr Lawlor's nominated next of kin to explain our investigation and to ask if she had any matters that she wanted us to consider. She did not respond.

20. We shared the initial report with the Prison Service. There were two factual inaccuracies and the report has been amended accordingly.

Background Information

HMP Parc

21. HMP Parc is a medium security private prison run by G4S. It holds around 1,600 prisoners and young adults who are either on remand or convicted. It also has a unit for around 60 young people under 18.

22. G4S Medical Services provide primary physical and mental health care services. There is 24-hour general healthcare and palliative care facilities. A local GP practice provides GP services, including a daily clinic and out-of-hours cover. Three healthcare staff are located in the prison at night.

HM Inspectorate of Prisons

23. The most recent inspection of Parc was in November 2019, but the findings have not yet been published. The previous inspection was in January 2016. Inspectors found that significant chronic recruitment and retention problems affected secondary health screening. They noted that significantly fewer prisoners than in comparable prisons found that the quality of health provision was good. Inspectors noted that support for prisoners with complex health needs, including life-long conditions, was generally good.

Independent Monitoring Board

24. 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 February 2019, the IMB was concerned with the number of violent incidents, substance misuse and acts of self-harm. They were pleased that the key worker programme was being rapidly rolled out across the prison. The IMB was pleased that the healthcare department had reduced numbers of prisoners not attending clinical appointments. They were very concerned about the lack of secondary psychiatric care, particularly for elderly prisoners.

Previous deaths at HMP Parc

25. Mr Lawlor was the sixteenth prisoner to die at Parc since October 2017. Eight of the previous deaths were from natural causes, five were drug-related and two were self-inflicted. There were no significant similarities between the circumstances of Mr Lawlor's death and the previous deaths.

Key Events

26. On 30 October 2007, Mr Frederick Lawlor was given a life sentence for murder. He served time at a number of prisons before he was transferred to HMP Parc on 24 February 2015.

27. At his initial health screen, a nurse noted that Mr Lawlor appeared fit and well but that he had had a mini-stroke in 2007. At his second health screen, a nurse noted that Mr Lawlor had had two hernias in 2007 and that his mother and brother had had cancer.

28. On 22 November 2017, Mr Lawlor saw a prison GP because he had had diarrhoea for four to five weeks. Mr Lawlor said that he was not passing blood, did not have abdominal pain or weight loss but felt weak. He said that he did not like having blood tests which he said he had refused in the past and that he had not had a bowel cancer screen in the community. She noted that Mr Lawlor's abdomen was soft but not tender or swollen. Even though she said that altered bowel habits could be a sign of bowel cancer, Mr Lawlor did not want to be referred to hospital for investigations. She planned to wait for the result of a stool sample and a trial of diarrhoea medication which she gave him.

29. On 11 December, a prison GP saw Mr Lawlor who still had diarrhoea. The GP told him that he could miss a life-threatening diagnosis of cancer because he would not go to hospital for tests. Mr Lawlor agreed to go to hospital for tests if his condition did not improve after a further two weeks of diarrhoea medication.

30. On 17 January 2018, Mr Lawlor saw a pharmacist because he still had diarrhoea. Mr Lawlor said that he had irritable bowel syndrome. She prescribed him more diarrhoea medication and referred him to the primary care mental health team because he said that he had anxiety.

31. On 8 March, Mr Lawlor saw the pharmacist and told her that his anxiety was better, that his irritable bowel had settled and that he now used diarrhoea medication less frequently. She re-prescribed it.

32. On 7 April, a mental health nurse assessed Mr Lawlor and discharged him from the mental health team's caseload.

33. On 4 June, a GP saw Mr Lawlor because he still had diarrhoea. Mr Lawlor again declined a referral to hospital and refused to have blood tests. Mr Lawlor said that he felt his anxiety caused his irritable bowel which he controlled with medication. The GP noted that he looked well, his abdomen was soft, that he had a visible hernia but his abdomen was not tender. The GP agreed to give him more diarrhoea medication but told Mr Lawlor that it was important that he should be referred for further investigation, which he again declined. The GP planned to review Mr Lawlor if his symptoms were not controlled.

34. On 25 February 2019, a healthcare administrator sent a bowel cancer screening kit to Mr Lawlor but he did not complete it.

35. On 6 March, the pharmacist reviewed Mr Lawlor's medication and re-prescribed his diarrhoea medication.

36. On 30 September, Mr Lawlor saw a nurse and told her that he had a swollen abdomen, that he was not eating, that he was drinking only small amounts of fluid and passing small amounts of watery stool. She referred him to see a prison GP.

37. A prison GP saw Mr Lawlor that day. He told her that his abdomen felt bloated, that he was not passing blood and that he had stopped taking his diarrhoea medication because it made him itch. She noted that Mr Lawlor's abdomen was swollen but soft and not tender. Mr Lawlor refused to allow further investigation of his bowel and abdomen and agreed to take a laxative for constipation.

