

A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

---

**Investigation into the death of a man, at HMP Parc, in  
November 2012**

## ***Our Vision***

*'To be a leading, independent investigatory body,  
a model to others, that makes a significant contribution to  
safer, fairer custody and offender supervision'*

This is the report of an investigation into the death of a man at HMP Parc, in November 2012. He was 27 years old and was found dead in his cell. A post-mortem examination was unable to ascertain a cause of death but noted it was possibly related to epilepsy. I offer my condolences to his family and friends.

The investigation was carried out by an investigator. The local Primary Care Trust (PCT) conducted a review of the man's clinical care in custody. HMP Parc cooperated fully with this investigation.

The man had been diagnosed with epilepsy in 2002 and took medication to help control his fits. During a morning unlock in November he was found unresponsive in his cell. Staff and paramedics attempted to resuscitate him, but he did not respond. He was pronounced dead at 6.43am.

Despite weaknesses in obtaining community medical records and the need to manage hospital appointments better, the PCT conclude that the clinical care the man received was equivalent to what he could have expected to receive in the community. However, I share their concern that Parc allocated him a single cell rather than a shared cell, contrary to their own epilepsy policy. It is possible that a cell mate could have raised an alarm when he was unable to do so. The investigation has identified a need for greater awareness of the risk of sudden death in epilepsy and a need to ensure prisoners at risk are identified and managed appropriately.

Although there was minimal delay in calling an emergency ambulance in this case, it was not called automatically despite the life-threatening situation. This is an issue that has arisen in other fatal incident investigations at Parc. I am, therefore, pleased that the prison accepted a recommendation about this in response to an investigation into another death that occurred around the same time as this one, and that lessons have now been learned.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

**August 2013**

## **CONTENTS**

Summary

The investigation process

HMP Parc

Key events

Issues

Recommendations

## SUMMARY

1. The man was remanded to HMP Cardiff on 5 October 2011. On 28 November, he was convicted of assault with intent to cause grievous bodily harm and sentenced to 4 years 6 months imprisonment. On 30 January 2012, he moved to HMP Parc.
2. The man had been diagnosed with epilepsy in 2002. He took epilim to help control his fits. HMP Parc's epilepsy protocol states that prisoners with epilepsy should be accommodated in a shared cell on the ground floor, but he was given a single cell on the first floor of a residential wing. His epilepsy consultant had advised that he should be moved to a cell with CCTV coverage, but this did not happen.
3. The man was due to go to hospital on 30 August for an electroencephalogram (EEG)<sup>1</sup>. His appointment was cancelled twice. The first time, the reason for the cancellation was not recorded and the second time was due to escort staff being late. He had to wait seven weeks for his EEG and eventually had the test on 19 October. The results of the EEG were normal.
4. During the morning roll one morning in November, the man was found unresponsive in his cell. Wing staff called a code red<sup>2</sup> emergency at around 6.10am, and started cardiopulmonary resuscitation (CPR – a mixture of rescue breaths and chest compressions to manually circulate oxygen around the body). The duty manager responded to the emergency call and when he arrived at the cell, he asked the control room to request an emergency ambulance. Two nurses also responded to the emergency call, taking oxygen and a defibrillator<sup>3</sup> with them. CPR was continued by wing staff and nurses, until paramedics arrived at about 6.30am. Despite the efforts of staff and paramedics, he did not respond and was pronounced dead at 6.43am.
5. The PCT concludes that the man's care was equivalent to the care he could have expected to receive in the community, but was concerned that the prison did not follow its own epilepsy protocol to manage the risk of sudden unexpected death in epilepsy. We make a recommendation about the cancellation of hospital appointments for operational reasons and we are concerned that his medical records were not complete. As we have found in previous investigations into deaths at Parc, there was also a need to ensure the automatic calling of an emergency ambulance in life threatening situations. Parc have now accepted this and we have, therefore, not repeated the recommendation.

---

<sup>1</sup> A test that records the electrical activity in the brain

<sup>2</sup> A code red emergency at Parc indicates a life threatening situation.

