

**Prisons &
Probation**

Ombudsman
Independent Investigations

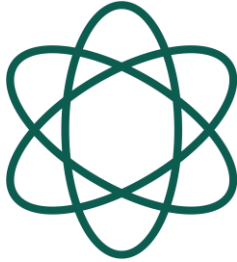
Independent investigation into the death of Mr David Price, a prisoner at HMP Garth, on 12 August 2022

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

OGL

© Crown copyright, 2023

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.

Summary

1. 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.
2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr David Price, who was 80 years old, died of pneumonia and metastatic lung cancer (cancer that has spread to other areas of the body), on 12 August 2022, while a prisoner at HMP Garth. We offer our condolences to Mr Price's family and friends.
4. The clinical reviewer concluded that the care Mr Price received at Garth was not of a required standard, and therefore not equivalent to that which would have been received in the wider community.
5. The clinical reviewer has made a number of recommendations, which we repeat below, in relation to the use of NEWS2 scores, communication between healthcare staff, the monitoring of secondary care referrals, the timeliness of reviewing blood test results, the reconciliation of a prisoner's prescribed medications when they arrive at Garth and the lack of follow up to prisoners who do not attend appointments with healthcare staff.
6. We did not find any non-clinical issues of concern.

Recommendations

- The Head of Healthcare should ensure that all staff are competent in the use of the NEWS2 assessment. This will ensure that patients who are deteriorating, or at risk of deteriorating, will have a timely initial assessment by a competent clinical decision maker.
- The Head of Healthcare should ensure that when an instruction to monitor a patient is made by a healthcare professional, the instruction is clearly communicated to the healthcare staff responsible and that outcomes are documented. This will ensure continuity of care and prompt recognition of a deteriorating patient.
- The Head of Healthcare should review the current process for monitoring secondary care referrals. This will ensure that the process is effective and that it is embedded within the administration team.
- The Head of Healthcare should ensure that there is a process in place to action the timely review of blood results. This will ensure that abnormal results are identified, and further treatment and monitoring implemented promptly.

- The Head of Healthcare should ensure that a medication reconciliation is undertaken as part of the reception process. This will ensure medication errors such as omissions, duplications, dosing errors, or drug interactions are avoided.
- The Head of Healthcare should ensure that patients who do not attend urgent healthcare appointments are followed up to determine the reason for their non-attendance. This will ensure that patients who are at risk of deterioration are monitored and assessed.

The Investigation Process

7. NHS England and NHS Improvement (NHSE&I) commissioned an independent clinical reviewer to review Mr Price's clinical care at Garth.
8. The PPO investigator investigated the non-clinical issues relating to Mr Price's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
9. The PPO family liaison officer wrote to Mr Price's next of kin, his partner, to explain the investigation and to ask if she had any matters she wanted us to consider.
10. She asked Ms Laing if the report could investigate the treatment Mr Price received following his diagnosis of bladder cancer, and she also raised the issue of a scar on his arm that she had not previously been aware of.
11. Mr Price's partner received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.
12. 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.

Previous deaths at HMP Prison

13. Mr Price was the eleventh prisoner to die at Garth since August 2020. Of the previous deaths, eight were from natural causes and two were self-inflicted. There has been one death since Mr Price's death, from drug related causes.
14. There are no similarities between our findings in the investigation into Mr Price's death and our investigation findings for the previous deaths.

