Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Frederick Heard, a prisoner at HMP Parc, on 9 August 2019

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

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 Frederick Heard died of pneumonia on 9 August 2019 while a prisoner at HMP Parc. He also had chronic obstructive pulmonary disease (COPD) which did not cause but contributed to his death. He was 87 years old. I offer my condolences to his family and friends.

Although prison and healthcare staff were compassionate and caring in their day to day dealings with Mr Heard, the clinical care he received at Parc was not equivalent to that which he could have expected to receive in the community.

I am concerned that prison healthcare staff did not adequately monitor Mr Heard's COPD and his COPD care plan did not fully meet his needs.

Mr Heard also had dementia. Within a few years of arriving at Parc it was clear that Mr Heard had no idea that he was serving a sentence in prison. I am very concerned that arguments about who was funded to assess and support Mr Heard's dementia meant that his needs were not met and that this significantly affected his quality of life.

This impasse should have been resolved promptly by Abertawe Bro Morgannwg University Health Board and I consider it completely unacceptable that the situation was allowed to continue for years and remained unresolved at the time of Mr Heard's death. As the clinical reviewer says in his report on Mr Heard's care, "It appears somewhere in this argument over funding that managers or clinicians in the NHS Health Board forgot that a patient was suffering at the heart of this, leading to significant distress for him, other prisoners, and indeed the HMP Parc staff doing their best for him".

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 **April 2020**

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Summary

Events

1. In November 2012, Mr Frederick Heard was convicted of sex offences and remanded to HMP Parc. In December, he was sentenced to 16 years in prison.

2. Mr Heard's community GP records noted that he had vascular dementia, COPD, osteoarthritis to the left hip and knee, a stomach ulcer and deafness.

3. From December 2012 onwards, prison GPs frequently referred Mr Heard to the local older adult community mental health team (OACMHT) in Bridgend for assessment and support for his dementia. However, the OACMHT said that they were not resourced to see prison patients and refused to provide input to Mr Heard's care.

4. Mr Heard frequently had acute exacerbations of COPD at Parc and was frequently sent to hospital. In February 2014, a prison GP reviewed Mr Heard's COPD for the first time since he had arrived at Parc.

5. Mr Heard's dementia worsened. In July 2017, prison, healthcare and social care staff held a multidisciplinary meeting. They were concerned because Mr Heard was distressed because he did not understand he was in prison and was injuring himself banging on his cell door at night.

6. In August 2018, the prison referred Mr Heard to the OACMHT in Newport (where he had previously lived) because the local OACMHT in Bridgend would not see him, and they provided input into his care.

7. On 4 March 2019, prison staff arranged to fit padding to Mr Heard's cell door because they were concerned for his safety as he kept hitting it. On 7 March, Mr Heard was sent to hospital because he had injured his hand, banging on his cell door. He developed pneumonia and remained in hospital until 17 March. When he went back to Parc, his health had deteriorated significantly, and he was assessed as at risk of falls.

8. On 2 July 2019, a prison GP saw Mr Heard as he was unwell, and diagnosed him with bronchopneumonia. She prescribed antibiotics, noted that he was very frail and that he may not recover. Throughout July, Mr Heard frequently fell over and went to hospital a number of times with breathlessness and an acute exacerbation of his COPD.

9. On 25 July, Mr Heard went to hospital, where his conditioned deteriorated. On 8 August, the prison submitted an application for Mr Heard's compassionate release from prison on medical grounds.

10. Mr Heard died of bronchopneumonia on 9 August. He also had COPD which contributed to but did not cause his death. He was granted compassionate release on the day of his death.

Findings

11. Although the clinical reviewer found that the day-to-day care Mr Heard received from healthcare and prison staff was compassionate and caring, he concluded that the overall care that he received at Parc was not equivalent to that which he could have expected to receive in the community.

12. Prison staff did not adequately monitor Mr Heard's COPD. Mr Heard did not have an appropriate COPD care plan, which led to his care being mainly reactive. He never had a spirometry test (a test to diagnose the severity of asthma and COPD) and only had one nurse-led chronic respiratory review.