<sup>3</sup> A device which measures electrical activity in the body and delivers brief electric shocks when appropriate to help the heart to re-establish its rhythm

## THE INVESTIGATION PROCESS

6. The Ombudsman's office was informed of the man's death on 6 November 2012. The investigator issued notices to staff and prisoners informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.
7. The investigator visited HMP Parc on 12 November. She met the Director and Deputy Controller (contracts for privately managed prisons are monitored on site by a Ministry of Justice appointed controller). She visited the man's cell and also spoke to the prison's family liaison officer.
8. Our investigation was suspended on 2 January 2013 because the man's cause of death could not be confirmed. Although his cause of death could still not be confirmed by a post-mortem examination, we began the investigation again on 11 February when the investigator received the inconclusive post-mortem report.
9. The investigator reviewed copies of the man's prison and medical records. The PCT conducted a review of his clinical care and had copies of all relevant medical records. The investigator and clinical reviewer carried out joint interviews with staff on 4 and 5 December 2012. The investigator fed back preliminary findings to the Director of Parc during the investigation.
10. HM Coroner was informed of the investigation and provided the post-mortem report. A copy of our investigation report has been sent to the Coroner.
11. One of the Ombudsman's family liaison officers contacted the man's father and mother shortly after his death and explained the purpose and scope of the investigation. They made no comments on the draft report.

## **HMP PARC**

12. HMP & YOI Parc opened in 1997 and is run by G4S. It can hold more than 1,400 convicted male adult prisoners on remand or convicted. It also has a unit for up to 64 people under 18.
13. There are 24 hour healthcare services at Parc provided by G4S. The healthcare centre has a 14 bed unit for older prisoners and those with increased health needs and six emergency care beds for patients with acute physical or mental health needs.

## **HM Inspectorate of Prisons (HMIP)**

14. HM Inspectorate of Prisons (HMIP) last completed a full unannounced inspection of Parc in September 2010. HMIP reported that, at the time, healthcare services were not delivered to an acceptable standard. Only basic health interventions were being delivered and prisoners were extremely unhappy with the overall service. G4S was about to take over the provision of healthcare services at the time of the inspection.

## **Independent Monitoring Board (IMB)**

15. Each prison in England and Wales has an Independent Monitoring Board of unpaid volunteers from the local community who monitor day-to-day life in the prison to help ensure that proper standards of care and decency are maintained. The last report published by the IMB for Parc, covering the period March 2011 – February 2012, noted that the prison was well-run and safe. Some problems with prisoners being made aware of medical appointments were noted.

## **Previous deaths at Parc**

16. In the last two years there have been nine deaths from natural causes at Parc, seven since the man died. We have repeated a recommendation in this report about the prompt calling of an ambulance.

## KEY EVENTS

17. The man was remanded to HMP Cardiff on 5 October 2011, charged with assault. Initially his medical records were handwritten before an electronic system was introduced in November 2011. His handwritten medical notes were not summarised in his electronic record, so there is no record of his initial health screens or treatment. There is no evidence that his community GP records were obtained. As part of the reception process he had a cell sharing risk assessment (CSRA) where it was recorded that, due to epilepsy, he needed to be given the bottom bunk in a shared cell.
18. On 23 November 2011, a nurse noted that the man had epilepsy and was taking epilim. This was the first reference of his condition in his medical record. His body mass index (BMI)<sup>4</sup> was noted as 32.1.
19. On 28 November, the man was convicted of assault with intent to cause grievous bodily harm and was sentenced to 4 years 6 months imprisonment.
20. The man had an epileptic fit early in the morning of 14 December. He was examined by a nurse after the fit and had no injuries. He was not assessed by a doctor.
21. On 3 January 2012, the man had another fit. A Healthcare Assistant went to his cell. When he arrived, his cell mate had put him in the recovery position on his bed. He was breathing, but still fitting. His cell mate stayed with him until he recovered. When he left, he left the cell door open so staff could get to him easily if necessary. His cell mate was asked to let staff know if there were any more problems.
22. Later that day a doctor assessed the man. She noted that he had suffered from epilepsy for ten years and had up to five fits a year, normally in his sleep. He said that recently he had been experiencing more fits and was worried and stressed about his sentence. He said that he had been sleeping erratically, but had no physical symptoms or complaints. It was noted that he was last seen in the neurology department at hospital in March 2011. There had been some findings on his EEG, but he did not go back for the results. She examined him and recorded that he was fit and well. His blood pressure was 113/82<sup>5</sup>, and she planned to increase his epilepsy medication and referred him back to the neurology department for further assessment.
23. On 12 January, a letter was received from the hospital to say that he had been put on the waiting list for an appointment.
24. On 17 January, a nurse saw the man in his cell after he had had a fit. It took him five or ten minutes to recover, which was much slower than normal. The