Key Events

15. On 18 October 2019, Mr David Price was remanded into custody charged with historic sexual offences. He was sent to HMP Altcourse.
16. A nurse carried out an initial health screen. She noted that in 2017, he had been diagnosed with bladder cancer for which he was receiving ongoing care from the urology department of Broadgreen Hospital, Liverpool. She also noted he had undergone a TURBT (trans urethral resection of bladder tumour) and required a follow up cystoscopy every three months (a thin camera passed into the bladder to look for early signs of a reoccurrence of his cancer). As part of his treatment, he had also received BCG injections (Bacillus Calmette–Guérin, a vaccine used to prevent tuberculosis which is also an effective treatment for bladder cancer) and that his next injection was due the following month. Mr Price told her he had also been previously diagnosed with ischaemic heart disease, raised blood pressure and type 2 diabetes.
17. Following her review, care plans were created to manage his care and referrals were made to secondary care providers to ensure continuity of his care. He was regularly reviewed by healthcare staff.
18. On 21 October, a prison GP reviewed Mr Price’s prescribed medications. He also requested full blood tests be carried out. The results indicated Mr Price had developed borderline anaemia (a condition in there are not enough healthy red blood cells to carry adequate oxygen to the body's tissues). The GP also noted Mr Price had developed testicular swelling. He planned ongoing reviews of both the swelling and his red blood cell count. He made a referral to the urology department of Broadgreen Hospital, Liverpool, for further review.
19. Over the months that followed, Mr Price was regularly reviewed by healthcare staff.
20. On 22 January 2020, he was reviewed by hospital staff. They noted the testicular swelling, and also noted evidence of fluid oozing from the swollen area. He underwent an urgent ultrasound, the results of which were normal.
21. On 27 January, a prison GP carried out a follow up review. He noted the swelling had increased in size. Following his review, he made a two week wait referral to the urology department at Broadgreen Hospital (an urgent referral for symptoms that may be an early indicator of cancer).
22. On 5 February, Mr Price transferred to HMP Berwyn. A nurse carried out an initial health screen and noted his pre-existing diagnoses. She also noted he was subject to ongoing referrals to secondary care providers. Following her review, she repeated the referrals to ensure continuity of his care. His care plans were reviewed and updated, and he was regularly reviewed by healthcare staff.
23. On 5 March, healthcare staff spoke with hospital staff at Royal Liverpool Hospital concerning his referrals. They were told that his care would be transferred to the urology department at Wrexham Maelor Hospital.

24. Mr Price was reviewed by a prison GP on 22 July. He noted his anaemia was worsening. He prescribed him a course of vitamin B12 injections to improve his red blood cell count.
25. On 24 August, a prison GP reviewed Mr Price. Mr Price told the GP he was experiencing difficulty and discomfort when urinating. The GP considered he may be developing a stricture (a narrowing of the urethra). Following his review, he made a referral to the urology department at Wrexham Maelor Hospital.
26. The referral was carried out on 14 September. Mr Price underwent a cystoscopy. The results were noted to be abnormal. He was referred for a further cystoscopy and for biopsies to be taken of his bladder.
27. On 13 October, a prison GP again reviewed Mr Price after he complained of increasing breathlessness. He carried out an ECG (electrocardiogram used to measure the electrical output of the heart), the results of which indicated he had developed atrial fibrillation (an irregular heart rate). As a result, the GP made a referral to the cardiology unit at Wrexham Maelor Hospital.
28. On 4 November, Mr Price was sentenced to fifteen years imprisonment, followed by five years on licence after release. He returned to Berwyn.
29. On 8 December, Mr Price transferred to HMP Garth. A nurse carried out an initial health screen. She noted his pre-existing diagnoses and previous referrals. She also noted he was to undergo a surgical procedure to take biopsies from his bladder but had been transferred before the procedure could take place. His care plans were reviewed, and he was referred to both secondary care providers and long-term clinics at the prison.
30. Later the same day, a prison GP reviewed Mr Price's prescribed medications. However, there is no evidence that a formalised medicines reconciliation template was completed. Following his review, the GP referred him to the urology department of Chorley District Hospital to ensure continuity of his care.
31. Over the months that followed, Mr Price was regularly reviewed by healthcare staff.
32. On 29 July 2021, Mr Price attended Chorley District Hospital to undergo the surgical procedure to take biopsies from his bladder. He was discharged back to the prison the same day with a catheter in situ.
33. On 16 August, hospital staff forwarded the results of the biopsies to healthcare staff. The results indicated that there was no evidence Mr Price's bladder cancer had returned. They planned to carry out a follow up cystoscopy in four months' time.
34. The cystoscopy was carried out on 16 December. Again, the results revealed nothing of note. A follow-up cystoscopy was planned for May 2022.
35. He continued to be regularly reviewed by healthcare staff in the months that followed.
36. On 11 February 2022, Mr Price was reviewed by a nurse after he reported experiencing ongoing bouts of dizziness. He took a note of his observations, which were all within a normal range.