13. Mr Heard arrived at Parc with dementia. When healthcare staff realised that he had significant cognitive impairment, he was appropriately referred for assessment. However, despite repeated efforts by prison healthcare staff, local community mental health services refused to engage in his care, and the local Health Board failed over a period of years to reach a solution to enable Mr Heard to access appropriate specialist care for dementia. We consider that this was unacceptable.

14. The clinical reviewer said that it became apparent within a few years that Mr Heard had no idea that he was serving a sentence in prison and that being locked in a cell caused him mental distress and physical injury. Staff at Parc appropriately made adjustments to reduce his distress and risk of injury by padding the cell door.

15. We are concerned, however, that an application for compassionate release was not made until a few days before Mr Heard's death.

Recommendations

- The Head of Healthcare should ensure that:
  - prisoners with COPD have an annual review, including a spirometry test;
  - nursing staff are trained to undertake chronic disease monitoring, including spirometry tests; and
  - when prisoners have repeated exacerbations of COPD and are on maximum inhaler therapy, healthcare staff consider referring them to a specialist.

- The Director and Head of Healthcare at Parc should liaise with the Medical Director for G4S and arrange an urgent meeting with the Chief Executive of Abertawe Bro Morgannwg University Health Board to ensure that full service provision for patients with suspected dementia is made within 3 months of this report, and that in the interim patients requiring access are not refused care.

- The HMPPS Executive Director for Wales should:
  - satisfy himself that effective action has been taken to ensure the provision of a full service for prisoners with suspected dementia at Parc;
  - satisfy himself that there are no barriers to the provision of a full service for prisoners with suspected dementia at other prisons in Wales; and
  - write to the Ombudsman to confirm that he is so satisfied.

- The Director and Head of Healthcare should remind staff that compassionate release applications on medical grounds may be made for prisoners who are incapacitated, and not only for those who are terminally ill.

The Investigation Process

16. The investigator issued notices to staff and prisoners at HMP Parc informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

17. The investigator obtained copies of relevant extracts from Mr Heard's prison and medical records.

18. Healthcare Inspectorate Wales (HIW) commissioned a clinical reviewer to review Mr Heard's clinical care at the prison. The investigator and clinical reviewer jointly interviewed four members of staff at Parc on 11 October.

19. We informed HM Coroner for South Wales Central of the investigation. He gave us the cause of death for Mr Heard. We have sent the Coroner a copy of this report.

20. The Ombudsman's family liaison officer wrote to Mr Heard's next of kin to explain our investigation. She had no specific questions or concerns.

21. We shared the initial report with the Prison Service. There were no factual inaccuracies.

22. Mr Heard's next of kin received a copy of the initial report. She identified one factual inaccuracy in the clinical review, which has been amended accordingly.

Background Information

HMP Parc

23. HMP Parc is a medium security private 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.

24. G4S Medical Services provide primary physical and mental health care services. The mental health inreach team and secondary mental health services are provided by Abertawe Bro Morgannwg University Health Board (ABMUHB).

25. There are 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 on duty in the prison at night.

HM Inspectorate of Prisons

26. The most recent inspection of Parc was in November 2019. The findings have not yet been published.

27. The previous inspection was in January 2016. Inspectors found that significant chronic recruitment and retention problems affected secondary health screening. They noted that significantly fewer prisoners than in comparator prisons said that the quality of health provision was good. Inspectors noted that support for prisoners with complex health needs, including life-long conditions, was generally good.

28. However, while primary care services were reasonably good, mental health provision was inadequate. Funding for secondary mental health had not increased since the doubling in the number of prisoners held at Parc. Inspectors found that this had created significant pressures in the team and led to comparatively restrictive acceptance criteria.

29. HMIP recommended that prisoners with primary and secondary mental health needs should receive satisfactory care-planned support from appropriately trained staff within agreed timescales. In its action plan in response, produced in September 2016, the prison said:

> "The recent expansion at HMP Parc has seen an acknowledged increase on demand in relation to secondary care service within the local health board. The Welsh Government are already in discussion with relevant officials within NOMS-Cymru, to determine how best to response to this increase and where responsibility sits for enhanced healthcare funding."

