Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Colin Barker a prisoner at HMP Gartree on 8 March 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 Colin Barker died in hospital of pneumonia caused by a stroke on 8 March 2019 while a prisoner at HMP Gartree. He also had chronic obstructive pulmonary disease (COPD), high blood pressure and frailty which contributed to but did not cause his death. He was 74 years old. I offer my condolences to his family and friends.

The clinical reviewer found that the care that Mr Barker received at Gartree after his strokes in December 2017 and February 2019 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 **August 2019**

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Summary

Events

1. On 6 October 2008, Mr Colin Barker was sentenced to life in prison. On 18 December 2008, he was transferred to HMP Gartree.

2. Mr Barker had several complex long-term conditions. He had a history of heart disease, high blood pressure, kidney failure and chronic obstructive pulmonary disease (COPD).

3. Healthcare staff reviewed and treated Mr Barker frequently for his medical conditions. Over time, Mr Barker's health deteriorated. He had three strokes.

4. The first stroke was in May 2015 after heart surgery. The second was on 9 December 2017.

5. On 7 February 2019, Mr Barker appeared unwell and lost the feeling in his arm. A prison GP reviewed him and thought he might have had another stroke. She sent him to hospital, where hospital doctors confirmed that he had had a stroke.

6. Mr Barker's condition deteriorated in hospital and he died on 8 March 2019.

Findings

7. The clinical reviewer concluded that Mr Barker received care after his strokes that was equivalent to that which he could have expected to receive in the community.

8. We are satisfied that prison GPs appropriately referred Mr Barker to hospital to investigate his symptoms. We found that healthcare staff provided a good standard of care and support and that Mr Barker received prompt and responsive primary care. We agree with the clinical reviewer that aspects of his care after December 2017 were positive, such as healthcare staff maintaining contact with him during his long hospital admissions, appointing a named nurse and creating appropriate care plans.

9. The clinical reviewer found that the management of Mr Barker's high blood pressure and the poor provision of inhalers to manage his COPD in the two years before he died were not equivalent to the care he could have expected in the community. These were unlikely to have changed the outcome for Mr Barker, so we do not repeat the clinical reviewer's recommendations here, although the Head of Healthcare will need to address them.

10. We do not make any recommendations.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Gartree 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 Barker's prison and medical records.

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

14. We informed HM Coroner for Leicester City and South District of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

15. One of the Ombudsman's family liaison officers contacted Mr Barker's brother to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond.

16. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Gartree

17. HMP Gartree, which is near Market Harborough in Leicestershire, holds approximately 700 prisoners sentenced to life imprisonment and other indeterminate sentences. MITIE Care and Custody (Health) Ltd provided healthcare until November 2018. The service is now provided by Nottinghamshire Healthcare Foundation Trust. Nursing staff are available 24 hours a day.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Gartree was in November 2017. Inspectors reported that new arrivals received prompt, comprehensive health screening and appropriate onward referrals. Inspectors said that the 24-hour primary care service had a limited range of services. They noted that waiting times for a routine GP appointment were good and emergency slots were allocated daily for patients needing to see a GP urgently.

19. Inspectors found that prison GPs managed long-term conditions because of staff shortages. However, they noted that not all patients with long-term conditions had been identified, and care plans were not always in place to manage chronic conditions such as diabetes and asthma. Inspectors found that administrators managed secondary appointments at a local external hospital well, they sought clinical input when required, and healthcare staff supported the escort risk assessment process.

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 November 2018, the IMB reported that the IMB was very concerned about the provision of healthcare services, particularly mental health services, following the introduction of the new healthcare provider (MITIE) in April 2017. They noted that with the change to a new provider, low and frequently changing staffing levels in the healthcare team were having a serious effect on the level of care offered to prisoners.

Previous deaths at HMP Gartree

21. Mr Barker was the third prisoner to die at HMP Gartree since March 2017, and there has been one death at the prison since Mr Barker's. One of the previous deaths was self-inflicted and the other was from natural causes. The death in April 2019 remains under investigation. There are no similarities between Mr Barker's death and the circumstances of the three previous deaths.

Key Events

22. On 6 October 2008, Mr Colin Barker was sentenced to life imprisonment for murder and sent to HMP Norwich. Mr Barker had several complex medical conditions, including heart disease, high blood pressure, chronic obstructive pulmonary disease (COPD) and kidney failure. He was transferred to HMP Gartree on 18 December 2008.

23. At an initial health screen, a nurse noted that Mr Barker was generally unwell, and needed a lot of medication to manage his conditions. A prison GP prescribed his medication and offered him advice about stopping smoking (which he declined). She arranged for him to have regular reviews in the hypertension clinic.

24. On 8 May 2015, Mr Barker had an urgent heart operation to replace his aortic heart valve. However, after his surgery, he had a stroke. Once his condition stabilised, he returned to Gartree.

25. Healthcare staff monitored Mr Barker's coronary heart disease, and regularly checked his blood pressure. He had COPD reviews annually. As they were concerned about his weight loss, prison GPs prescribed food supplements.

26. On 16 February 2017, Mr Barker told a nurse that he was short of breath. A prison GP examined him and noted that despite using a nebuliser and oxygen, he remained short of breath and was sweating. He described his chest as wheezy. His oxygen saturation level was low (81%). A nurse administered oxygen, which increased his saturation level to 97% (still a little low) and called for an emergency ambulance. Hospital staff noted that Mr Barker's COPD had worsened and discussed his resuscitation plans.

