Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Robert Angus, a prisoner at HMP Parc, on 26 October 2020

A report by the Prisons and Probation Ombudsman

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

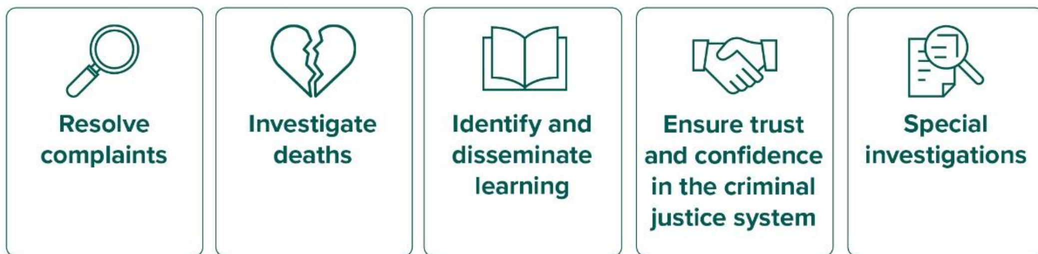
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

© 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.

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 Robert Angus died in hospital of aspiration pneumonitis and multi-organ failure on 26 October 2020 while a prisoner at HMP Parc. Mr Angus was 50 years old. I offer my condolences to Mr Angus's family and friends.

The clinical reviewer considered that the care Mr Angus received when he became acutely unwell was appropriate. However, he was concerned about the poor management of Mr Angus's chronic health conditions and that he was prescribed drugs which might affect his kidney function.

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 **August 2021**

Contents

Summary 1

The Investigation Process...2

Background Information..3

Key Events...4

Findings 6

Summary

Events

1. In June 2018, Mr Robert Angus was sentenced to 37 months imprisonment for grievous bodily harm. He was released in April 2020 and recalled to prison two days later. He was transferred to HMP Parc on 28 May.

2. When he arrived at Parc, Mr Angus had an initial health screen and a secondary health screen. He had several long-term medical conditions, including high blood pressure, chronic back pain and alcohol dependency. He was due an annual kidney function check because he was taking ramipril, a drug that can affect kidney function, but this did not take place while he was at Parc.

3. In July and again in September, Mr Angus was prescribed naproxen for back pain, although this drug can also affect kidney function. No-one reviewed him in person on either occasion.

4. In October, Mr Angus's health deteriorated suddenly. On 18 October, a nurse assessed him after his mother called the prison concerned about his health, and he was transferred to hospital urgently. He was diagnosed with acute pancreatitis and acute kidney failure due to dehydration and naproxen use.

5. On 26 October, Mr Angus died in the hospital's intensive care unit. The coroner accepted his cause of death was aspiration pneumonitis and multi-organ failure, as a result of severe pancreatitis.

Findings

6. The clinical reviewer found that Mr Angus received appropriate care when he became acutely unwell in October 2020.

7. However, he found some shortcomings in the management of Mr Angus's long-term health conditions. In particular, Mr Angus did not have an annual kidney function review, and he was prescribed Naproxen on two occasions without any record that the risks and alternatives were considered and without a review of his physical health.

Recommendations

- The Head of Healthcare should ensure that a clear plan for all long-term conditions is documented, including the need for appropriate monitoring to ensure safe prescribing.

- The Head of Healthcare should ensure that medication is not prescribed without proper assessment and full consideration of risks and alternatives.

- The Head of Healthcare should discuss the clinical reviewer's findings with the healthcare team, including GPs.

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 Angus's clinical care at Parc. He spoke to healthcare staff on the telephone with the PPO investigator.

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 Angus's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. We did not receive a response.

12. After we issued our initial report, we were contacted by a prison chaplain at Parc who said that Mr Angus's mother would like a copy of the report. We sent her a copy. She did not identify any factual inaccuracies.

13. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies.

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 Angus was the 16th prisoner to die at Parc since October 2018. Nine 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 Angus's death and the previous deaths.

Key Events

19. On 18 June 2018, Mr Robert Angus was sentenced to 37 months imprisonment for grievous bodily harm with intent. He was released on 1 April 2020 but was recalled to prison two days later. He was transferred to HMP Parc on 28 May 2020.

20. When he arrived at Parc, Mr Angus said that he had a past medical history of high blood pressure, alcohol dependency, anxiety, depression, post-traumatic stress disorder (PTSD), chronic back pain and arthritis. Mr Angus was also on regular medication, including ramipril (a drug for high blood pressure that can affect kidney function). Basic physiological measurements and baseline blood tests were not taken.

