# Investigation into the circumstances surrounding the death of a prisoner at HMP&YOI Parc on 9 January 2009

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

**July 2009**

This is the report into the circumstances surrounding the death of a prisoner at HMP/YOI Parc. After going through the reception process at Parc on 3 November 2008, the man was immediately located in the healthcare wing to be treated for his existing medical conditions. He remained in the healthcare wing for most of the time. On 9 January 2009, he was discovered collapsed in his cell by a nurse. Nursing staff quickly responded and administered cardio pulmonary resuscitation which continued until the arrival of paramedics. Sadly, resuscitation attempts were unsuccessful, and the man was pronounced dead by paramedic staff at 4.21pm. He was 58 years old.

I would like to offer my condolences to those who knew him and have been touched by his death.

One of my investigators conducted the investigation on my behalf. I am grateful to the Director of Parc and her staff for their assistance and co-operation. I am also grateful to the Healthcare Inspectorate Wales who carried out a review of the man's medical care while in custody.

The clinical review concludes that the healthcare afforded to the man appears to have been generally good. Medical records were in good order, and staff reacted swiftly and correctly to resuscitate him when he collapsed. However, the report expresses concern that the confusion that he exhibited a fortnight before his death was not investigated more thoroughly to eliminate a medical cause. I concur with the reviewers views and endorse two recommendations made by them.

**Stephen Shaw CBE**
**Prisons and Probation Ombudsman** **July 2009**

**CONTENTS**

## SUMMARY

The man was sentenced to 50 weeks imprisonment on 3 November 2008. On his reception at HMP/YOI Parc he was assessed by a member of the healthcare team who quickly identified the need for him to be located in the healthcare wing. He had sores that appeared to be infected and these were re-dressed by the nursing staff.

The following day, a doctor who had been asked to see him concluded that he would benefit from being admitted to the local hospital for his condition to be properly assessed. He was escorted to Princess of Wales Hospital later that afternoon where he was seen by a consultant. The hospital did not admit the man and discharged him back to the prison with advice for medical staff on dressing the wounds on his lower body.

Over the next few weeks, he was treated by nursing staff in line with a care plan that had been agreed. However, it is recorded that he would often refuse to bath or allow nurses to change his dressings despite the possibility of further infection if he failed to do so.

He was seen by a member of the Independent Monitoring Board (IMB) on 30 December, after complaining of being assaulted by a nurse. The IMB member spoke at length to the man and reported the complaint to the duty director who also spoke to him. However, no formal investigation took place despite the serious nature of the allegations. This has since been addressed by the Director of HMP/YOI Parc.

The man was moved to a residential wing on 31 December as he had been considered fit to do so by a doctor. His care plan remained in place and he was taken to the healthcare unit every two days for his wounds to be re-dressed and to use the bath. During one of these visits on 6 January, it was found that his wounds had become further infected. He was re admitted to the healthcare wing and his care plan revised.

At 4.00pm on 9 January 2009, a nurse unlocked him and found him lying on the floor of his cell. The nurse called for help and, along with her colleagues, administered cardio pulmonary resuscitation (CPR). An ambulance was called and the nursing staff continued CPR until the arrival of paramedics. Paramedics gave further treatment and continued first aid, but at 4.21pm they pronounced the man dead. He was 58 years old.

He died from natural causes, but the exact cause of death has yet to be established. Funeral arrangements were made by the prison, in consultation with a rabbi, as he was estranged from his family.

I am satisfied that the care given to the man during his sentence was generally appropriate and that staff made every effort to resuscitate him when he was found. I have endorsed two recommendations arising from the review into his medical care. I also reflect on the prison's response to the complaint of bullying/assault he made.

## THE INVESTIGATION PROCESS

1. The Director of Parc, provided the man's prison and medical records for examination. Notices were issued to staff and prisoners to inform them of the investigation process and to give them the opportunity to speak with the investigator. No responses were received.

2. My investigator visited Parc on 19 February and met with the liaison officer. While at Parc, the investigator spoke at length with a member of the prison's Independent Monitoring Board (IMB), who had seen the man in December. The member of the IMB raised concerns regarding allegations of bullying, and these were looked into by my investigator. He also spoke with the nursing staff that had been responsible for caring for the man at Parc.

3. The investigator wrote to HM Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. A copy of my report will be made available to the Coroner to assist with his enquiries.

4. Healthcare Inspectorate Wales, conducted the clinical review of the man's medical care. During this process, they looked at all the available documentation and also obtained further information that was not initially available in relation to the wound management in place at HMP Parc. In addition, the review has looked at the treatment the man received at Princess of Wales Hospital.

5. A Family Liaison Officer (FLO) from my office was appointed. The man had not had contact with his family for some time before his death. My investigator was able to contact the rabbi in Cardiff who had known him and his family. The rabbi confirmed to the investigator that the man's elderly mother and sister had been notified of his death but had no wish to be contacted further or involved in the investigation.

## HMP&YOI PARC

6. HMP&YOI Parc is a modern prison that opened in November 1997 on the outskirts of Bridgend, South Wales. It is operated by G4S and is the only privately run prison in Wales. The prison holds sentenced male adults and sentenced and remand young offenders in addition the prison also holds young people (those under 18 years of age.)

7. Primecare Forensic Medical Services provide healthcare services at Parc and employ three doctors and 25 nurses. The healthcare centre has 24-hour primary care and 13 in-patient beds.

