

**The death in custody of a man  
HMP and YOI Parc – 3 July 2004**

**Report by the Prisons and Probation Ombudsman  
for England and Wales**

**September 2004**

This is the report of an investigation into the circumstances of the death of a man on 3 July 2004.

All deaths of prisoners in custody are investigated, including those due to natural causes. The responsibility for carrying out these investigations traditionally fell to the Prison Service itself, but has now been passed to the Prisons and Probation Ombudsman (PPO) to bring independence and greater consistency to the task.

In this case, the investigation has been carried out by one of my investigators Thea Walton. Emma Bradley, Deputy Ombudsman, conducted an independent clinical review.

The man died in the Prince of Wales hospital, Bridgend. He was serving a life sentence at Parc at the time of his death. He had spent over half his life in prison.

My colleagues and I would like to extend our condolences to the man's family and friends for their loss. We would also like to thank the Director at Parc Prison at the time of our investigation, and the other members of his staff who assisted us for their help. We found staff helpful and cooperative.

**Stephen Shaw**  
**Prisons and Probation Ombudsman**

**September 2004**

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## **Summary**

The man died at the age of 59 at the Prince of Wales Hospital, Bridgend, following a long illness and subsequent liver failure, which resulted in his death. He was serving a life sentence in HMP and YOI Parc. His death was not connected to the fact that he was in prison or to the level of care that he received there.

The man was a person with multiple medical problems, including liver failure, cirrhosis of the liver, hypertension, chronic active hepatitis, diabetes and thyroid problems.

He had been in prison for 31 years and was therefore acutely familiar with prison life. The report concludes he had as good access, if not better, to medical services in prison as he would have had outside.

The man received a high level of care for his needs both inside and outside of prison. There are, however, some improvements that can be made in regard to the standards of record keeping of healthcare notes.

## **Background**

The man was born on 22 November 1944 and was 59 years old when he died on 3 July 2004. He was one of a large family and seems to have had a troubled childhood.

On leaving school the man found work as a tea boy, then as a labourer, then later as a crane driver in a steel works. This employment was interspersed with periods where he lived off the proceeds of petty theft.

His first custodial sentence was imposed in 1964, when he was given 6 months imprisonment. This was followed by a six-year sentence in 1966, before being sentenced to life imprisonment in 1973 aged only 28.

In 1999, he was assessed as suitable for open conditions and he was transferred to HMP Leyhill where he completed a Sex Offender Treatment Booster Programme. A number of high risk factors and concerns were identified and it was recommended that he return to closed conditions in order to complete the Extended Sex Offender Treatment Programme. It was not until July 2002 that the man went to HMP Usk to undertake the programme, however illness meant he was unable to attend many sessions. At the time of his death, he had been in custody in Parc since 25 November 2003. He had spent time in 13 different prisons over the previous 31 years.

The man was well known to the staff at Parc as a result of his poor health since he arrived there. He was particularly well known to healthcare staff who had dealt with many of his physical problems on a daily basis including the provision of insulin for his diabetes. The man preferred to be located on the wing rather than in healthcare whenever possible.

Other prisoners described him as a nice man, generally keeping himself to himself and being resigned to his fate.

## **Investigation process**

All the indications were that this was a death from natural causes. In these circumstances, it may be sufficient for a clinical review to be carried out by an independent health care professional, rather than a full investigation. My approach in cases of apparent natural cause deaths has been to conduct an initial review to determine if a full investigation is justified. In this man's case, I decided that the circumstances did not require a full investigation.

I did so after the investigator visited Parc and had a helpful discussion with the deputy Director, as well the Head of Residence, a Senior Officer of the wing where the man lived, other prisoners and the Head of Healthcare. The investigator recommended that a full investigation was not warranted and, in light of the circumstances, I agreed.

My investigator visited Delta wing, where the man was a resident. Here my investigator was able to visit his cell. The cell was on the ground floor and was large, allowing easy movement, and was appropriate for a man with his medical condition. The supervisor in charge of the wing, said sometimes the man needed help with fetching his food and cleaning his cell. There was no formal provision for this, but the wing supervisor would arrange this when it was needed. He also commented that wing staff were kept well informed of the man's medical needs by healthcare staff. The only concern the wing supervisor had was that sometimes wing staff had been worried by the man's behaviour. He would often appear confused and occasionally exhibited strange behaviour such as dressing inappropriately. Emma Bradley, who conducted the clinical review, explained that confused and strange behaviour was not uncommon amongst people with end stage liver failure, due to toxicity. This could perhaps have been better communicated to wing staff.

My investigator met the Chair of the Independent Monitoring Board (IMB). The only issue the IMB wanted to raise was the time that passed between a death occurring and the inquest taking place. This had been many months following previous deaths in custody, and placed extra stress on both family members of the deceased and staff. In the case of this man, the inquest was timely, and was held in October 2004.

My investigator was given access to all the man's prison records, including his medical records, and obtained copies of everything she required.

My family liaison officer was unable to contact the man's brother, by telephone. A letter was sent by the investigator inviting him to get in touch to make any comments or ask questions if he wished.

