Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mark Stewart Park, a prisoner at HMP Northumberland, on 17 August 2021

A report by the Prisons and Probation Ombudsman

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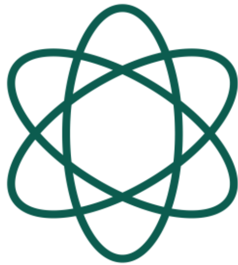
Our vision

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

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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.

The Ombudsman's 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 Mark Stewart Park died on 17 August 2021 of a heart attack while a prisoner at HMP Northumberland. He was 55 years old. I offer my condolences to Mr Park's family and friends.

The clinical reviewer concluded that the healthcare Mr Park received at Northumberland was not equivalent to that which he could have expected to receive in the community.

She was concerned that although healthcare staff noted when Mr Park arrived at Northumberland in August 2018, that he had been previously diagnosed with high blood pressure, it was not until July 2020 that he was referred to a clinic for prisoners with long-term health conditions. She was also concerned that it was not until July 2021, that a care plan was created to manage Mr Park's high blood pressure.

I am concerned that on the night of Mr Park's death, prison staff did not radio a medical emergency code immediately to indicate that Mr Park was having chest pains and breathing difficulties. As a result, there was a 15-minute delay in control room staff calling an emergency ambulance. We cannot say if this affected the outcome for him.

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

Elizabeth Moody
Deputy Prisons and Probation Ombudsman **February 2022**

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Summary

Events

1. In June 2000, Mr Mark Stewart Park was remanded to prison charged with sexual offences and was subsequently sentenced to life imprisonment.

2. Mr Park transferred to HMP Northumberland in September 2018. At his initial health screen, healthcare staff noted that he had been previously diagnosed with a number of conditions including anxiety, depression and hypertension (high blood pressure) for which he was prescribed medication. He was not referred to the prison's long-term clinic to manage his hypertension and he did not have a secondary health screen.

3. In July 2020, Mr Park was referred to the prison's long-term clinic. Following the referral, a nurse saw him in July 2021 to review his high blood pressure and a care plan was created to manage his condition.

4. At 8.40pm on 17 August, Mr Park pressed his emergency cell bell. He told a night patrol officer that he was experiencing chest pains and shortness of breath. The night patrol officer left the cell and used a telephone in the wing office to summon help. Other staff attended and radioed the night orderly officer to inform him that Mr Park needed medical attention. An ambulance was called 8.56pm.

5. Paramedics arrived at 9.08pm and Mr Park was taken to hospital by emergency ambulance at 9.50pm. Shortly after his arrival at the hospital, Mr Park had a heart attack. At 11.00pm, it was confirmed that Mr Park had died.

6. The post-mortem report gave Mr Park's cause of death as a heart attack caused by coronary thrombosis (a blood clot in the heart), with hypertension as a contributory factor.

Findings

7. The clinical reviewer concluded that the clinical care Mr Park received at Northumberland was not of an acceptable standard and not equivalent to that which he could have expected to receive in the community.

8. She was concerned that despite healthcare staff at Northumberland recording in September 2018 that Mr Park had been previously diagnosed with high blood pressure, they did not make a referral to the prison's long-term clinic to manage his condition. There is also no evidence to indicate that Mr Park had a secondary health screen.

9. It was not until July 2020 that Mr Park was referred to the long-term clinic for review, and he was not seen until July 2021, at which point a care plan for his high blood pressure was created.

10. The clinical reviewer considered that as a result of these omissions between September 2018 and July 2021, healthcare staff failed to identify that Mr Park was potentially at high risk of cardiovascular disease and that this was a missed opportunity to put prevention strategies in place.

11. We are concerned that staff did not use a medical emergency code when Mr Park complained of chest pain and shortness of breath on 17 August. As a result, there was a 15-minute delay in calling an ambulance.

Recommendations

- The Head of Healthcare should review the system of referrals to long-term conditions clinics and ensure these are implemented and completed in line with NICE clinical guidance.
- The Head of Healthcare should ensure that processes are in place for all prisoners to have a secondary reception/transfer screen and to allow for appropriate long-term planning for prisoners, in line with NICE guidance NG 57.
- The Head of Healthcare should ensure that healthcare staff initiate care plans in a timely manner following identification of a health need to allow for timely individualised care.
- The Director should ensure that all prison staff understand their responsibilities during medical emergencies and ensure staff use an emergency medical code promptly to communicate the nature of an emergency effectively.
- The Director should ensure that a copy of this report is shared with the staff named in this report and that a senior manager discusses the Ombudsman’s findings with them.

