Prisons &
Probation
Ombudsman
Independent Investigations

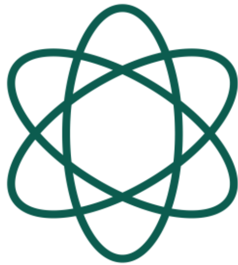
Independent investigation into the death of Mr Joseph Purcell, a prisoner at HMP Long Lartin, on 11 November 2021

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100

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.

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 Joseph Purcell died in hospital of sepsis on 11 November 2021, while a prisoner at HMP Long Lartin. He was 55 years old. I offer my condolences to Mr Purcell's family and friends.

Mr Purcell had advanced liver failure and had been in poor health for several months before he died. The clinical reviewer found that the care provided to Mr Purcell at Long Lartin was equivalent to that he could have expected to receive in the community.

However, the clinical reviewer was concerned that Mr Purcell was not taken to hospital on the evening of 10 October. A nurse told the Night Orderly Officer, who was in charge of the prison at that time, that Mr Purcell needed to go to hospital, but she decided not to send him because earlier that day ambulance paramedics had said there was nothing the hospital could do. Mr Purcell was sent to hospital by emergency ambulance the next morning.

I have recommended that the Governor and Head of Healthcare review the reasons for the decision not to send Mr Purcell to hospital on the evening of 10 October, and that they ensure staff know how to escalate concerns where healthcare staff and prison staff disagree on whether a prisoner should be sent to hospital.

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
Acting Prisons and Probation Ombudsman **May 2022**

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Summary

Events

1. In March 2019, Mr Joseph Purcell was convicted of grievous bodily harm with intent and sentenced to 14 years in prison. On 18 April 2019, he was moved to HMP Long Lartin.

2. In February 2021, Mr Purcell, who already had pancreatitis (inflamed pancreas), was diagnosed with advanced liver failure and told he was unlikely to recover.

3. On 4 October, a prison GP told Mr Purcell he had weeks to months left to live.

4. On the morning of 10 October, a prison nurse requested an ambulance, as Mr Purcell said he was in extreme pain and that medication was not helping. Paramedics attended and assessed that a hospital could not offer any additional support with pain relief, so Mr Purcell remained at the prison.

5. That evening, a nurse found Mr Purcell on his cell floor. Staff helped him back to bed. The nurse took Mr Purcell's clinical observations but could not get a blood oxygen reading. She spoke with an out of hours GP on the phone, who said Mr Purcell needed to go to hospital and she then told the Night Orderly Officer (the most senior officer in the prison at that time).

6. The Night Orderly Officer was reluctant to call for an ambulance as she was aware of the events of earlier that day. She spoke to the Duty Governor, who agreed that an ambulance should not be called. The nurse tried calling the Head of Healthcare for advice but could not get an answer. Mr Purcell remained at the prison. His cell door was left unlocked, and an officer sat with him.

7. On the morning of 11 October, prison nurses completed observations on Mr Purcell. He struggled to respond to questions asked, had a weak pulse and a low blood oxygen level. A nurse requested an emergency ambulance and Mr Purcell was taken to hospital.

8. Mr Purcell's condition continued to deteriorate, and he died in hospital on 11 November.

9. The post-mortem concluded that Mr Purcell died of sepsis, caused by an abdominal infection, pancreatitis and bronchopneumonia (lung infection).

Findings

10. The clinical reviewer found that the care Mr Purcell received at Long Lartin was of a good standard and was equivalent to that which he could have expected to receive in the community.

11. However, she was concerned that Mr Purcell was not taken to hospital on the evening of 10 October. We are concerned that the Night Orderly Officer and Duty Governor took this decision without consulting with senior healthcare staff, and that the nurse was unclear about how to escalate the matter.

12. The clinical reviewer found that healthcare staff did not document Mr Purcell's reading and writing difficulties as a clinical concern until late into his time at Long Lartin.

Recommendations

- The Governor and Head of Healthcare should:
    - Review the reasons for the decision not to send Mr Purcell to hospital and ensure that respective roles and responsibilities in the decision-making process are properly understood and communicated.
    - Ensure that both prison and healthcare staff are aware of the senior healthcare staff on duty at night to discuss or escalate concerns.
- The Head of Healthcare should ensure staff clearly document reading and writing difficulties as a clinical concern in medical records.

