Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Malcolm Vickery, a prisoner at HMP Parc, on 11 March 2023

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 l 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

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 Malcolm Vickery died of heart disease on 11 March 2023 at HMP Parc. He was 76 years old. We offer our condolences to Mr Vickery's family and friends.

4. The PPO family liaison officer wrote to Mr Vickery's next of kin to explain the investigation and to ask if she had any matters she wanted us to consider. She told us that the family liaison officer (FLO) at Parc had been very helpful and supportive. She asked for a copy of our report.

5. The PPO investigator investigated the non-clinical issues relating to Mr Vickery's care. We did not find any non-clinical issues of concern.

6. We found that the FLO at Parc built a good relationship with Mr Vickery's next of kin, who felt supported throughout the process. We consider this to be good practice.

7. Health Inspectorate Wales (HIW) commissioned an independent clinical reviewer to review Mr Vickery's clinical care at HMP Parc.

8. The clinical reviewer concluded that the clinical care Mr Vickery received at Parc was largely equivalent to that which he could have expected to receive in the community. He found that overall, the healthcare team appeared to have displayed a caring and compassionate approach to Mr Vickery's care in prison. He made several recommendations not related to Mr Vickery's death that the Head of Healthcare will wish to address.

9. The clinical reviewer found that the adrenaline given to Mr Vickery during the emergency response was at the wrong dose for a suspected cardiac arrest. The correct adrenaline dose was not available in the emergency bag so healthcare staff gave a lower dose used for severe allergic reactions rather than cardiac arrests. We recommend:

   The Head of Healthcare should ensure that all emergency response equipment is regularly checked to ensure that the correct stocks of equipment and drugs are present to treat cardiac arrests.

10. We shared our initial report with HMPPS. They found no factual inaccuracies. They provided an action plan which is annexed to this report.

11. We sent copies of our report to Mr Vickery's next of kin. They did not notify us of any factual inaccuracies.

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

Inquest

The inquest, held on 6 January 2025, concluded that Mr Vickery died from 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 l 020 7633 4100