The Investigation Process

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

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

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

15. We informed HM Coroner for Northumberland North of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

16. Mr Park's next of kin, his brother, received a copy of the initial report. He did not raise any further issues, or comment on the factual accuracy of the report.

17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Northumberland

18. HMP Northumberland is a Category C training prison that holds up to 1,348 men and is managed by Sodexo Justice Services. Spectrum Community Health CIC provide the healthcare services. Healthcare staff are on duty on Monday - Thursday from 7.30am to 7.30pm and on Fridays from 7.30am to 6.00pm. They are also on duty at weekends and on Bank Holidays from 8.00am to 6.00pm. Northern Doctors Urgent Care provide an out-of-hours service at other times.

HM Inspectorate of Prisons (HMIP)

19. The most recent full inspection of HMP Northumberland was in August 2017. Inspectors criticised many aspects of the prison but noted the Director's determination and leadership in making improvements.

20. Inspectors found that agency staff were regularly used in the healthcare department to cover vacancies and the nursing team struggled to achieve their core functions. Despite this, most healthcare needs were met. Inspectors reported that a nurse completed an initial health assessment with all new arrivals in reception. An appropriate range of healthcare services was delivered, and prisoners requested services through the electronic kiosk system. Waiting times were reasonable. Nurse-led clinics were limited, but a dedicated chronic disease management nurse led on the identification and management of prisoners with long-term conditions. Care planning for these patients was in the early stages of development.

21. In September 2020, HMIP carried out a Scrutiny Visit (a shortened inspection during the COVID-19 pandemic). Inspectors found that the healthcare department had responded well to the pandemic situation, maintaining all essential processes in spite of staffing problems.

Independent Monitoring Board

22. 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 report for the year to December 2020, the IMB considered that prisoners' health and well-being needs were well met, and that since Spectrum took over the provision of healthcare services in April 2020, there had been a more cohesive approach to the delivery of healthcare services. The IMB were also pleased to note the implementation of medical provision on the residential house blocks.

Previous deaths at HMP Northumberland

23. Mr Park was the eighth prisoner to die at Northumberland since August 2019. Of the previous deaths, four were from natural causes and three were self-inflicted. There have been two further deaths at Northumberland since Mr Park's death, one self-inflicted and one which is awaiting classification.

24. In a previous investigation into a death at Northumberland in 2017, we were concerned about the failure to use medical emergency codes. We recommended that the Director ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including that staff know when to enter a cell, and that staff promptly use an emergency code to effectively communicate the nature of an emergency so there are no delays in calling an ambulance.

25. The prison accepted our recommendation and said that the night operating procedures had been updated and circulated to all night staff. All night patrol staff had been given additional training about the need to enter a cell as quickly as possible in potentially life threatening situations and that staff may enter a cell on their own. The training also made it clear that this was subject to staff undertaking a dynamic risk assessment and the member of staff calling for assistance, via the radio, giving their exact location.

26. A revised staff notice about emergency codes was also published. The notice included a reminder of the urgent actions that staff should take to ensure that the nature of the medical emergency was communicated effectively to prevent delays in calling an ambulance. The prison told us that the notice would be re-issued twice a year.

Key Events

27. On 9 June 2000, Mr Mark Stewart Park was remanded to HMP Durham charged with sexual offences. On 9 November, Mr Park was sentenced to life imprisonment. He transferred to HMP Frankland in June 2009.

HMP Frankland

28. Mr Park had been previously diagnosed with anxiety, depression, reflux and psoriasis. He was also noted to be a heavy smoker. Despite repeated efforts by healthcare staff, he consistently refused smoking cessation advice.

29. In November 2009, a nurse saw Mr Park after he complained of feeling unwell while exercising in the prison gym. The nurse took his observations and noted that his blood pressure was high. The nurse considered that the episode of raised blood pressure might have been brought about through overexertion. Mr Park was subject to regular ongoing blood pressure monitoring after this.

30. In April 2012, a nurse saw Mr Park after he complained of a severe headache and a bloodshot right eye. She took his blood pressure, and it was dangerously high. Mr Park was taken to hospital by emergency ambulance for further review and treatment.

