

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Malcolm James, a prisoner at HMP Parc, on 5 October 2024

A report by the Prisons and Probation Ombudsman

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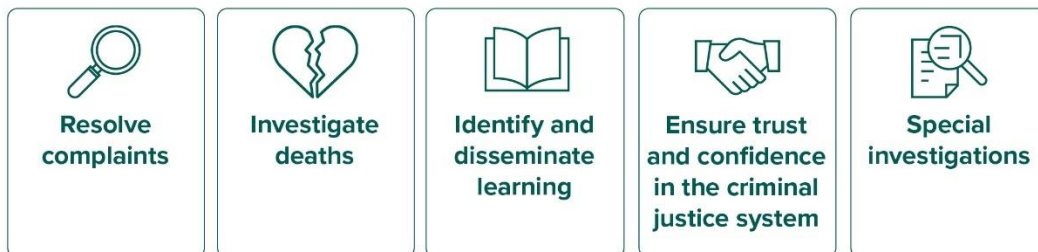
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OUR VISION

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



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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. On 12 July 2024, Mr Malcolm James was sentenced to three years imprisonment for sexual offences. He died of metastatic bowel cancer on 5 October, at HMP Parc. He was 85 years old. We offer our condolences to Mr James' family and friends.
4. The Ombudsman's office wrote to Mr James' next of kin, his wife, to explain the investigation. Mr James' wife said there had been a significant delay in allowing Mr James access to a telephone. She also asked about the decision-making around Mr James' discharge from hospital and whether the prison had considered early release on compassionate grounds. She praised the prison's family liaison officer for his caring support.
5. Healthcare Inspectorate Wales commissioned an independent clinical reviewer, to review Mr James' clinical care at Parc. The clinical reviewer's report is attached as Annex 1.
6. The clinical reviewer concluded that the clinical care Mr James received at Parc was equivalent to that which he could have expected to receive in the community. He found that appropriate care plans were in place, with dignified end of life care. The clinical reviewer made recommendations about the need for healthcare staff to make timely applications for early release on compassionate grounds and training to use a syringe driver, which the Head of Healthcare will wish to address.
7. The PPO investigator investigated the non-clinical issues relating to Mr James' care. We did not find any non-clinical issues of concern. We make no recommendations.
8. We sent a copy of our report to Mr James' next of kin. She did not report any factual errors.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies.

Director to note

10. Mr James was unable to make telephone calls from his cell for the first 20 days at Parc, due to a fingerprinting fault in the prison's Custodial Management System and his wife did not know where he had been taken until 10 days after he was sentenced. After Mr James' wife contacted the prison, a manager arranged for him to use an office telephone to keep in touch until the fault was resolved. However, it

is unclear why staff had not facilitated Mr James' statutory entitlement to send a letter on reception or make a telephone call within 24 hours of his arrival, to inform his family of his whereabouts.

Inquest

11. At an inquest held on 4 June 2025, the coroner concluded that Mr James died from natural causes.

Adrian Usher
Prisons and Probation Ombudsman

September 2025



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