Responsibility for action in response to HMIP's recommendation lay with the Healthcare Clinical Lead with a target date of 31 May 2018.

Independent Monitoring Board

30. 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 very concerned about the lack of secondary psychiatric care, particularly for elderly prisoners.

31. In their previous report for the year to February 2018, the Board had noted that there had been no increase in the mental health inreach service to reflect the prison's growing population and the increasing number of elderly prisoners. They said they were pleased to hear that the issue of appropriate funding for the size and needs of the current population had been raised at a high level and was on the 'at risk register' with the Welsh Assembly. They also said that some mental health services, such as personality disorder and dementia, were not covered by the inreach contract and that, as the local hospital was not commissioned to provide a psychiatric service to Parc, there was no access to secondary care in these areas.

Previous deaths at HMP Parc

32. Mr Heard was the thirteenth prisoner to die at Parc since August 2017. Six of the previous deaths were from natural causes, 12 were drug-related and two were self-inflicted. There were no significant similarities between the circumstances of Mr Heard's death and the previous deaths.

Key Events

33. On 19 November 2012, Mr Frederick Heard was convicted of sex offences and sent to HMP Parc. He was sentenced to 16 years in prison.

34. On 20 November, a prison GP noted that Mr Heard had vascular dementia (a common type of dementia caused by reduced blood flow to the brain), significant memory impairment, COPD, osteoarthritis, a stomach ulcer and he was deaf. On 3 December, the GP referred him to a community memory clinic run by the local older adult community mental health team (OACMHT) at Bridgend for a dementia assessment.

35. Mr Heard went to hospital a number of times in late 2012 and 2013 when his COPD symptoms worsened.

36. In March 2013, an in-reach psychiatrist reviewed Mr Heard and noted that he had moderately severe dementia, for which he was prescribed medication.

37. On 9 April, a community psychiatrist who worked for a consultant old age psychiatrist with Bridgend OACMHT, assessed Mr Heard's memory and referred him for further assessment.

38. On 26 November, a specialist community dementia nurse with Bridgend OACMHT, noted that Mr Heard had vascular dementia and was taking aspirin but should not be prescribed specialist dementia medication. She noted that he should be referred to the consultant old age psychiatrist, if needed.

39. On 18 February 2014, a prison GP reviewed Mr Heard's COPD and gave him a tiotropium bromide inhaler. It was the first time that his COPD had been reviewed at Parc.

40. On 24 February, Mr Heard was referred to the consultant old age psychiatrist at the community memory clinic. However, the psychiatrist noted that the community clinic was not adequately resourced to see prison patients. He noted that he and the Clinical Services Manager at ABMUHB had had no confirmation of funding arrangements to see prison patients and that "prison in-reach need to look at a buy-in to our services".

41. On 10 November, the consultant old age psychiatrist rejected a second referral to the memory clinic. The Deputy Healthcare Manager at Parc challenged the refusal by email. She noted her view that prisoners at Parc were entitled to services at hospital. There is no response to her email in Mr Heard's medical records.

42. On 30 January 2015, a nurse saw Mr Heard because he had chest pain. She sent him to hospital with a COPD exacerbation and a chest infection. He returned to Parc with antibiotics.

43. On 7 September, a nurse noted that she was concerned about Mr Heard's memory loss and confusion, and that he needed help from wing staff and prison buddies (prisoners who assist their peers with daily care). She arranged for a healthcare assistant to review him weekly.

44. On 27 October 2016, a nurse completed a COPD review.

45. On 24 February 2017, a nurse saw Mr Heard because his COPD symptoms had worsened. She sent him to hospital because she was unable to get a prison GP to review him. Hospital staff sent him back to Parc with antibiotics for a chest infection but nursing staff saw that he was still unwell. He returned to hospital the next day and stayed there until 1 March.

46. In June and July, Mr Heard's COPD symptoms flared up again and he was admitted to hospital in July for a day.

47. On 20 July, prison and healthcare staff held a multidisciplinary meeting as they were concerned that Mr Heard was distressed every night. He did not understand that he was in prison and wanted to go home, was kicking and hitting his cell door, and calling out until late at night. A prison GP considered sedative medication but decided against it because it would increase his risk of falling over.