31. While in hospital, Mr Park was diagnosed with hypertension (high blood pressure). He was admitted as an inpatient for observation. He was prescribed amlodipine (used to treat high blood pressure) and discharged back to Frankland. Following his discharge from hospital, he was prescribed lisinopril (for high blood pressure) and was subject to blood pressure monitoring, although not regularly.

32. Mr Park had little significant contact with healthcare staff over the years that followed.

HMP Northumberland

33. In September 2018, Mr Park transferred to HMP Northumberland.

34. A nurse carried out an initial health screen and a prison GP saw Mr Park two days later. Mr Park disclosed that he had various health conditions, including hypertension. They took his blood pressure, which was within a normal range. There is no evidence in Mr Park's medical records to indicate he was referred for any ongoing blood pressure checks or to the prison's long-term clinic to manage his hypertension. No secondary health screen took place.

35. Following blood tests in November and December 2018, a prison GP requested that Mr Park be seen by a nurse to discuss a low cholesterol diet as his lipid levels were recorded as borderline. This request was completed on 28 December 2018. There is no record of any follow up and Mr Park had no further significant contact with healthcare staff over the next 18 months.

36. On 27 July 2020, a nurse identified that there had been no follow up in relation to Mr Park's hypertension and referred him to the prison's long-term conditions clinic for a high blood pressure review.

37. Mr Park was not seen until 27 July 2021, when he was reviewed by a long-term conditions nurse. She took his blood pressure, which was in the normal range, and created a blood pressure care plan. The care plan said that if Mr Park's blood pressure was recorded as being higher than 140mmHg, then his blood pressure should be checked on two further occasions. If the reading remained high, he would need to go to hospital.

Events of 17 August 2021

38. At 8.40pm on 17 August, Mr Park pressed his emergency cell bell. An Operational Support Officer (OSO), the night patrol officer, responded immediately. Mr Park told him that he was experiencing chest pains, was short of breath and felt generally unwell. The OSO noted that Mr Park was alert and able to talk normally.

39. The OSO left Mr Park's cell and went to the wing office to telephone a Senior Prison Custody Officer (SCPO), the Night Orderly Officer, to inform him of Mr Park's condition. The SCPO used his radio and asked night staff to go to Mr Park's cell.

40. At approximately 8.50pm, two Prison Custody Officers (PCOs) entered Mr Park's cell and saw that he was pale in colour, sweating heavily, short of breath and feeling nauseous. One PCO used her radio to inform the SPCO that Mr Park was very unwell and would an ambulance. Mr Park told the PCO that he was going to be sick. She handed him a glass of water and noted that he had blood in his mouth. She asked him how long he had felt unwell, and he told her he had felt unwell while in the visits hall four days earlier. (There is no record of this.)

41. At 8.56pm, prison control room staff telephoned for an ambulance. The ambulance arrived at 9.08pm and the paramedics were taken to Mr Park's cell. They assessed him and considered he was extremely unwell and needed to go to hospital. They fitted a heart monitor to his chest and left the prison at 9.50pm.

42. While en route to Northumbria Specialist Emergency Care Hospital, Mr Park's condition deteriorated. Paramedics decided to divert to Freeman Hospital, Newcastle. When they arrived at Freeman Hospital, Mr Park was taken to the coronary care unit to undergo an emergency surgical procedure. While being prepared for surgery, Mr Park had a heart attack.

43. Hospital staff attempted CPR (cardiopulmonary resuscitation) but were unable to revive Mr Park. At 11.00pm, a hospital doctor confirmed that Mr Park had died.

Contact with Mr Park's Family

44. Following Mr Park's emergency admission to hospital on 17 August, the prison appointed a Family Liaison Officer (FLO).

45. Before the FLO could contact Mr Park's next of kin, the local police had visited him at his home address. She contacted Mr Park's next of kin by telephone the following day and remained in contact with him, offering him support and information.

Support for prisoners and staff

46. After Mr Park's death, a prison manager debriefed the staff who were involved giving them the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

47. The prison posted notices informing other prisoners of Mr Park'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 his death.

Post-mortem report

48. The post-mortem report gave Mr Park's cause of death as acute myocardial infarction (heart attack) caused by coronary thrombosis (a blood clot in the heart). Mr Park also had hypertension (high blood pressure), which did not cause but contributed to his death.

Findings

Clinical care

49. The clinical reviewer concluded that the care Mr Park received at Northumberland was not of an acceptable standard and not equivalent to that which he could have expected to receive in the community.