---

<sup>4</sup> A tool used to check if you are a healthy weight for your height. A healthy BMI is between 18.5 – 25. Over 30 is classed as obese.

<sup>5</sup> An “ideal” blood pressure reading is between 90/60 and 120/80.

nurse described him as very lethargic and disorientated during the recovery, but noted no further concerns.

25. A doctor saw the man on 20 January. He told the doctor that, before a seizure, he would get a dry mouth before a fit, so he would lie down and tell his cell mate. She planned to check the dose of his epilepsy medication in his blood and then review him in four weeks. The results of the blood test were normal.
26. On 30 January 2012, the man transferred to HMP Parc. At his initial health screen a registered mental health nurse (RMN) noted that he had been diagnosed with epilepsy ten years previously and he was taking medication. The nurse recorded that it was recommended he should be in a ground floor cell, but did not record that he should share a cell or be on the bottom bunk. He signed an epilepsy disclosure document, which was scanned into his electronic medical record. In the document he undertook to tell healthcare staff if he had a seizure. In the event of a prolonged seizure, he agreed that rectal diazemuls<sup>6</sup> could be administered.
27. The man was assessed as an increased risk for sharing a cell, but there is no further explanation. It was also recorded that he was epileptic and that he had said he was okay. There is no record of any consideration that, according to the prison's epilepsy policy, he should have been in a shared cell on the ground floor.
28. A doctor reviewed the man on 31 January. He noted that he had no other health problems, apart from epilepsy. The doctor asked that the hospital should be informed of his change of address, so that future correspondence would be sent to HMP Parc. A medical administrator did this later that day and recorded that the hospital said there was a five month waiting list.
29. On 7 March, the man requested to see a nurse and was given an appointment for the same day. He did not attend, but the appointment was rebooked for 13 March when a nurse saw him. He said that his urine had an offensive smell and he was experiencing pain when he urinated. A urine sample was sent for analysis. He was advised to drink more fluids and that he would be seen by a doctor the next day. A doctor reviewed him the next day and said that the urine sample had been normal, so he did not require treatment.
30. On 31 July, the man attended a neurology appointment at hospital. A letter summarising the consultation was sent to the healthcare centre at Parc, confirming that he had been diagnosed with epilepsy when he was a teenager. He told the consultant that sometimes he woke up feeling that he was choking and that air was being sucked out of him. This lasted a matter of seconds and was followed by a seizure. He would have two to three larger "events" a month and one minor, all of which occurred during his sleep. It was noted that he probably had frontal lobe epilepsy (the second most common

---

<sup>6</sup> A drug used to sedate someone who is having a prolonged seizure. The drug is administered rectally as this is the safest route when someone is fitting.

form of epilepsy) and the consultant advised that his medication dose be increased. He was to have an EEG and MRI (Magnetic Resonance Imaging) scan. The consultant said it would be helpful if he could be moved to a room in the prison with CCTV where any seizures could be recorded. He was to be reviewed by the consultant in four months. On 14 August, a doctor changed his prescription, but did not record anything about the frequency of his fits, or that he needed to be in a cell with CCTV coverage.