38. On 2 October, a healthcare support worker reviewed Mr Lawlor and noted that he was not in any pain or discomfort from his swollen stomach but that he was still having trouble passing stools. She told Mr Lawlor that if he had any trouble passing a stool, he should speak to the night staff. She gave the night nurse a handover and asked that Mr Lawlor be reviewed that evening. We do not know if a nurse reviewed him that evening.

39. At 6.20pm on 3 October, an officer called a medical emergency code blue because Mr Lawlor was short of breath and was struggling to breathe. A nurse saw Mr Lawlor and took his observations. He had a very low blood oxygen level (89%) and a swollen stomach. She gave him oxygen. Mr Lawlor did not want to go to hospital but she said that she was concerned about his health. Healthcare staff continued to monitor him. At 9.00pm, paramedics arrived at Parc and took Mr Lawlor to hospital.

40. Before he went to hospital, healthcare and prison staff completed an escort risk assessment. A mental health nurse noted that she had no medical objections to the use of restraints and that Mr Lawlor did not have reduced mobility. A security officer noted that Mr Lawlor posed a medium risk to the public, a medium risk of taking a hostage, a medium risk of escape and a medium risk to females and hospital staff. She noted that overall, he was a standard risk of escape. An operational manager recommended that Mr Lawlor should be escorted by two officers, that he should be restrained by a single cuff and that this should be reduced to an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer) for hospital treatment. A senior operational manager authorised that Mr Lawlor should be restrained with a single cuff which should be reduced to an escort chain in hospital.

41. Healthcare staff remained in frequent contact with hospital staff, who told them that Mr Lawlor had been diagnosed with a twisted bowel and was refusing treatment. On 4 October, Mr Lawlor agreed to have surgery.

42. At 4.30pm on 4 October, the Operational Functional Head of Safety authorised that Mr Lawlor's restraints should be removed for his operation. He was not restrained again after the operation.

43. On 7 October, Mr Lawlor died in hospital. A hospital consultant said that he died of septic shock as a result of a bowel obstruction.

Contact with Mr Lawlor's family

44. On 4 October, the Head of Safer Custody appointed a chaplain as the family liaison officer and another chaplain as the deputy family liaison officer.

45. The deputy family liaison officer went to the hospital and saw Mr Lawlor who said that he would like her to telephone his sister (not his nominated next of kin). She telephoned his next of kin, but she did not answer. The following day, she telephoned Mr Lawlor's next of kin but, again, she did not answer.

46. On 7 October, after Mr Lawlor died, the Director of HMP Oakwood told Mr Lawlor's nominated next of kin, who lived in Rochdale, that he had died and offered his condolences.

47. On 8 October, both Mr Lawlor's next of kin separately telephoned the deputy family liaison officer, who offered her condolences.

48. The deputy family liaison officer remained in contact with Mr Lawlor's nominated next of kin. Mr Lawlor's funeral took place on 21 October. The prison contributed to its cost in line with national instructions.

Support for prisoners and staff

49. After Mr Lawlor's death the Head of Compliance and Assurance debriefed the hospital escort staff to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

50. The prison posted notices informing other prisoners of Mr Lawlor'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 Lawlor's death.

Post-mortem report

51. There was no post-mortem examination. A hospital consultant concluded that Mr Lawlor died of septic shock as a result of "sigmoid volvulus (operated)", a twisted bowel obstruction.

Findings

Clinical care

52. The clinical reviewer found that the care that Mr Lawlor received at Parc was equivalent to that which he could have expected to receive in the community. He noted that there was no clear relationship between Mr Lawlor's ongoing diarrhoea and the bowel obstruction which caused his death.

53. Mr Lawlor refused to go to hospital for assessment of his medical condition despite staff warning him on many occasions of the risks of not doing so. He refused blood tests and other investigations at the prison. Even after he went to hospital, Mr Lawlor initially refused surgery and the clinical reviewer noted that this would have led to a deterioration in his condition. He was assessed as having the mental capacity to make these decisions.

54. Mr Lawlor had regular reviews with a pharmacist for his symptoms before further medication was prescribed. When he told a pharmacist that he was anxious, she promptly referred him to the mental health team for assessment.

55. The clinical reviewer has made a number of recommendations about points of detail which the Head of Healthcare will need to address.

Use of restraints

56. When prisoners travel outside of prison, staff complete a risk assessment to determine the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public which must be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk, taking into account factors such as the prisoner's health and mobility.

57. We are satisfied that before Mr Lawlor went to hospital on 3 October, healthcare and prison staff appropriately completed an escort risk assessment. Healthcare staff said that his mobility was not affected by his condition and we are satisfied that, in the circumstances, it was reasonable for him to be restrained with a single cuff on his way to hospital and an escort chain while in hospital for treatment. A prison manager appropriately reviewed the use of restraints on 4 October, and removed them. They were not reapplied.

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