DRAFT

INVESTIGATION INTO THE DEATH OF A MAN AT HMP PARC ON 21 AUGUST 2004

REPORT BY THE PRISONS AND PROBATION OMBUDSMAN FOR ENGLAND AND WALES

MARCH 2005

A man died at HMP Parc in August 2004. An investigation was begun by my office, but regrettably was not completed at the time. The inquest took place on 11 November and reached a verdict of death by natural causes. The coroner requested that the jury should not add any rider to this verdict. He went on to say that, if they chose otherwise, it should not be directed against any individual.

So that any learning and good practice can be identified for the benefit of the Prison Service, the investigation has now been completed by one of the team leaders in my office. She has been assisted by an RGN who has undertaken a clinical review of the man's healthcare whilst he was in custody.

Having been recalled to prison, the man was located in the healthcare centre at HMP Swansea and then transferred to HMP and YOI Parc where he was placed on normal location. Sadly, he died the following day. My investigation is satisfied that his location at Swansea was decided for good, non medical reasons, and that staff at Parc took all sensible steps before deciding where he should be located there. There are no recommendations arising from the investigation but good practice has been identified at both prisons.

The man's family have lost a father and grandfather, and I would like to take this opportunity to add my condolences to those already expressed. I apologise for the delays in completing this report, but hope that it answers some of their questions.

Finally, I would like to thank the Governor at Swansea and the Director at Parc along with their staff for their assistance throughout the investigation.

Stephen Shaw CBE
Prison and Probation Ombudsman

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SUMMARY

1. At the time of his death the man was 78 years old. In October 2002 he was convicted of indecent assault and sentenced to three years imprisonment, which he served at HMP Usk and Parc. He was assessed for release on licence and released in August 2003, initially to probation approved premises. He signed on the Sex Offender Register and was monitored under the Multi-Agency Public Protection Arrangements. In February 2004, he moved to independent accommodation.

2. His behaviour brought him to the attention of the authorities who considered that he was at risk of reoffending and requested that his licence be revoked. He was recalled to prison on 17 August 2004 and taken to Swansea where he was located in the healthcare centre.

3. In the early hours of 20 August, he complained of pains in the abdomen and was treated for these. No further complaints were made and later that morning he was transferred to Parc and placed in D wing.

4. Soon after 7:00 am the next day, his cellmate told staff that he had collapsed on the cell floor. Nursing attention was provided and an ambulance called for. Despite these interventions, he was certified dead at 8:00 am.

5. The inquest into his death took place on 11 November and reached a verdict of death by natural causes.

HMP SWANSEA AND HMP AND YOI PARC

6. HMP Swansea is a Victorian prison near to the centre of the town. In August 2004 when the man was admitted, 348 prisoners were present. The prison has a healthcare centre which has ten inpatient beds on the first floor and is accessible by lift. Seven of the beds are in a ward and the others are in single cells. Each of the beds in the ward has its own call bell, used to alert staff. The room has a gate, which is closed during the night and at lock up, and a door, which can be left ajar. Nursing staff do not hold keys and at night-time would call prison staff if they needed to get into the ward. Prisoners can come to the gate, where nursing staff can speak to them face to face and can take their vital signs if required.

7. The prison also has a Rule 45 unit used for prisoners who request protection, either for reasons of offence or vulnerability. When the man was admitted this unit was closed for refurbishment and older prisoners convicted of sex offences were located in the healthcare centre, even if they had no medical needs.

8. HMP Parc is a modern prison on the outskirts of Bridgend and 25 miles from Swansea. It currently has space for 1,000 prisoners on different wings, including D wing which is used for sex offenders. This wing is separated from the rest of the prison by fencing and prisoners there have separate regimes, including visits and education. Parc also has a healthcare centre with inpatient beds.