31. The man received an appointment for an EEG on 30 August, but it was changed to 17 September. There is no record as to why the appointment was changed. Due to a delay in the escort services returning from another hospital appointment, he missed his EEG appointment on 17 September; he eventually attended one on 19 October. The results of the EEG were normal, and it was agreed that he would be reviewed again once he had had the MRI scan, arranged for 16 November.
32. Just before 6.10am, Prison Custody Officer (PCO) A carried out the morning roll count one morning in November. He opened the observation panel on the man's cell door and saw that he was kneeling on the floor with his head on the bed. The PCO could not get a response from him, so called for assistance from PCO B and they went into the cell. The PCO could not find any signs of life, so the officers moved him onto his back and started cardiopulmonary resuscitation (CPR). At 6.10am PCO A called a code red<sup>7</sup> emergency. The duty manager arrived 30 seconds after the code red was called. When he arrived at the cell, he asked the control room to request an emergency ambulance. Two nurses were in the healthcare department when they heard the emergency call and went to the cell, taking oxygen and a defibrillator with them. It took about three minutes for them to get to the cell, so they arrived at about 6.13am.
33. When the nurses arrived, oxygen was administered and the defibrillator was attached. CPR was continued in rotation by wing staff and nurses, until paramedics arrived at about 6.30am. The paramedics took over the resuscitation attempt and administered adrenaline (drug used to stimulate the heart). A second ambulance arrived to assist with the resuscitation attempt. Despite the efforts of staff and paramedics, the man did not respond to the resuscitation attempts and was pronounced dead by paramedics at 6.43am.

### **Support for prisoners**

34. Notices were displayed in the prison to let prisoners know of the man's death and the support that was available to them. All prisoners subject to suicide prevention monitoring were reviewed. A memorial service was held at the prison later on 6 November.

---

<sup>7</sup> A code red emergency indicates a life threatening situation.

### **Support for staff**

35. The duty director held a debriefing session to support to the officers and nurses who had been involved in the emergency incident.

### **Family liaison**

36. The prison chaplain was appointed as the prison family liaison officer. On the morning of the man's death, the chaplain and the Director of Parc went to see the man's father and broke the news. His father said that he would let his wife know what had happened. The chaplain explained that she would be the main point of contact and was there to support them. She returned to the family home the next day to meet other members of his family. The prison contributed to the funeral in line with national guidelines. The funeral was held on 23 November 2012.

### **Post-mortem report**

37. The post-mortem examination was unable to ascertain a cause of death. The pathologist commented "this young man appears to have been taking his anti-epileptic medication. The autopsy showed no features to suggest a life-threatening disease. The toxicological analysis showed no evidence of intoxication by, or exposure to, alcohol or drugs. The cause of this man's death is unclear. I note he was an epileptic, and epilepsy could account for his death in the manner described. However, in the absence of eye-witness evidence I consider it safest to record a cause of death as unascertained".

## ISSUES

### Clinical care

38. The man suffered from epilepsy, which was diagnosed in 2002. He took epilim to help prevent his fits. He did not have any other health concerns. The PCT concludes that the overall clinical care he received while at HMP Parc was equal to what he might have expected in the community. He was referred for appropriate tests (an EEG and MRI scan), and at Cardiff a doctor requested a blood test, which was good practice.

### Epilepsy protocol

39. HMP Parc's epilepsy protocol is intended to ensure that prisoners who suffer from epilepsy are treated in line with National Institute for Health and Clinical Excellence (NICE) guidelines. The protocol states that prisoners with epilepsy should be accommodated on the bottom bunk of a shared cell on the ground floor of a wing. A risk assessment should be completed for epileptic prisoners to assign them suitable employment, avoiding machinery and kitchen equipment for safety reasons.
40. Despite the policy, the man was accommodated in a single cell at Parc on the first floor of the wing. When he was at Cardiff, his cell mate raised the alarm when he was having a fit, and was asked to alert staff if there was an emergency. He did not have a cell mate at Parc. Although a hospital consultant requested that his fits at night should be monitored by using a cell with CCTV, there is no evidence that this was considered.
41. The PCT explains sudden unexpected death in epilepsy (SUDEP)<sup>8</sup> in the clinical review. The risk factors including being a young male adult and having sleep seizures, so his was at raised risk. The PCT advises that the epilepsy protocol should include a risk assessment for SUDEP. The risk of sudden death reinforces the importance of Parc following its own procedures for prisoners with epilepsy, which was not done in this case.
42. Had the man been in a shared cell at Parc, in line with the protocol, it is possible that a cell mate could have raised the alarm if it was evident he was ill. Parc did not follow its own epilepsy protocol when considering his location or identify his risk of sudden death.