2018

48. On 4 January 2018, a healthcare assistant documented a typical daily review of Mr Heard at this time, recording that he was exhibiting confused and aggressive behaviour, shouting and pulling at his cell door and asking to be let out because he lacked awareness that he was in prison, and required considerable daily intervention by prison wing and healthcare staff to calm and reassure him.

49. On 2 March 2018, Mr Heard's COPD symptoms worsened, and a nurse sent him to hospital. He returned to Parc the next day with antibiotics.

50. On 12 March, a locum prison GP noted that the prison inreach team had declined to see Mr Heard because they did not feel competent to decide how to manage his dementia. The GP again referred Mr Heard to the consultant old age psychiatrist at the OACMHT.

51. On 26 March, the locum prison GP recorded:

> "Rang Memory Clinic from the CVOP [Clinically Vulnerable Older Prisoners] meeting. The Consultant, Older Persons Mental Health, will not see this man and they are about to write back to me again. We need help and they are refusing. I asked to speak to the consultant direct and he is apparently incommunicado at present, so I have been advised to email him. I have the gravest concerns that this chap will come to harm as a result of us not being helped by Secondary Care. If I do not have a reply from him in the next week, I will have to escalate the matter. The commissioning process is not the appropriate mechanism by which to sort the lack of cover for this particular gentleman – the assistance we require is more urgent. He is now extremely distressed at night and spends about 3 hours 23:30-02:30 banging on his door and shouting."

52. On 21 May, the consultant old age psychiatrist emailed the locum prison GP to confirm that he would not be involved in Mr Heard's care and that Mr Heard was the responsibility of the inreach team as they provided all secondary mental health services. The GP emailed the Chief Executive of ABMUHB to ask them to consider the matter. On the same day, the consultant wrote to an inreach consultant psychiatrist to say that he could not assess Mr Heard because of funding arrangements. He provided some advice on Mr Heard's behaviour but did not suggest any medications that would help.

53. On 31 May, it was recorded that, as a result of the locum prison GP's complaint to ABMUHB, the Bridgend OACMHT manager had arranged for a psychologist and occupational therapist to complete assessments of Mr Heard prior to a review by the consultant old age psychiatrist. On 23 June, a community psychologist and a community occupational therapist assessed Mr Heard and noted that they would send their report to the GP for review. There is no record that the GP reviewed it.

54. On 23 August, the inreach consultant psychiatrist referred Mr Heard to Newport OACMHT, as Bridgend OACMHT would not see him. (Newport was Mr Heard's last place of residence.) He also recommended that Mr Heard should be prescribed lorazepam (a sedative) to help calm his agitation at night.

55. On 8 September, a nurse sent Mr Heard to hospital because he was struggling to breathe, and his COPD symptoms had flared up. The next day, he returned to Parc.

2019

56. On 7 January 2019, a locum GP noted that they were still waiting for a response from Newport OACMHT following their assessment of Mr Heard the previous month. Later that day, Mr Heard's COPD symptoms flared up again and she arranged for him to go to hospital. He returned to Parc with antibiotics and steroids.

57. On 17 January, a team leader at the Newport OACMHT sent a report to Parc which recommended that Mr Heard should be prescribed zopiclone (a sedative) at night or temazepam (a stronger sedative). She said that the Newport team did not plan to see Mr Heard again but would be happy to do so if asked.

58. A typical daily health care review was recorded by a support worker on 17 January, reporting that Mr Heard was confused, self-neglecting, was not eating without prompting (and had been prescribed food supplements as a result) and was often distressed and banging on his cell door for hours each night. On 23 January, a speech and language therapist carried out a swallowing assessment as he struggled to eat.

59. On 14 February, the inreach consultant psychiatrist noted that Mr Heard should have had a dementia assessment in November. A senior social worker and an occupational therapist said that without it, they could not complete an application for early compassionate release for Mr Heard.