9. Swansea and Parc, together with the other Welsh prisons, have operated the Welsh Prison Population Protocol since 2003. It was amended in August 2004. It states that all sex offenders will normally be allocated to Parc, pending transfer to HMP Usk which offers specialist offending behaviour programmes. If Parc is full, prisoners might come to Swansea, where they would be located in the Segregation Unit until a place at Parc becomes available. The Protocol had been further amended by the time the investigation was completed as funding for 20 sex offenders had been withdrawn from Parc.

CONDUCT OF THE INVESTIGATION

10. The investigation began in August 2004 and regrettably has only now been completed. In August, meetings took place with the man's cellmate on the night of his death, and the chaplain at Parc who liaised with the family. A Family Liaison Officer from my office met the man's daughters in September and the investigator met them at the inquest.

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11. There were further meetings with the Governor and healthcare staff at Swansea in March 2005 and with the Director and healthcare staff at Parc the same month. Both the Governor and the Director were given feedback on the findings of the visits.

12. My Deputy Ombudsman conducted a clinical review of the healthcare provided for the man by both prisons.

KEY FINDINGS

13. The man was charged with sexual offences against children on 15 May 2002 and was remanded in custody to Parc. He was convicted on 29 October and sentenced to three years imprisonment. In February 2003, he was transferred to Usk, and remained there until he was released on licence on 13 August.

14. The terms of his licence under the Criminal Justice Act 1991 included that he must live in a place directed by his probation officer, which in this case was Quay House hostel in Swansea. He was also required not to commit any offences, engage in work or other organised activity with under 18 year olds, or live in the same household as a child under 18 years. He was ordered not to approach the victims of the offences or their families. The licence was to run to 28 September 2004 and his sentence would expire on 11 May 2005. He was required to register on the Sex Offender Register and was monitored by police and probation through the local Multi-Agency Public Protection Arrangements, which in his locality were known as the MARAC.

15. He was considered to have complied with the conditions of his licence and, on 21 February 2004, he moved into his own accommodation. However, in July he was thought to be in breach of his licence. He had been seen driving a car in an area where he should not have been. The Home Office were informed but declined to revoke the licence, instead issuing a stricter licence with a prohibition from entering a specified locality. In the following month, further reports were made to the police that he had broken licence conditions which he admitted in interview on 16 August.

16. His licence was revoked on 17 August and he was recalled to prison. That day, Parc prison had 1,036 places and actually held 978 prisoners. However D wing, which is the one used to accommodate prisoners who request protection under Rule 45, was full and so he was taken to Swansea. The Rule 45 unit at Swansea was closed in August for refurbishment and the prison normally located such prisoners in the segregation unit, until Parc had spaces.

17. However, rather than put an elderly man in the segregation unit, he was located in the healthcare centre. Because he was admitted for protection rather than medical needs, a nursing care plan was not prepared and any notes would have been made on the F2050 which is the standard prison record, rather than the Inmate Medical Record (IMR). These records have not been made available to the investigation team.

18. The man went through the standard prison reception procedures including the reception healthscreen. In the interview, he said that he usually had painkillers for his bowels and medication for his nerves, and that he was worried about arthritis. He saw the doctor later in the day who also noted

these comments. The doctor observed that the man was incontinent but that his general health was good.

19. The man remained in the healthcare centre without any occurrences until 4:00am on 20 August when he complained of pain in the lower abdomen, saying this was because he had not been receiving his usual medication for his bowels. The nurse did not examine him and the ward was not unlocked. Medication was administered and a nursing care plan drawn up, to be followed up by the medical officer in the morning. The man was observed by nursing staff on three occasions and at 7:00am was walking around the cell without any further complaints of pain.

20. At 7:30am, he was seen by the nurse again and said that the pain was still present but had reduced. The assessment concluded with the comment that he was fit for transfer. The Healthcare Manager said that there is not a standard procedure for assessing a prisoner's fitness for transfer to another prison. The nurse would have visually observed the man and asked him whether he was fit to travel.