21. Mr Angus's most recent annual kidney function check had taken place in July 2019. He did not have a kidney function check at Parc.

22. On 10 July and again on 24 September, a pharmacist prescribed Mr Angus naproxen, a painkiller, after he complained of back pain. Although naproxen can affect kidney function, there is no record that the pharmacist considered the risks or whether alternative pain relief was more suitable. There is no record that anyone examined Mr Angus's physical health on either occasion.

23. On 16 October, a nurse assessed Mr Angus in his cell after he complained that he had stomach pain, had vomited and felt lightheaded. He recovered after 10 minutes. The nurse noted that naproxen could cause gastric bleeding. She asked the duty doctor to review Mr Angus's medication, but there is no record of this review.

Events of 18 October

24. On 18 October, Mr Angus's mother called the prison to say he was very ill and needed to see a doctor. At 10.00pm, a nurse went to his cell and used the National Early Warning Score (NEWS2), a tool to detect acute illness and deterioration, to assess Mr Angus. The score was 8, which indicated Mr Angus's condition was serious, so she contacted the on-call doctor and they agreed to transfer him to hospital immediately. Mr Angus was taken to hospital at 12.57am on 19 October. (His medical record indicates that he was not taken to hospital until 6.03am, but the investigator established that the delay was in documenting his transfer, rather than the transfer itself.) Mr Angus was not restrained on his transfer to hospital due to his poor health.

25. When he arrived at hospital, Mr Angus was diagnosed with acute pancreatitis and acute kidney failure due to dehydration and naproxen use. He was moved to the intensive care unit. On 25 October he had a cardiac arrest. He died at 11.40am on 26 October. His next of kin were notified by hospital staff.

Contact with Mr Angus's family

26. On 25 October 2020, the Duty Governor asked a prison chaplain to contact Mr Angus's next of kin as his condition was critical. It was later decided that hospital

staff were best placed to contact the family to update them on Mr Angus's condition and prognosis.

27. The prison chaplaincy kept in touch with Mr Angus's family and offered support as his condition continued to deteriorate and after he died.

28. Mr Angus's funeral took place on 20 November. The prison offered to contribute to its cost, in line with guidelines.

Support for prisoners and staff

29. The prison posted notices informing other prisoners of Mr Angus'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 Angus's death.

Post-mortem report

30. Mr Angus did not have a post-mortem examination. The hospital consultant provided a medical cause of death, which the coroner has accepted. Mr Angus died of aspiration pneumonitis (inhaling stomach contents causing lung injury) and multi-organ failure, as a result of small bowel dilation caused by necrotising pancreatitis. (Necrotising pancreatitis is a serious condition where the pancreas loses its blood supply, causing some of the tissue of the pancreas to die. When this happens, the pancreas can become infected, which can spread into the blood causing sepsis and organ failure.)

Findings

Clinical care

31. The clinical reviewer acknowledged the difficulties of delivering healthcare during the COVID-19 pandemic. However, he identified concerns with Mr Angus's chronic disease management and the prescription of pain relief. He also identified concerns about healthcare record keeping, which the Head of Healthcare will need to address.

32. When Mr Angus arrived at Parc, healthcare staff did not carry out a review of his medications to ensure that his health conditions were managed appropriately. As he was prescribed rampiril, which can affect kidney function, he should have had a kidney function check at least once a year. He was due to have his annual kidney check in July 2020, but this did not take place.

33. The clinical reviewer was also concerned that Mr Angus was twice prescribed naproxen for pain relief, a drug which can cause kidney damage and raised blood pressure and further increases the risk, alongside ramipril, of kidney failure. The clinical reviewer was concerned that there was no evidence that risks or alternatives were considered on either occasion, and nothing was done to ensure Mr Angus had adequate kidney monitoring or a physical assessment. He said that the prescription of naproxen might have been understandable in the context of the pandemic if it had only happened once; it was poor practice to prescribe naproxen a second time.

34. The clinical reviewer considered that these aspects of Mr Angus's care fell below the standard of care which he could have expected to receive in the community.

35. We make the following recommendations:

The Head of Healthcare should ensure that a clear plan for all long-term conditions is documented, including the need for appropriate monitoring to ensure safe prescribing.

The Head of Healthcare should ensure that medication is not prescribed without proper assessment and full consideration of risks and alternatives.

The Head of Healthcare should discuss the clinical reviewer's findings with the healthcare team, including GPs.

Inquest

36. The inquest into Mr Angus's death concluded on 26 April 2023, with a verdict of natural causes.

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 I 020 7633 4100