

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Smith, a prisoner at HMP Parc, on 24 December 2020

A report by the Prisons and Probation Ombudsman

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*



© Crown copyright, 2022

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 Smith died in hospital of pneumonia on 24 December 2020, while a prisoner at HMP Parc. Mr Smith was 80 years old. I offer my condolences to Mr Smith's family and friends.

The clinical reviewer considered that the overall care Mr Smith received was equivalent to the care he could have expected to receive in the community. However, he was concerned about instances when Mr Smith's care was not timely and appropriate. In particular, the clinical reviewer was concerned that a GP did not assess Mr Smith in person as his health deteriorated in the days before he died, despite nurses' urgent requests.

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

January 2022

Contents

Summary	1
The Investigation Process	2
Background Information	3
Key Events	4
Findings.....	7

Summary

Events

1. In February 2019, Mr Peter Smith was sentenced to 16 years imprisonment for rape and was taken to HMP Parc.
2. Mr Smith had several long-term medical conditions, including high blood pressure, insulin-dependent diabetes and kidney disease, and he had had a stroke, a heart attack and four triple bypasses.
3. He had recurrent falls which were appropriately assessed by the healthcare staff and physiotherapy, and a number of wounds and infections on his legs which were appropriately managed by healthcare nursing staff. He was sent to hospital on occasions to rule out any fractures following falls and for review of his other conditions.
4. On 7 and 14 December 2020, Mr Smith had falls in his cell. When he fell again on 16 December, a nurse asked for a GP review, but this did not take place.
5. On 21 December, a nurse was concerned about Mr Smith's deteriorating condition and asked for an urgent GP review. The GP responded that she could not see Mr Smith in person unless it was an emergency because of the COVID-19 restrictions and requested more tests.
6. On 22 December, the nurse again asked a GP to review Mr Smith because he had a swollen abdomen and was not eating. In response, a GP advised the nurse about treatment options, but did not review Mr Smith in person, as requested.
7. Just after midnight on 24 December, a nurse found Mr Smith collapsed in his cell. She took his observations and started treating his low oxygen and low blood sugars. When his condition deteriorated, she requested an ambulance. Mr Smith was taken to hospital but died at 6.33am.
8. The post-mortem examination confirmed that Mr Smith died of pneumonia with heart disease, bowel disease and peritonitis as contributory factors.

Findings

9. The clinical reviewer found that, overall, the care Mr Smith received at Parc was equivalent to that that he would have expected to receive in the community.
10. However, he was concerned that the prison GPs did not review Mr Smith in person in the days before he died. He considered that such a review would have been beneficial and might have led to an earlier detection of pneumonia or peritonitis.

Recommendations

- The Head of Healthcare should discuss the clinical reviewer's findings with the healthcare team, including GPs, to ensure in person consultations take place when appropriate.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Parc informing them of the investigation and asking anyone with relevant information to contact her.
12. Healthcare Inspectorate Wales commissioned an independent clinical reviewer to review Mr Smith's clinical care at Parc.
13. We informed HM Coroner for Powys, Cardiff and the Vale of Glamorgan District of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
14. The Ombudsman's family liaison officer contacted Mr Smith's wife to explain the investigation and to ask if she had any matters she wanted the investigation to consider. We did not receive a response.
15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Parc

16. HMP Parc is a medium security 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.
17. 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

18. The most recent inspection of Parc was in November 2019. Inspectors found that most health services remained reasonably good, although secondary mental health provision was poor. Many prisoners described access to health services and treatment as being problematic, but Inspectors found an appropriate range of appropriate primary care services, with short waiting times for most, including the GP. Support for patients with long-term conditions had improved as a result of enhanced staffing. Social care arrangements were well established, and good individual support packages were delivered.

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 February 2019, the IMB were concerned about 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. They noted that the healthcare department had reduced non-attendance of prisoners at clinical appointments.

Previous deaths at HMP Parc

20. Mr Smith was the 17th prisoner to die at Parc since December 2018. Ten of the previous deaths were from natural causes, three were drug-related and three were self-inflicted. There were no significant similarities between the circumstances of Mr Smith's death and the previous deaths.

Key Events

21. On 21 February 2019, Mr Peter Smith was sentenced to 16 years imprisonment for rape. He went to HMP Parc and remained there until his death.
22. Mr Smith's initial health screens identified several long-term medical conditions, including high blood pressure, intermittent chest pain, insulin-dependent diabetes and kidney disease. He had previously had a stroke, a heart attack and four triple bypasses.
23. In February and March 2019, two medical emergency codes were called when Mr Smith had chest pain and breathing difficulties. (A medical emergency code indicates a life-threatening emergency and should trigger the control room to call an ambulance immediately and healthcare staff to attend with the appropriate equipment.) Healthcare staff took his observations but concluded he did not need to be taken to hospital.
24. Mr Smith underwent various tests and treatment for cellulitis, falls, diabetes management and anaemia over the following months. He was assessed by social services because of his risk of falls and grab rails and other facilities were installed in his cell. In November, a comprehensive wound care plan was begun as his wounds were not healing and healthcare staff performed wound care two to three times a week for three months until his wounds healed.
25. In February 2020, he was taken to hospital following further falls, but x-rays found no fractures. Later that month he was treated for a lower respiratory tract infection. In May and October, he had scans in hospital for possible deep vein thrombosis, but no issues were found.
26. On 7 October, a medical emergency code was called after Mr Smith was found on the floor of his cell with pain in his left leg. He was taken to hospital but was discharged the same day.
27. On 23 November, Mr Smith was discussed at a Clinically Vulnerable Older Persons meeting. A general decline in health was noted and he was observed not to be eating his meals, but he was able to so with encouragement.