21. He was received into the custody of the escort company some time before 2:05pm that day. The escort records describe him as elderly and infirm. He travelled in the cellular van which is the property of Parc and arrived there at 2:51pm. Two checks were made during the journey and both state that he appeared to be alright.

22. On arrival at Parc, he went through a similar reception process, which included the completion of the transfer in checklist by healthcare staff. The checklist was completed by a senior nurse at Parc. The entries were similar to those at Swansea and included reference to unnamed bowel medication and arthritis. The senior nurse recalled her meeting with the man and described him as elderly who had no disabilities and was mobile. He was administered medication for constipation. The senior nurse had his IMR with her when she talked to him, and was aware that he had been located in the healthcare centre when he was at Swansea. She told the investigators that, as a precaution, she telephoned Swansea healthcare centre that evening to check the reasons that he had been located there. She was satisfied with the information and the man was located in cell 17, which is on the ground floor of D wing. Parc has designated cells for prisoners with mobility needs and this is one of them. It contains two single beds, furniture and a toilet behind a partition.

23. He shared the cell with another prisoner who had also arrived there on the same day. The cellmate was interviewed by the investigation team and has signed a note of the conversation. The man complained of pain to his cellmate several times during the night of 20/21 August but refused to allow him to call for assistance. The call bell records verify that the bell was functioning, but that it was not used.

24. The PCO was on night duty on D wing on 21 August. She confirmed to the investigators that the cell bell was rung at 6:35am. This is during the

hours that the prison is on night state and when wing staff do not carry keys to cells. The cell bell system allows staff in the office to identify which cell has called and to talk to the prisoner. The PCO said that she was told the man was on the floor of the cell by his cellmate. The officer said that she went to the cell and lifted the observation flap in the door to look in. She was carrying a radio and used it to call the control room and summon assistance.

25. The IMR records that at approximately 6:45am a Nurse was called to D unit to provide assistance. The PCO said that the nurse arrived at the cell at the same time as Oscar 1, which meant that he was in charge and was carrying keys to unlock the cell. The cell was opened and the nurse was able to attend to the man. The PCO said that his vital signs were checked and were satisfactory and the IMR records that he had a brief conversation with the nurse. The man asked if he could turn over on the floor, and did so with assistance for his legs which had been under the bed.

26. He was then lifted on to the bed and the Nurse stayed with him whilst a healthcare assistant went back to the healthcare centre for his IMR. His breathing became shallow and his pallor went pale so Oscar 1 and the nurse placed him in the recovery position. Other healthcare staff also attended, including the Senior Nurse. Oxygen and a defibrillator were requested from healthcare and an emergency ambulance was called for at 7:05am. His pulse was taken again but it became weaker until the nurse was unable to take a reading. Oxygen was administered and chest compressions began for about five minutes before the ambulance arrived at 7:13am.

27. The paramedics were unable to revive him and he was pronounced dead by the doctor at 7:55am. The police were then called.

28. The Senior Nurse was asked about support for staff after the incident and she said that good support was offered by the prison and that healthcare staff also supported each other.

29. The inquest took place on 11 November and confirmed that the man's death was due to natural causes.

RECOMMENDATIONS

There are no recommendations to be made to the Prison Service. Both prisons cared for the man appropriately and followed all relevant procedures.

GOOD PRACTICE

There were several examples of good practice at both prisons.

HMP SWANSEA

1. With the closure of its Rule 45 unit for refurbishment, it was good practice to place the man in the healthcare centre.

2. Emergency equipment is located near to the wings of the prison so that staff do not have to go far from the scene of an incident to locate it. A team of discipline officers have been trained in Advanced Life Support and ensure that emergency aid is commenced at the earliest opportunity.

HMP PARC

1. The nurse completing the transfer healthscreen had access to the man's IMR and followed it up with a telephone call to Swansea to confirm the reason for his location in healthcare.

2. The prison has designated ground floor cells for the use of prisoners with disabilities. There are signs on the cell doors which indicate that the occupant requires assistance in the event of emergency procedures being activated.