## **The events leading up to the man's death**

The man arrived at HMP and YOI Parc on 25 November 2003. Prior to this, he had spent time in 13 other establishments during his sentence. From 4 July 2002 till 7 November 2003, the man was in HMP Usk during which time he had visited outside hospitals on seven occasions with several long stays in hospital from July 2003. These were all related to the man's liver failure. The head of healthcare at Parc prison, believed that the man was transferred to Parc because of Parc's inpatient healthcare facility.

Between 10 December 2003 and 3 July 2004, when the man died, he visited the Prince of Wales Hospital nine times for investigations and treatment of his liver failure. On all but one of these visits, he stayed in for several days. The head of healthcare informed the investigation that healthcare, and hospital doctors believed each time the prognosis was so poor that he would not return from hospital. But, in fact, he would recover enough to return to Parc.

A report in April 2004 by a probation officer, commented that early in 2004 a senior nurse had asked the prison doctor to furnish a report on the man with a view for release due to ill health. However, the doctor felt unable to do so due to the nature of the man's offences. The probation officer made enquiries with two hospices in Teeside, where the man's mother lived. Both operated a policy of either short-term stay or long-term stay in the final stages of illness. The improvements the man was able to make in hospital denied him access to either hospice at that time but the probation officer felt that hospice care should be considered should the man's health dramatically deteriorate.

In May 2004, while the man was in hospital, forms were raised by Parc's duty director, for the man's release on compassionate grounds. However, they would not be submitted until the man was diagnosed "not for resuscitation". The man recovered from this episode and returned Parc on 10 May 2004.

The wing supervisor on Delta wing, knew the man was very ill, and would often check to see how much of his meal he had eaten, as he knew this was important due to the man's diabetes. The wing supervisor reported that healthcare staff would see the man on the wing daily to give him his insulin as he would often refuse to take it himself. This was confirmed by the head of healthcare. However, this information was not regularly recorded in the man's medical records (IMR).

By 18 May 2004, the man had once more been discharged to the Prince of Wales Hospital. He returned to Parc on 15 June 2004 and he refused to go to healthcare. His insulin was administered on his return from hospital but no other medication was administered as no discharge information was received from the hospital.

The man made his final trip to hospital on 26 June 2004. No entry could be found in the IMR as to why he was admitted to hospital on this occasion. Entries in the IMR after this date were made every two days until he passed away.

The bedwatch log records that the prison chaplain visited the man on 30 June 2004 and arranged to contact the man's brother. The man was able to speak to his family on the phone on 1 July 2004. The bedwatch log also states that the man was never in handcuffs.

The man's death on 3 July was expected. The post mortem report defined the cause of death as end-stage liver failure and cryptogenic cirrhosis of the liver.

## **Post Incident Response**

All the necessary information was gathered together for the purposes of the investigation. Arrangements were made for my investigator to see the relevant members of staff so that we could satisfy ourselves as to the way in which the man had been cared for in prison.

## **Findings and Conclusions**

Staff on the wing where the man was situated were aware of his needs and acted on these needs. However, consideration might be given to asking a trusted prisoner to have acted as a helper to him during the terminal stages of his illness.

Furthermore, there were times when wing staff were concerned by the man's behaviour, that could have been explained by his illness. Communication between wing staff and healthcare staff could have alleviated some of this concern.

Standards of healthcare in prison are intended to mirror those available in the outside community. The man was well cared for in Parc, and probably received better healthcare when he was there than he would have accessed outside in the community. However, information regarding the care he received was not always recorded in a systematic and comprehensive matter and this undermines the work that is being achieved. The clinical review found that the Care Plans were *"of a variable quality and whilst the problem has in the main been correctly identified the goal and the objectives do not always match, particularly when the standardised care plan has been used"*. Furthermore, the review found that *"the nursing documentation is poorly completed often with questions unanswered and information missing"*.

Documentation in the IMR also refers to prisoners by their surnames only, which is inappropriate and disrespectful.

Proper consideration was given to the possibility of the man being released on compassionate grounds. A report giving consideration to hospice care was completed by a Probation officer in April 2004. When the man was ill in April 2004, a Compassionate Medical Condition Report was raised. However, the medical officer has not signed this, no clear reasons are given as to why the man should not be considered, and no reasons are given to why his care should be reviewed in three months.

## **Recommendations**

There are three recommendations deriving from the investigation into this man's death.

### **For the prison service:**

#### **Recommendation 1:**

The Compassionate Medical Report Form is not signed by the completing medical officer and it is noted there is no part on the form requesting them to sign the form.

**The Compassionate Medical Report Form should be reviewed to include the provision for the Managing Medical Officer to sign the report.**

### **For the establishment:**

#### **Recommendation 2:**

The care plans were of variable quality and, whilst the problem has in the main be correctly identified, the goal and the objectives do not always match, particularly when the standardised care plan has been used.

**The use of standardised care plans should be reviewed and, if a decision is taken to continue using them, there must be adequate space for patient specific issues.**

#### **Recommendation 3:**

The nursing documentation was poorly completed often with questions unanswered and information missing. The use of surnames only is inappropriate and disrespectful.

**All nursing documentation must be completed in accordance with the NMC Guidelines for Records and Record Keeping.**