37. On 7 April, a prison GP reviewed Mr Price. As part of that review, he requested that full blood tests be carried out. The GP reviewed the results of the blood tests on 14 April. The results revealed Mr Price's haemoglobin levels were low at 93 (a normal haemoglobin level for men is between 135 and 170, if the haemoglobin level becomes low, it is necessary for a blood transfusion). The GP telephoned hospital staff, who advised him that a transfusion would not be carried out until his haemoglobin level had fallen to 80. It is not clear why the results of the blood tests took seven days to be reviewed.
38. A prison GP reviewed Mr Price on 27 April. He noted Mr Price's haemoglobin level had improved to 100. However, he also noted Mr Price's anaemia had worsened, and that he had experienced abnormal weight loss. Following his review, he considered that Mr Price's cancer may have returned, and he made a two week wait referral to the colorectal department at Chorley District Hospital. He was subject to regular blood tests at the prison to monitor his condition.
39. On 23 May, Mr Price attended the urology department at Chorley District Hospital to undergo his follow up cystoscopy. The results revealed nothing of note.
40. A healthcare administrator contacted hospital staff on 12 July as there had been no response to the prison GP's previous colorectal referral. However, there is no outcome to the enquiry recorded in Mr Price's medical records, nor is there further reference to the referral.
41. An assistant practitioner had planned to review Mr Price on 31 May. However, Mr Price failed to attend for the appointment. There is no evidence in his medical records to indicate the reason for his non-attendance, nor to indicate if he was encouraged to attend future appointments.
42. He also failed to attend subsequent GP reviews on 7 July and 26 July. As previously, there is no evidence in his medical records to indicate the reason for his non-attendance, or if healthcare staff had encouraged him to attend.
43. A prison GP reviewed Mr Price on 30 June. He told the GP he had noted some blood in his sputum (haemoptysis, originates in the respiratory tract below the level of the larynx). He also told the GP he had had a sore throat for an extended period of time and suffered continued weight loss. The GP repeated his previous two week wait referrals. He also requested an urgent chest X-ray and that daily observations be recorded for the following three days.
44. However, the reviews were not commenced until 4 July. A healthcare assistant made a note of his observations, which she recorded as being within a normal range. However, she did not record a NEWS2 score (National Early Warning Score a system to standardise the assessment and response to acute illness). She reviewed him again the following day. Again, she noted his observations were within a normal range but did not record a NEWS2 score.
45. On 21 July, Mr Price failed to attend healthcare for his chest X-ray. There is no evidence in his medical records to indicate the reason for his non-attendance.
46. Mr Price attended Chorley District Hospital to undergo a CT scan (computerised tomography) of his chest on 25 July. The results of the scan indicated a large

abnormal mass of tissue in the area of his upper right lung. There was also possible indication of a spread of cancer to other areas of his body. However, the results of the scan were not sent to healthcare staff until 12 August.

47. On 29 July, a nurse raised his concerns about Mr Price's condition with a prison GP. He told the GP that Mr Price had been struggling to eat and was still experiencing a cough and sore throat. He told the GP that Mr Price had again seen evidence of blood in his sputum. The GP requested that Mr Price's observations and weight be recorded, and also that full blood tests to be carried out. However, there is no evidence in his medical records to indicate his weight was recorded.
48. The nurse reviewed Mr Price again later the same day to carry out blood tests. However, he was unable to obtain a blood sample for testing due to an issue with Mr Price's veins. During his review, he noted Mr Price's observations, but did not record his weight, or note a NEWS2 score.
49. A prison GP reviewed Mr Price on 4 August. He told the GP he had noticed his stools were dark and that he continued to be experiencing some weight loss. The GP considered Mr Price was dehydrated and required a review by hospital staff. He was taken to Chorley District Hospital by emergency ambulance.
50. Following a review, hospital staff diagnosed Mr Price with lung cancer, sepsis and possible multi organ failure. They considered his prognosis was poor, and that he had less than two weeks to live. The only treatment option open to him was palliative care. Hospital staff signed a DNACPR on his behalf.
51. His condition continued to deteriorate, and at 4:15pm on 12 August, Mr Price died. His death was confirmed by a hospital doctor at 4.37pm.

Cause of death

52. The coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Price's cause of death as pneumonia. Metastatic lung cancer was also listed as a contributory factor

Inquest into Mr Price's death

53. The inquest into Mr Price's death was held on 9 June 2023 and a verdict of natural causes was recorded.
54. The coroner concluded Mr Price's death was due to pneumonia. Metastatic lung cancer was also listed as a contributory factor.

Kimberley Bingham
Acting Prisons and Probation Ombudsman

July 2023

**Prisons &
Probation**

Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100