27. Healthcare staff at Gartree continued to monitor him. From April 2017, Mr Barker had high blood pressure (206/117). Healthcare staff discovered that he had not taken any prescribed blood pressure medication for one week but the record was not clear if this was because he chose not to or if there had been problems ordering his medication from the pharmacy. On 6 June, a prison GP prescribed amlodipine to help lower Mr Barker's blood pressure.

28. By September 2017, a prison GP reviewed Mr Barker. He noted that his COPD was stable, that he appropriately had an order in place not to be resuscitated if his heart or breathing stopped, and that his current medication should continue.

29. When a prison GP checked Mr Barker's blood pressure on 29 November, she noted that it was high. She arranged blood tests and represcribed amlodipine.

30. On 9 December, a nurse examined Mr Barker because he said that he was unable to move his left arm. The nurse arranged for an ambulance to take Mr Barker to hospital. Hospital staff diagnosed that he had had a stroke. Healthcare staff from the prison remained in contact with the hospital for updates about Mr Barker's condition and visited him in hospital.

31. Mr Barker returned to Gartree on 7 February 2018. Healthcare staff continued to monitor him frequently. Nurses saw him daily and gave him his medication. A

nurse was appointed as his named nurse and completed a care assessment for nurses to visit him three times a day to help him wash and dress. Another nurse created a falls risk assessment as he was underweight and frail. Another nurse arranged for grab rails to be in his cell to help him walk to the toilet.

2019

32. On 7 February 2019, a nurse examined Mr Barker as he had weakness on his right side and slurred speech. His oxygen saturation level was a little low (93%). He administered oxygen which increased his saturation level to 99% and asked for a prison GP to review him. A prison GP examined Mr Barker and noted that he was unable to move his right arm and fingers. She suspected that he had had a stroke and arranged for an emergency ambulance. Two officers escorted Mr Barker unrestrained to the hospital.

33. On 20 February, hospital staff transferred him to another hospital. Hospital staff treated Mr Barker with intravenous antibiotics, intravenous fluids and oxygen therapy.

34. At the beginning of March, Mr Barker developed a chest infection. Hospital staff treated Mr Barker with antibiotics and steroids. On 5 March, the prison started an application for compassionate release as Mr Barker's prognosis was between three to six months. Staff collated relevant information but his condition deteriorated and he died in hospital on 8 March before a decision was made.

Contact with Mr Barker's family

35. On 7 February 2019, the prison appointed an officer as the family liaison officer and a prison manager as the deputy family liaison officer. The duty manager contacted Mr Barker's brother, who was his nominated next of kin, to let him know that Mr Barker was in hospital after a suspected stroke. He arranged for his brother to visit him. The prison chaplain visited Mr Barker in hospital.

36. When Mr Barker's health deteriorated in hospital, the family liaison officer telephoned Mr Barker's brother on 23 February 2019 to let him know. The family liaison officers maintained regular contact with Mr Barker's brother. They helped arrange family visits and provided updates about his health.

37. When Mr Barker died, the family liaison officer telephoned his brother to break the news and offer her condolences and support by telephone, as previously agreed with them. Gartree arranged and paid for Mr Barker's funeral, which was held on 25 March 2019.

Support for prisoners and staff

38. After Mr Barker's death, the duty manager debriefed the escorting staff to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

39. The prison posted notices informing other prisoners of Mr Barker'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 Barker's death.

Cause of death

40. The Coroner established that Mr Barker had died of pneumonia caused by a stroke. Mr Barker also had COPD, hypertension and frailty which contributed to but did not cause his death.

Findings

41. The clinical reviewer concluded that for the care that Mr Barker received in prison after his strokes in December 2017 and February 2019 was equivalent to that which he could have expected to receive in the community.

42. The clinical reviewer concluded that after Mr Barker's stroke in December 2017, healthcare staff created a comprehensive care package. He had daily nurse and social care visits two or three times a day. Prison GPs prescribed appropriate medication for his cardiovascular disease and COPD. He was very frail and prison GPs prescribed food supplements. He was admitted promptly to hospital when he had his third stroke in February 2019 and there was good communication between healthcare and hospital staff. We agree that healthcare staff provided a good standard of care and support and that Mr Barker received prompt and responsive primary care. We agree that aspects of his care after December 2017 were positive such as healthcare staff maintaining contact with him during his long hospital admissions, appointing a named nurse and creating appropriate care plans.

43. There were two aspects of care which the clinical reviewer found were not equivalent to the community. There were the management of his high blood pressure in the two years before his death and the poor provision of inhalers. The clinical reviewer made two recommendations about these areas but they were unlikely to have changed the outcome for Mr Barker. We do not therefore repeat them here, although the Head of Healthcare will need to address them.

44. The clinical reviewer found that in 2017, the prison GPs did not address Mr Barker's high blood pressure but she could not say definitively that the high blood pressure caused his second stroke as he had other significant risk factors for cardiovascular disease. She said that his care in respect of this aspect was not equivalent to that which he could have expected to receive in the community.

45. The clinical reviewer also said that the pharmacy staff refused to give him inhalers in 2017 to manage his COPD, and there was nothing in his medical record to explain why. The clinical reviewer said that it was unacceptable for someone with serious lung disease not to be given inhalers.

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