Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Blowers, a prisoner at HMP Parc, on 25 December 2020

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 John Blowers died at HMP Parc of a pulmonary embolism in both lungs caused by deep vein thrombosis on 25 December 2020. Mr Blowers was 85 years old. I offer my condolences to Mr Blowers' family and friends.

The clinical reviewer considered that the care Mr Blowers received was the equivalent to that which he could have expected to receive in the community. The clinical reviewer concluded that the circumstances of Mr Blowers' death were neither preventable nor foreseeable.

We found no non-clinical concerns and have not made any 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 **January 2022**

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Summary

Events

1. In July 2018, Mr John Blowers was sentenced to six years imprisonment for sexual offences. He was taken to HMP Parc and remained there until his death.

2. On 3 April 2020, Mr Blowers agreed to shield in line with national Prison Service guidance, because his age made him clinical extremely vulnerable to COVID-19. Staff undertook regular welfare checks.

3. In November, Mr Blowers tested positive for COVID-19 and was admitted to hospital twice for oxygen therapy. He was eventually discharged on 4 December and it was documented that he made a good recovery.

4. When staff unlocked Mr Blowers' cell on 25 December to give him his breakfast, an officer found him unresponsive in bed. The officer called for help, radioed a medical emergency and started cardiopulmonary resuscitation (CPR). Healthcare staff took over CPR until paramedics arrived. Paramedics continued CPR, but confirmed that Mr Blowers had died at 9.46am.

5. The post-mortem examination confirmed that Mr Blowers died of a pulmonary embolism in both lungs, which was caused by deep vein thrombosis in his pelvis.

Findings

6. The clinical reviewer found that Mr Blowers received equivalent care during his time at Parc. He concluded that Mr Blowers' death could not have reasonably been foreseen or prevented by staff at the prison.

7. We make no recommendations.

The Investigation Process

8. 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.

9. Healthcare Inspectorate Wales commissioned an independent clinical reviewer to review Mr Blowers' clinical care at Parc.

10. We informed HM Coroner for Powys, Cardiff and the Vale of Glamorgan District (Wales) of the investigation. He gave us the cause of death. We have sent the coroner a copy of this report.

11. The Ombudsman's family liaison officer contacted Mr Blowers' husband to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not have any initial questions but asked to receive a copy of this report.

12. Mr Blowers' husband received a copy of the draft report. He pointed out a factual inaccuracy. This report has been amended accordingly. Mr Blowers' husband also raised a number of issues and questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

13. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out a factual inaccuracy and this report has been amended accordingly.

Background Information

HMP Parc

14. 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.

15. 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

16. 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

17. 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

18. Mr Blowers was the 18th prisoner to die at Parc since December 2018. Eleven of the previous deaths were from natural causes, three were drug-related and three were self-inflicted. Since Mr Blowers died, five more prisoners have died at Parc, three of whom died from natural causes. There were no similarities between the findings of this investigation and our other fatal incident investigations.

Key Events

19. On 27 July 2018, Mr John Blowers was sentenced to six years imprisonment for sexual offences and was taken to HMP Parc. He remained there until his death.

20. Mr Blowers was regularly reviewed and treated for issues concerning his leg and mobility. Mr Blowers fell several times in his cell. Healthcare staff carried out a falls risk assessment at appropriate intervals and he was frequently assessed by physiotherapy and nursing staff to manage his risk.

21. On 3 April 2020, Mr Blowers agreed to shield because his age made him clinically extremely vulnerable to COVID-19. In line with Prison Service national guidance, officers regularly checked Mr Blowers' welfare.

22. On 13 November, an officer asked healthcare staff to assess Mr Blowers because he was breathless and confused. Mr Blowers had been in contact with another prisoner who had subsequently tested positive for COVID-19. Mr Blowers was taken to hospital, where he tested positive for COVID-19. Mr Blowers returned to Parc the following day with medication and oxygen. On 17 November, his condition deteriorated and Mr Blowers was taken back to hospital the next morning. He stayed in hospital until 4 December, when he was discharged back to the prison.

23. On 17 December, a physiotherapist recorded that Mr Blowers had recovered his mobility since his admission to hospital, although he still felt breathless occasionally. Later that day, Mr Blowers fell in his cell. A nurse examined him and determined that his NEWS2 score was 0, which meant he was not seriously ill. (NEWS2 is a tool used to detect and monitor acute illness.) On 19 December, Mr Blowers fell out of bed in his cell. A nurse examined him and noted some bruising on his head.

25 December

24. At about 9.00am on 25 December, an officer unlocked Mr Blowers' cell to give him a cooked breakfast. She found Mr Blowers unresponsive in his bed. She called to an officer nearby and radioed a code blue (an emergency code used to describe a prisoner with breathing difficulties). The officers started cardiopulmonary resuscitation (CPR). Healthcare staff got to Mr Blowers' cell promptly and took over CPR. When the ambulance arrived at the prison, paramedics assessed Mr Blowers and continued CPR. However, paramedics confirmed that Mr Blowers had died at 9.46am.

Contact with Mr Blowers' family

25. At about 10.15am on 25 December, a prison chaplain contacted Mr Blowers' husband to notify him of Mr Blowers' death. The prison chaplaincy and family liaison officers maintained regular communication with Mr Blowers' husband to offer support.

26. Mr Blowers' funeral took place on 11 February 2021. The prison offered to contribute to its cost, in line with guidelines.

Support for prisoners and staff

27. The prison posted notices informing other prisoners of Mr Blowers' 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 Blowers' death.

Post-mortem report

28. The post-mortem examination confirmed that Mr Blowers died of a bilateral occlusive pulmonary embolism (a blood clot in both lungs blocking blood flow) caused by deep vein thrombosis in his pelvis.

Findings

Clinical care

29. The clinical reviewer concluded that the clinical care Mr Blowers received was equivalent to the care he could have expected to receive in the community. He considered that neither healthcare nor prison staff could have foreseen or prevented Mr Blowers' death.

30. The clinical reviewer was concerned that staff did not consistently record a full set of observations when Mr Blowers had COVID-19 or after he had fallen in his cell. The clinical reviewer recommended that the prison review emergency protocols, including the provision of emergency drugs, such as oxygen. As the clinical reviewer concluded that none of these recommendations were related to his cause of death or would have affected the outcome for Mr Blowers, we have not repeated them here.

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