The Investigation Process

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

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

15. NHS England commissioned an independent clinical reviewer to review Mr Purcell's clinical care at Long Lartin.

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

17. The investigator interviewed one member of staff from Stafford on 3 February 2022.

18. The Ombudsman's family liaison officer contacted Mr Purcell's next of kin, his wife, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She had questions about Mr Purcell's health, how this was managed in prison, the use of restraints and about the amount the prison contributed towards Mr Purcell's funeral. These have been addressed in this report and in the clinical review.

19. Mr Purcell's family received a copy of the draft report. They did not make any comments.

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

Background Information

HMP Long Lartin

21. HMP Long Lartin is a high security prison in the Vale of Evesham, Worcestershire. It holds up to 609 men across five main wings and two support wings. All prisoners live in single cells. Practice Plus Group provides the healthcare services at the prison.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Long Lartin was in January 2018. Inspectors reported that Long Lartin was a well-run prison, where prisoners generally spoke positively about staff members. They also reported healthcare staff provided a well-run service which was accessible to prisoners. The inspectors described the food as reasonable and portion sizes as adequate.

Independent Monitoring Board

23. 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 December 2020, the IMB reported that Long Lartin was a safe prison and overall, prisoners were treated fairly and humanely, and health and wellbeing needs of prisoners were met, despite the difficulties they faced as a result of the COVID-19 pandemic.

Previous deaths at HMP Long Lartin

24. Mr Purcell was the eighth prisoner to die at Long Lartin since November 2019. Of the previous deaths, six were from natural causes and one was self-inflicted. There are no similarities between our findings in the investigation into Mr Purcell’s death and our investigation findings for the previous deaths.

Key Events

25. In March 2019, Mr Joseph Purcell was convicted of grievous bodily harm with intent and sentenced to 14 years in prison. On 18 April 2019, he was moved to HMP Long Lartin.

26. Before going to prison, Mr Purcell had been diagnosed with chronic pancreatitis (inflamed pancreas) and type 2 diabetes.

27. On 6 February 2021, a prison nurse saw Mr Purcell due to a recent deterioration in his health and his swollen legs and abdomen. Mr Purcell was taken to hospital where he was diagnosed with advanced liver failure (a life limiting condition associated with pancreatitis). He returned to Long Lartin on 24 February.

28. On 1 March, a prison GP told Mr Purcell he was unlikely to recover as he was too weak to undergo a liver transplant.

29. Between March and October, Mr Purcell's health continued to deteriorate.

30. On 4 October, a prison GP told Mr Purcell he had weeks to months left to live. Staff discussed with Mr Purcell his wishes for his end of life care, and he agreed that the focus should be on symptom control and keeping him comfortable. He said he wanted to stay in his cell on the wing where he had friends and only wanted to go to hospital for life-saving treatment.

31. However, on 6 October, after a fall, Mr Purcell agreed that he was struggling on the wing and he was moved to the healthcare unit for additional support with his care.

32. On the morning of 10 October, a prison nurse requested an ambulance, as Mr Purcell said he was in extreme pain and that medication was not helping. Paramedics attended and assessed that a hospital could not offer any additional support with pain relief, so Mr Purcell remained at the prison. The prison nurse arranged for the prison GP to review Mr Purcell's pain relief the following day.

33. At around 10.00pm that night, a nurse noticed that Mr Purcell was on the floor of his cell. She called for staff to help her move Mr Purcell and the Night Orderly Officer (NOO) (the most senior officer, who was in charge of the prison at that time), and other officers, helped her get him back into bed. Mr Purcell told the NOO that he had got out of bed but then could not get back in. The nurse took Mr Purcell's clinical observations but was unable to get a blood oxygen level reading. She called the out of hours GP, who said Mr Purcell needed to go to hospital. She asked the NOO to arrange a transfer to hospital.

34. The NOO told the investigator that she was aware an ambulance had been called for Mr Purcell earlier that day, and that the paramedics had not taken him to hospital because there was nothing further the hospital could do. She said the nurse did not say it was an emergency.

35. The NOO phoned the Duty Governor, who said Mr Purcell should not be taken to hospital. She told the nurse that she was not going to send Mr Purcell to hospital. She agreed for Mr Purcell's cell door to stay open and for a prison officer to sit with him, to support him and monitor his condition.

36. The nurse told the investigator that she tried to call the Head of Healthcare but did not get an answer. The Head of Healthcare told the investigator that there was an on-call manager who would take calls during the night and who should have been contacted.