**The Director and Head of Healthcare should ensure that prisoners with epilepsy are assessed for the risk of sudden death, accommodated and managed appropriately and that staff adhere to the protocol for all epileptic prisoners.**

---

<sup>8</sup> When a person with epilepsy dies unexpectedly, and no obvious cause of death can be found. The single most important risk factor is uncontrolled seizures which involve loss of consciousness, when the body goes stiff and starts jerking.

## Retrieval of community medical records

43. The Nursing and Midwifery Council (NMC) is a regulatory body for England, Wales, Scotland and Northern Ireland. The NMC has clear guidelines relating to record keeping. Good record keeping is an integral part of nursing, and is essential to the provision of safe and effective care. Good record keeping helps to improve accountability, continuity of care and effective clinical judgements and decisions.
44. The PCT is concerned that written records from HMP Cardiff are missing and staff at HMP Parc did not follow these up. There is no evidence that his community medical records were sought by either Parc or Cardiff.
45. Prison Service Order (PSO) 3030, Continuity of Healthcare for Prisoners states that when a new prisoner arrives,  

“...Efforts should be made to retrieve any information required from the prisoner's GP or other relevant service he/she has recently been in contact with. The prisoner's explicit consent should be obtained before doing this...”
46. We make the following recommendation:

**The Heads of Healthcare at HMP Cardiff and HMP Parc should ensure that community medical records are obtained as part of the reception health screening process, particularly when a prisoner has a pre-existing condition.**

## Cancelled hospital appointments

47. The man was due to have an EEG at hospital on 30 August, but this was changed to 17 September. There is no record to explain why the appointment was changed. On 17 September, escort officers were delayed, so he missed another appointment. He eventually attended his EEG appointment on 19 October, seven weeks after the date of his original appointment.
48. It is unacceptable that the man missed two hospital appointments and had to wait seven weeks for his EEG. When prisoners' hospital appointments are cancelled there should be fully documented reasons given to explain and justify the cancellation. We make the following recommendation:

**The Director should ensure that hospital appointments are cancelled only as a last resort and that staff clearly record the reasons for cancellations.**

## **Calling an emergency ambulance**

49. A code red was called at 6.10 am. Officers waited for the duty manager to get to the cell to request the ambulance. The duty manager said that when a code red is called it is his responsibility, as the duty manager, to assess the situation and call an ambulance. Although there was almost no delay in this case, as a code red signifies a life threatening situation we consider that this should trigger an ambulance to be called automatically. This is now a requirement of PSI 03/2013 about medical emergency response codes. (We also draw to the attention of the prison that the PSI now requires a two level code system which differentiates between injuries. It recommends that 'Code Red' should be used for blood/burns and 'Code Blue' for breathing/collapses. This helps emergency responders know what equipment to bring.)
  
50. In an investigation into a death at Parc in December 2012, we recommended that the Director ensure that the control room calls an emergency as soon as an emergency code is called, which is now also required by PSI 03/2013. We do not repeat the recommendation here as Parc has accepted the recommendation in that case.

## RECOMMENDATIONS

1. The Director and Head of Healthcare should ensure that prisoners with epilepsy are assessed for the risk of sudden death, accommodated and managed appropriately and that staff adhere to the protocol for all epileptic prisoners.

**The prison accepted this recommendation.**

**“All prisoners with epilepsy have a full assessment for sudden death. All prisoners with epilepsy will have a Supported Living Plan opened, which will include a care plan advising staff on appropriate accommodation, work allocation and management.”**

2. The Heads of Healthcare at HMP Cardiff and HMP Parc should ensure that community medical records are obtained as part of the reception health screening process, particularly when a prisoner has a pre-existing condition.

**The prison accepted this recommendation.**

**“Community GP records are now routinely requested from GP surgeries – for ALL offenders.”**

3. The Director should ensure that hospital appointments are cancelled only as a last resort and that staff clearly record the reasons for cancellations.

**The prison accepted this recommendation.**

**“Only the Director, Deputy Director or Head of Security will have the authority to cancel hospital appointments. A dated record of the person giving authority to cancel the appointment and the reasons why will be placed on a prisoners file. A central register is also held with the Security Department.”**