60. On 26 February, Mr Heard was taken to A&E with a hand injury thought to have been caused by hitting his cell door.

61. On 28 February, a nurse found Mr Heard slumped in his cell, short of breath, barely conscious, with swollen legs and low blood oxygen levels (90%). She sent him to hospital, but he returned to Parc later that day.

62. On 4 March, prison staff arranged to fit padding to Mr Heard's cell door in April to prevent him harming himself as he was constantly hitting his cell door. On 7 March, Mr Heard injured his hand, banging on his cell door and was sent to hospital, where he stayed until 17 March as he developed pneumonia. When he returned to Parc, his health had deteriorated significantly and he was assessed as at risk of falls.

63. On 18 March, a locum prison GP prescribed Mr Heard temazepam because he was very distressed at night. On 21 March, a consultant psychiatrist at Newport OACMHT reviewed Mr Heard and recommended a trial of lorazepam, an additional sedative. She also arranged for Mr Heard to have an MRI and a CT scan because she was concerned that he had both vascular dementia and Alzheimer's.

64. That day, the multidisciplinary team at Parc submitted an Adult Protection Referral Form to Bridgend Social Services because of their concerns about Mr Heard's vulnerability and risk of injury to himself. The referral was countersigned by the Deputy Director of Parc, who formally raised concerns that custody was inappropriate as they could not meet Mr Heard's personal and social care needs.

65. In April and May, Mr Heard was frequently found on the floor of his cell. On 24 May, Mr Heard weighed 56 kilograms (8 stone 11lbs) and had lost 14.5% of his body weight since he had arrived at Parc.

66. On 30 May, members of the community mental health team saw Mr Heard. They recommended that in addition to his evening dose of temazepam, Mr Heard should take zopiclone and diazepam. (There is no evidence to confirm whether or not this happened.)

67. On 7 June, a psychiatrist from the Newport OACMHT and a forensic psychiatrist on the ABMUHB saw Mr Heard. They said that he should stop having zopiclone at night but increased his nightly dose of temazepam. On 12 June, the CT head scan showed that Mr Heard had vascular dementia. Throughout June, Mr Heard was noted to be drowsy for most of the day and often fell over.

68. On 2 July, a prison GP saw Mr Heard and said that he had bronchopneumonia. She gave him antibiotics and noted that he was very frail and might not recover. The following day, his COPD symptoms flared up and he was sent to hospital. Two days later, he returned to Parc with antibiotics and steroids.

69. Throughout July, Mr Heard frequently fell over and went to hospital with breathlessness and COPD. Mr Heard's health deteriorated further. A nurse noted that he was only able to stand with assistance, was incontinent of faeces and had a pressure sore on his sacrum. On 25 July, Mr Heard went back to hospital.

70. That day, at a safeguarding meeting, which the Deputy Director attended, agreed that they should try to expedite a move for Mr Heard to a more suitable location in the community.

71. On 2 August, staff at POWH informed prison healthcare that Mr Heard was continuing to deteriorate, and on 5 August they said that he was now being managed palliatively and was not expected to survive

72. On 8 August, prison staff completed a compassionate release application to Prison Service Headquarters. A hospital consultant noted that Mr Heard had advanced dementia and was at immediate risk of death.

73. Mr Heard remained in hospital, where he received palliative care. On 9 August, Mr Heard died. The application for compassionate release was granted the same day.

Contact with Mr Heard's family

74. On 10 March 2019, a prison chaplain was appointed as the prison's family liaison officer. On 11 March, she telephoned Mr Heard's next of kin and told her that he was in hospital. On 13 March, she met Mr Heard's next of kin at the hospital.

75. On 3 July, the chaplain telephoned Mr Heard's next of kin and told her that he was again in hospital. She remained in contact with her.

76. Mr Heard's next of kin was with him when he died on 9 August. Mr Heard's funeral took place on 10 September. The prison contributed to the cost in line with national instructions.

Support for prisoners and staff

77. The prison posted notices informing other prisoners of Mr Heard'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 Heard's death.