37. On 11 October, prison nurses completed observations on Mr Purcell. He struggled to respond when asked questions, had a weak pulse and a low blood oxygen saturation level. A nurse requested an emergency ambulance, and he was taken to hospital. The same day, the prison started an application for Mr Purcell's release on compassionate grounds.

38. On 12 October, the hospital told the prison that Mr Purcell was being treated for sepsis. The prison contacted the hospital for regular updates.

39. On 27 October, a prison nurse contacted the hospital for an update on Mr Purcell's care and to get a prognosis for the compassionate release application. She noted that a hospital consultant had advised that Mr Purcell might have more than three months left to live following recent improvements in his condition. She also noted that a hospital nurse told her that Mr Purcell's behaviour had deteriorated, and he had thrown a cup of water over a nurse. As a result, prison officers restrained Mr Purcell. The following day, Mr Purcell's health worsened, and officers removed the restraints.

40. The prison GP made several attempts to contact a hospital consultant for a formal report on how long Mr Purcell had left to live, to use in his application for compassionate release. The hospital later said they could not provide this for medico-legal reasons. As a result, the prison could not complete Mr Purcell's application for compassionate release.

41. On 10 November, prison nurses visited Mr Purcell in hospital. A hospital consultant told them he was being treated for pneumonia and a bacterial infection in his stomach.

42. Mr Purcell died in hospital at 6.07am on 11 November.

Contact with Mr Purcell's family

43. On 7 October 2021, the prison appointed a family liaison officer (FLO).

44. At 9.30am on 11 October 2021, the FLO spoke with Mr Purcell's family at the hospital following his death.

45. The prison contributed financially to Mr Purcell's funeral in line with national guidance.

Support for prisoners and staff

46. After Mr Purcell's death, a Duty Governor debriefed one of the officers who was at the hospital supervising Mr Purcell. Prison staff debriefed the other officer supervising Mr Purcell the following day when he arrived in work, to ensure they both had 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 Purcell's death and offering support.

Post-mortem report

48. The post-mortem concluded that Mr Purcell died of sepsis, caused by spontaneous bacterial peritonitis (infection within abdomen), acute on chronic pancreatitis and bronchopneumonia (lung infection). He also had alcoholic hepatic (liver) cirrhosis and malnutrition, which did not cause but contributed to his death.

Findings

Clinical care

49. The clinical reviewer concluded that the care Mr Purcell received was of a good standard and was at least equivalent to that which he could have expected to receive in the community. However, she had several concerns.

Failure to call an ambulance on the evening of 10 October

50. Given the events on the morning of 10 October, when ambulance paramedics refused to take Mr Purcell to hospital because they said there was nothing the hospital could do for him, we can understand why the NOO was reluctant to call for an ambulance when the nurse told her that evening that Mr Purcell needed to go to hospital. The NOO sought advice from the Duty Governor, who agreed that Mr Purcell should not be sent out. We are concerned, however, that this decision was taken without consulting senior healthcare staff.

51. We also found that the nurse was unclear on the escalation process. She tried to contact the Head of Healthcare when she should have contacted the on-call manager. We recommend:

The Governor and Head of Healthcare should:

- **Review the reasons for the decision not to send Mr Purcell to hospital and ensure that respective roles and responsibilities in the decision-making process are properly understood and communicated.**
- **Ensure both prison and healthcare staff are aware of the senior healthcare staff on duty at night to discuss or escalate concerns.**

Recording literacy concerns in medical notes

52. The reviewer also found that healthcare staff were aware of Mr Purcell's reading and writing difficulties, but healthcare staff did not record this as a clinical concern until late into his time at Long Lartin. We recommend:

The Head of Healthcare should ensure staff clearly document reading and writing difficulties as a clinical concern in medical records.

Mr Purcell's diet and nutrition

53. Mr Purcell's family raised concerns about his malnutrition. The clinical reviewer noted that malnutrition is an unfortunate consequence of pancreatitis and liver failure, which was accentuated by Mr Purcell refusing to follow guidance given by health professionals. The clinical reviewer found that Mr Purcell had a nutritional care plan and that he was encouraged to eat and drink regularly. Kitchen staff visited him daily to discuss the foods available that he could eat (as he wrongly believed he was gluten intolerant). He was also prescribed nutritional supplements and had several consultations with a dietician. The clinical reviewer had no concerns with this aspect of Mr Purcell's care.

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