Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Pesticcio, a prisoner at HMP Parc, on 19 December 2023

A report by the Prisons and Probation Ombudsman

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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

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. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. Mr Paul Pesticcio died of hepatocellular carcinoma (liver cancer) on 19 December 2023, at HMP Parc. He was 84 years old. We offer our condolences to Mr Pesticcio's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Pesticcio received at HMP Parc was equivalent to what he could have expected to receive in the community. He commended the staff involved in Mr Pesticcio's care as they provided an excellent standard of palliative care to him. The clinical reviewer made recommendations not related to Mr Pesticcio's death that the Head of Healthcare will wish to address.

5. We found that a prison family liaison officer (FLO) was not allocated when Mr Pesticcio became seriously unwell. The prison did not contact Mr Pesticcio's next of kin until after his death.

Recommendation

The Director should ensure that a family liaison officer is allocated as soon as possible when a prisoner becomes seriously or terminally ill, in compliance with Prison Service Instruction (PSI) 64/2011 Managing prisoner safety in custody.

The Investigation Process

6. HMPPS notified us of Mr Pesticcio's death on 19 December 2023.

7. NHS England commissioned an independent clinical reviewer to review Mr Pesticcio's clinical care at HMP Parc.

8. The PPO investigator investigated the non-clinical issues relating to Mr Pesticcio's care.

9. The Ombudsman's office contacted Mr Pesticcio's family to explain the investigation and to ask if they had any matters they wanted us to consider. They raised concerns about Mr Pesticcio's dietary needs, medication, general welfare, and his application for Early Release on Compassionate Grounds. They also asked for a copy of our report. We have addressed their concerns in our report and in the clinical review.

10. 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.

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

Previous deaths at HMP Parc

12. Mr Pesticcio was the 14th prisoner to die at HMP Parc since December 2021. Of the previous deaths, eight were from natural causes, three were drug-related, one was self-inflicted, and one is unascertained. Up to the end of March 2024, there has been one natural causes death at Parc since Mr Pesticcio's death. There are no similarities between the findings in our investigation into Mr Pesticcio's death and the findings from our investigations into the previous deaths.

Key Events

13. In December 2017, Mr Paul Pesticcio was sentenced to 16 years imprisonment for committing sexual offences. He was sent to HMP Stafford.

14. Mr Pesticcio had several documented health conditions including type 2 diabetes mellitus, hypertension, hypercholesterolaemia, atrial fibrillation, heart failure, and visual impairment. He was receiving appropriate treatment for these conditions.

15. On 18 May 2023, prison officers escorted Mr Pesticcio to a hospital appointment where he was diagnosed with primary liver cancer. He was told that due to his general health he was not suitable for treatment.

16. In June, prison staff at Stafford started an application for Early Release on Compassionate Grounds (ERCG). The application was not completed as Mr Pesticcio transferred to another establishment. This meant a new ERCG application would need to be started at Mr Pesticcio's next establishment.

17. On 24 July, Mr Pesticcio was transferred to HMP Parc so that he could be closer to his family to receive visits.

18. A healthcare support worker saw Mr Pesticcio for a first reception health screen and undertook a comprehensive assessment to determine his physical, mental and social needs.

19. On 26 July, a doctor at the prison saw Mr Pesticcio for a second reception health screen where he confirmed the medications prescribed and illnesses. The doctor noted that Mr Pesticcio had a cataract in his left eye, was blind in his right eye, had a speech impediment and was deaf in his right ear, in addition to being a wheelchair user. He referred Mr Pesticcio to the speech and language therapists for assessment and to the palliative care specialist service.

20. On 4 August, a speech and language therapist conducted a review with Mr Pesticcio. There was a clear, well documented plan for him to continue fluids with a straw and recommendations for his diet.

21. On 8 August, the palliative care nursing team discussed Mr Pesticcio's care wishes with him.

22. Prison and healthcare staff at Parc considered starting a new ERCG application, but decided not to proceed as they did not have a clear prognosis of life expectancy from a healthcare specialist (a requirement of the application).

23. On 18 August, Mr Pesticcio said that he did not want anyone to resuscitate him if his heart or breathing stopped and signed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order to that effect.

24. At 10.18am on 19 December, a Prison Custody Officer discovered Mr Pesticcio unresponsive in his cell. He attempted to wake him, but after checking his pulse realised that Mr Pesticcio had died (he was aware that Mr Pesticcio had a DNACPR order in place). He left the cell and went to inform an Operational Manager (OM). He and the OM returned to Mr Pesticcio's cell at 10.20am and called a Code Blue.

25. A nurse attended Mr Pesticcio's cell at 10.22am and an ambulance was stood down due to there being a DNACPR in place. The prison doctor certified Mr Pesticcio's death at 11.50am.

Post-mortem report

26. The coroner accepted the cause of death provided by a prison doctor and no post-mortem examination was carried out. The doctor gave Mr Pesticcio's cause of death as hepatocellular carcinoma (liver cancer). Mr Pesticcio also had heart failure, which contributed to but did not cause his death.

27. At the inquest held on 13 August 2024, the Coroner concluded that Mr Pesticcio died of natural causes.

Non-Clinical Findings

Liaison with Mr Pesticcio's family

28. Prison Service Instruction (PSI) 64/2011, about safer custody, says that prisons must have arrangements in place for an appropriate member of staff to engage with the next of kin of prisoners who are either terminally or seriously ill.

29. Although Mr Pesticcio received his terminal diagnosis in May 2023, the prison did not appoint a family liaison officer until after his death, on 19 December 2023. This meant that Mr Pesticcio's wife did not have a named contact at the prison with whom she could share her concerns with. We make the following recommendation:

The Director should ensure that a family liaison officer is allocated as soon as possible when a prisoner becomes terminally or seriously ill, in compliance with Prison Service Instruction (PSI) 64/2011 Managing prisoner safety in custody.

Adrian Usher
Prisons and Probation Ombudsman **September 2024**

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