Post-mortem report

78. There was no post-mortem examination. A hospital doctor gave the cause of death as pneumonia. He said that Mr Heard also had COPD which contributed to but did not cause his death.

Findings

Clinical care

79. When Mr Heard went to Parc, he was elderly, frail and had a number of pre-existing health conditions which were compounded by his dementia. The clinical reviewer noted that the day-to-day care that healthcare and prison staff provided was compassionate and caring, particularly a locum GP's efforts in providing dementia care.

80. However, the clinical reviewer found that the healthcare that Mr Heard received at Parc was not equivalent to that which he could have expected to receive in the community.

81. Although Mr Heard's cause of death does not refer to dementia, the clinical reviewer said that it is likely that the COPD and dementia influenced each other and led to both conditions deteriorating at a faster rate than would have occurred if both conditions had been optimally managed.

COPD

82. The clinical reviewer found that Mr Heard's COPD was not adequately monitored at Parc in line with the Quality and Outcomes Framework. Despite several acute exacerbations of COPD in his first year at Parc, Mr Heard did not receive preventative treatment until 15 months after he arrived.

83. The clinical reviewer said that due to the frequency of Mr Heard's admissions to hospital for COPD, he should have been referred to a consultant respiratory physician who may have considered further treatments to reduce the number of hospital admissions. He also said that Mr Heard did not have an appropriate COPD care plan in place, which resulted in mainly reactive care.

84. Parc's Head of Healthcare agreed that Mr Heard's COPD care was below standard but said that in the last year, formal chronic disease review clinics had been implemented. She accepted that Parc had spirometry equipment, but that staff were not trained to use it. We make the following recommendation:

The Head of Healthcare should ensure that:

- **prisoners with COPD have an annual review, including a spirometry test;**
- **nursing staff are trained to undertake chronic disease monitoring, including spirometry tests; and**
- **when prisoners have repeated exacerbations of COPD and are on maximum inhaler therapy, healthcare staff consider referring them to a specialist.**

Dementia

85. Mr Heard arrived at Parc with dementia. During the seven years Mr Heard spent at Parc, his dementia worsened. His clinical records show that he changed from being someone who was occasionally confused and with some short term-memory impairment but generally content, to a man who was suffering significant daily mental distress, physical injury and harm and general deterioration in activities of daily living such as self-care and feeding himself.

86. When healthcare staff realised that Mr Heard had significant cognitive impairment, he was appropriately referred to the local OACMHT in Bridgend for specialist dementia assessment and treatment. However, the OACMHT repeatedly refused to accept referrals for Mr Heard over a period of years. The consultant old age psychiatrist from the Bridgend OACMHT said that his team were not resourced to provide care to people in prison and argued that the prison inreach team was funded to provide mental healthcare to all prisoners, including older adults. For their part, the inreach team said that they did not have the skills to deal with dementia and that it was for the community mental health team to assess Mr Heard and provide advice on his management and care.

87. Prison healthcare staff made a formal complaint to the Director of Mental Health Services at ABMUHB in May 2018. However, although this resulted in a preliminary assessment of Mr Heard by a psychologist and occupational therapist from Bridgend OACMHT, this was never followed up by a review by the consultant old age psychiatrist.

88. In August 2018, with no help from the Bridgend OACMHT, healthcare staff turned to the OACMHT in Newport (where Mr Heard had lived before entering prison). Although they could have declined (as they had no responsibility for Mr Heard or Parc), they tried to help and we commend them for doing so. However, this should not have been necessary and led to a significant delay in diagnosing and supporting Mr Heard.

89. The clinical reviewer noted that, although it was generally assumed that Mr Heard had vascular dementia, this diagnosis appears to have been made prematurely and was not confirmed until Newport OACMHT arranged for him to have a CT scan in March 2019. The clinical reviewer said that, given the delay, it was “fortuitous” that Mr Heard was not found to have a form of dementia, such as Alzheimer’s or mixed dementia, that might have responded to drug treatments to slow its progress.

90. By the time Newport OACMHT became involved in Mr Heard’s care, the only support that they could offer him was sedation medication which increased his risk of falls.