50. She was concerned that despite healthcare staff noting Mr Park's diagnosis of high blood pressure during his initial health screen in September 2018, they failed to refer him to the prison's long-term conditions clinic for ongoing management of his condition.

51. The clinical reviewer was also concerned that, following Mr Park's initial health screen at Northumberland, there is no evidence that he had a secondary health screen. This is contrary to the National Institute for Health and Care Excellence (NICE) guidance NG57, which recommends that a healthcare professional should carry out a second stage health assessment on every person received into a prison within seven days of their arrival. The clinical reviewer said that this should have been an opportunity to identify the initial failure to refer Mr Park to the long-term conditions clinic.

52. The clinical reviewer was also concerned that it was not until July 2020, following a review by a prison nurse, that a referral to the long-term clinic was made, despite the fact that Mr Park had continued to be prescribed medication for high blood pressure during this two-year period.

53. The Head of Healthcare told us that hypertension long-term clinics were considered to be non-urgent during the COVID-19 pandemic and were paused during this time. As a result, Mr Park was not reviewed by the long-term clinic until July 2021, when a blood pressure care plan was created.

54. The clinical reviewer accepted that the difficulties caused by the COVID-19 restrictions explained the delay between the referral in July 2020 and the review in July 2021. However, she said that this did not explain the lack of monitoring and reviews between September 2018 and July 2020. She said that Mr Park had a medical history of high blood pressure and should, therefore, have been reviewed in line with clinical guidance following his transfer to HMP Northumberland. She concluded that the failure to monitor Mr Park's hypertension between September 2018 and July 2021 meant that his risk of cardiovascular disease was not assessed, he was given limited preventative advice and no statin medication was considered. She said that this increased his risk of cardiovascular disease.

55. We recommend:

The Head of Healthcare should review the system of referrals to long-term conditions clinics and ensure these are implemented and completed in line with NICE clinical guidance.

The Head of Healthcare should ensure that all prisoners have a secondary reception/transfer screen to allow for appropriate long-term planning for prisoners, in line with NICE guidance NG 57.

The Head of Healthcare should ensure that healthcare staff initiate care plans in a timely manner following identification of a health need to allow for timely individualised care.

Emergency response

56. Prison Service Instruction (PSI) 03/2013 requires prisons to have a medical emergency response code protocol which ensures that healthcare staff are alerted, and an ambulance is called automatically in a life-threatening emergency. It says that all prison staff must be made aware of and understand the protocol and their responsibilities during medical emergencies, and that local procedures must ensure that staff understand they should not delay summoning emergency assistance. For example, it must not be a requirement for a member of the prison healthcare team or a Duty Manager to attend the scene before emergency services are called. The PSI emphasises that it is essential that an ambulance is called in all cases where there are serious concerns about the health of a prisoner and that if staff are in any doubt about the nature of the situation, they must call an ambulance as it is better to act with caution and request an ambulance that can be cancelled if it is later assessed as not required.

57. Northumberland's local emergency response protocol says that when a member of staff on scene discovers a potentially life-threatening medical emergency, they must call the appropriate emergency code red or code blue.

58. When the OSO responded to Mr Park's emergency cell bell on 17 August, Mr Park had chest pain and was short of breath. The OSO left the cell to use the telephone in the wing office to alert the Night Orderly Officer. We consider that he should have used his radio to call a code blue as soon as Mr Park told him he was experiencing chest pains.

59. When other officers arrived, a PCO used her radio to inform the Night Orderly Officer that Mr Park was very unwell and would need an ambulance. We consider that she or one of her colleagues should have used their radio to call a code blue as soon as they realised how ill Mr Park was.

60. Calling a code blue would have automatically alerted the prison control room to call an ambulance. As it was, control room staff were not asked to call an emergency ambulance until 8.56pm, a delay of 16 minutes after the OSO first responded to the emergency cell bell.

61. We cannot say if this delay made a difference to the outcome for Mr Park, but we do know that a delay of even a minute can make a critical difference in a medical emergency. We make the following recommendations:

    The Director should ensure that all prison staff understand their responsibilities during medical emergencies and ensure staff use an emergency medical code promptly to communicate the nature of an emergency effectively.

    The Director should ensure that a copy of this report is shared with the staff named in this report and that a senior manager discusses the Ombudsman's findings with them.

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