December 2020

28. On 7 December, and again on 14 December, officers found Mr Smith had fallen and was lying on his cell floor. He was taken to hospital both times. The hospital found no fractures on either occasion, and he was taken back to prison.
29. On 16 December, Mr Smith fell again and hit his head on the wall. A nurse found that he did not have a head injury but asked for a GP to review him. There is no record that a GP saw him on this occasion. Later that day, another medical emergency code was called as Mr Smith was complaining of chest pain. A nurse examined him and decided to check him 30 minutes later, but he said that he no longer had any chest pain.
30. On 21 December at 4.33am, a nurse went to Mr Smith's cell for a routine social care check. She was concerned that he was confused, unsteady and his skin was yellow. She used the National Early Warning Score (NEWS2), a tool to

detect acute illness and deterioration, to assess Mr Smith. The score was 2, which meant he was a low clinical risk. However, she asked for the prison GP to review Mr Smith urgently in person because he was unwell, confused and had not been eating or drinking properly.

31. A prison GP responded to the nurse's request, asking for a urine test. A nurse responded to the GP's message, again requesting a face-to-face review because of Mr Smith's deterioration, but the GP replied that patients were not being seen face to face unless it was an emergency. A nurse assessed Mr Smith again later that morning and his condition had improved.
32. The next day, a nurse asked the GP to review Mr Smith because he was not eating, had diarrhoea and a swollen abdomen. The prison GP spoke to the nurse about Mr Smith's symptoms, and suggested an enema, but did not see Mr Smith in person.

Events of 24 December

33. On 24 December at 00.05am, a nurse found Mr Smith on the floor of his cell with an injury to his toe, confused and with limited speech. She could not take Mr Smith's observations, but when she did so at 12.40am, she assessed that he had low temperature and low blood sugar, and his NEWS2 score was 15, which is very high, indicating that he required emergency treatment. He was given oxygen and an ambulance was called at 1.40am. The prison called the Ambulance Service three times to communicate the urgency of Mr Smith's condition.
34. The ambulance arrived at the prison at 4.15am and Mr Smith was transferred to hospital, where he died at 6.33am.

Contact with Mr Smith's family

35. At 5.00am on 24 December, a member of the chaplaincy team was asked to contact Mr Smith's next of kin because he was seriously ill. Mr Smith's wife could not travel to the hospital, but it was agreed that she would be kept updated. Half an hour later, the chaplain told Mr Smith's wife that Mr Smith might only have a couple hours left to live.
36. At around 8.00am, the chaplain notified Mr Smith's wife of his death. The prison chaplaincy kept in touch with Mr Smith's wife and offered continued support.
37. Mr Smith's funeral took place on 27 January 2021. The prison offered to contribute to its cost, in line with guidelines.

Support for prisoners and staff

38. The prison posted notices informing other prisoners of Mr Smith'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 Smith's death.

Post-mortem report

39. A post-mortem examination concluded that Mr Smith died of pneumonia, with heart disease, diverticular disease (a bowel condition which can cause

constipation, diarrhoea and abdominal distention) and peritonitis (infection of the lining of the abdomen) as contributory factors.

Findings

Clinical care

40. The clinical reviewer concluded that, overall, the care of Mr Smith's medical conditions was equivalent to the care he could have expected to receive in the community. However, although the clinical reviewer found that there were many instances of timely and appropriate care, he was concerned that healthcare staff had requested a GP review three times in the days before Mr Smith died, but a GP did not see him in person.
41. The clinical reviewer was particularly concerned that nurses requested an urgent face to face GP review on 21 December and 22 December, which did not take place. The doctor said that GPs were not expected to assess prisoners in person unless it was emergency, due to the need to minimise contact because of COVID-19. However, the clinical reviewer noted that according to the Welsh Government *Prison regime levels and recovery planning for healthcare template* no face-to-face reviews would indicate the highest COVID-19 stage of 5 with Parc being in complete lockdown. He said that at that time Parc was not in stage 5 or complete lockdown. The clinical reviewer considered that a review by a GP would have been beneficial and could possibly have picked up symptoms of pneumonia and peritonitis, both contributory factors in Mr Smith's death.
42. We make the following recommendation:

The Head of Healthcare should discuss the clinical reviewer's findings with the healthcare team, including GPs, to ensure in person consultations take place when appropriate.

**Prisons &
Probation**

Ombudsman
Independent Investigations