91. The clinical reviewer noted that there was a complete failure between Parc and the local Health Board (which funds both the inreach team and the OACMHT) to reach a solution to enable Mr Heard to access appropriate specialist care for dementia. The clinical reviewer said,

> “It appears somewhere in this argument over funding that managers or clinicians in the NHS Health Board forgot that a patient was suffering at the heart of this, leading to significant distress for him, other prisoners, and indeed the HMP Parc staff doing their best for him.”

92. We are not in a position to say whether the prison inreach team or the Bridgend OACMHT was funded to provide care for Mr Heard. However, we consider that the failure by the ABMUHB to resolve the impasse promptly and ensure that Mr Heard received the care he so clearly needed, was unacceptable. We find it very difficult to understand how this shocking situation was allowed to continue for years.

93. We note that HMIP identified the problem in January 2016, and that the prison had undertaken in response to determine where the funding responsibility sat by May 2018. It is very troubling to find that that the issue had still not been resolved by the time Mr Heard died in August 2019.

94. In July 2016, we published a Learning Lessons Bulletin about dementia. We identified that prisoners aged over 60 are the fastest-growing segment of the prison population and that this has led to an increase in deaths from natural causes and increasing social care needs of elderly and infirm prisoners. In the context of an aging prison population, it is likely that there will be many elderly prisoners like Mr Heard with dementia needs. It is essential that they have access to specialist mental health care.

95. We make the following recommendations:

The Director and Head of Healthcare at Parc should liaise with the Medical Director for G4S and arrange an urgent meeting with the Chief Executive of Abertawe Bro Morgannwg University Health Board to ensure that full service provision for patients with suspected dementia is made within 3 months of this report, and that in the interim patients requiring access are not refused care.

The HMPPS Executive Director for Wales should:

- **satisfy himself that effective action has been taken to ensure the provision of a full service for prisoners with suspected dementia at Parc;**
- **satisfy himself that there are no barriers to the provision of a full service for prisoners with suspected dementia at other prisons in Wales; and**
- **write to the Ombudsman to confirm that he is so satisfied.**

96. The clinical reviewer has made a number of other recommendations which the Head of Healthcare will need to address.

Compassionate release

97. Prison Service Order (PSO) 6000 provides for the compassionate early release of prisoners on medical grounds where:

- the prisoner is suffering from a terminal illness and death is likely to occur soon; or the prisoner is bedridden or similarly incapacitated; and
- the risk of re-offending is past; and
- there are adequate arrangements for the prisoner's care and treatment outside prison; and

- early release will bring some significant benefit to the prisoner or his/her family.

98. The PSO says that release on compassionate grounds is granted in only the most exceptional of circumstances, and the overriding factor in deciding whether or not to grant an application is risk to the public. Prisons should submit applications to the Public Protection Casework Section at HMPPS Headquarters.

99. The clinical reviewer said that it became apparent within a few years that Mr Heard had no idea that he was serving a sentence in prison and that being locked in a cell caused him mental distress and physical injury. He spent his days playing dominoes, colouring, threading beads on string and occasionally visiting the prison's collection of animals. He constantly asked to 'go home'. He was not restrained during his frequent hospital admissions.

100. The prison applied for Mr Heard's compassionate release on 8 August 2019, the day before he died, after hospital staff said on 5 August that he was unlikely to survive. We appreciate that there may have been difficulties in finding suitable accommodation for Mr Heard in the community. However, we consider that the prison could have applied for compassionate release earlier than they did when it became clear that Mr Heard was effectively incapacitated by advanced dementia. We are concerned that both prison and healthcare staff were under the impression that they could only apply for compassionate release if Mr Heard had a terminal prognosis (which he did not until the last few days of his life). We cannot say whether an earlier application would have been granted, but we recommend:

The Director and Head of Healthcare should remind staff that compassionate release applications on medical grounds may be made for prisoners who are incapacitated, and not only for those who are terminally ill.

Inquest

101. An Inquest for Mr Heard's death was opened on 16 August 2019 and concluded on 28 March 2025. It found that Mr Heard died from bronchopneumonia, chronic obstructive pulmonary disease and dementia.

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