8. HM Chief Inspector of Prisons, Dame Anne Owers, last inspected the prison in 2006. In her report on the inspection, Dame Anne said of healthcare:

> "An impressive and varied range of healthcare services was available, although prisoners' perception of provision was poor in comparison to the benchmark. Primary care clinics were well established and all nursing staff had individual responsibility for specific clinical areas. Inpatients had long periods out of their cells and good levels of interaction with staff. Dental services were very good and the waiting list had been significantly reduced over the previous six months. There was excellent support from the mental health services, which were well established but struggling to meet the needs of prisoners because of insufficient staffing. Relationships with local NHS organisations were extremely good and there was evidence of good joint working."

9. The Independent Monitoring Board at Parc published their last annual report in August 2008. In concluding their report the IMB said of Parc:

> "During the current reporting period, HMP & YOI Parc again made conspicuous ongoing efforts to ensure that all prisoners felt safe and were treated humanely and with dignity and fairness by all those charged with their care."

10. As noted above, my investigator spoke with a member of the IMB who had spoken to the man following a complaint he had made about bullying. She told my investigator that she had concerns about the investigation carried out by the prison following the man's complaint. However, it is also right to say that in their most recent report the IMB commended G4S on the rigour of its approach to bullying at Parc.

11. I was given responsibility for investigating all deaths in prison custody in April 2004. During this time, there have been nine other deaths at Parc attributed to natural causes. Recommendations that I have made as a result of these investigations are not repeated in this report.

## KEY FINDINGS

12. The man had been made the subject of an Anti-Social Behaviour Order (ASBO) in February 2004. This was in relation to abusive and threatening behaviour towards medical staff, particularly female nurses at his local surgery. In view of this, his medical appointments had to be at a specified surgery, with notification to the local police. He breached the order in June 2008 when he became abusive during a medical appointment. He was subsequently convicted on 6 October and remained on bail awaiting sentence. On 3 November 2008, he was sentenced to 50 weeks imprisonment and went to HMP/YOI Parc. This was the second time that the man had been in custody. He had previously served a 28-day sentence at HMP Cardiff in 1994 in relation to non-payment of fines.

13. On arrival at Parc, the man went through the normal reception procedures, part of which involved a health screen conducted by a nurse. When asked by the nurse whether he had seen a doctor in the last few months, he said that he had been admitted to University Hospital of Wales (UHW) in Cardiff to be treated for septicaemia in August 2008. (Septicaemia, also known as blood poisoning, is the presence of bacteria in the blood stream that can lead to sepsis – a serious medical condition which affects the vital processes of the body such as blood pressure, breathing and organ function and can lead to death.) The man also told the nurse that he was allergic to penicillin and had received treatment for depression some four years earlier. The nurse recorded on the health screen that the man's general appearance on reception was unkempt and he had extensive sacral (lower body) wounds. In view of his physical condition she referred him to the doctor and arranged for him to be located in the healthcare wing.

14. Once the reception process had been completed, he was located on the healthcare wing and a second nurse continued the medical admission process. The nurse recorded the following during her assessment:

> "… Appears flat in mood. When discussing sacral/buttock wounds appeared unconcerned and said that, he had had them for years. Appears to of (sic) had a very transient lifestyle. No current GP. No thoughts self-harm or suicidal intent. Openly admits to being unable to care for himself or his flat, does his own shopping but survives on ready meals and pizza.
>
> Refer to doctor reference pain relief and wounds. Wounds to be dressed daily and referral to Social Services."

15. After completing the admission process, a third nurse assessed the wounds on the man's buttocks and lower body. The nurse wrote in his medical record:

> "… Different stage wounds, superficial to Dermis depth. Surrounding skin macerated. Appears to have been redressed with only allevyn [type of dressing]. Areas cleansed, swabs taken left and right, redressed with aquacell [moisture retaining dressing].

> Numerous stage 1 &2 wounds to right calf. Previous mesh dressing still in place. Cleansed, redressed with iodine and dressing secured. Offered entonox [pain relief often referred to as 'gas and air'] but declined. He said that he was being treated at Cardiff Royal Infirmary (CRI) twice a week but did not know the name of the doctor."

16. A care plan was put in place for nursing staff to treat and dress the wounds. The day after his arrival, he was seen by a prison doctor who felt that the wounds needed to be assessed at the local hospital. The doctor wrote to the hospital indicating that the man had previously had septicaemia. In order to obtain some further background on his treatment at University Hospital Wales, a nurse also contacted the records department.

17. He was escorted to Princess of Wales Hospital, Bridgend, later that afternoon. He was initially assessed by a triage nurse, then a doctor, skin specialist and a nutritionist. Swabs of his wounds were taken and the areas were again cleaned and dressed. Initially, the doctor told him that he was likely to remain in hospital for a few days. The man was unhappy about this. However, at around 5.50pm that day the prison escort staff contacted the healthcare department at Parc and advised a nurse that the man was being discharged.

18. A nurse was asked to contact the hospital to enquire why they had decided not to admit him. She was told by the senior nurse in the Accident and Emergency Department that the man had been seen by a consultant who was content for him to be discharged back to Parc. The senior nurse said that the doctor had suggested that iron supplements be added to the man's medication and that he must have a high red meat diet. The nurse was also told that a tissue viability nurse had reviewed the wounds on his body and considered them to be superficial and exacerbated by incontinence of urine. Dressings would be done prior to his discharge and a detailed letter would be sent back with him to Parc outlining the treatment given.

19. The nurse who had spoken with the hospital spoke with the man later the same evening on his return from the hospital. She noted that he looked tired and that he asked for some toast and crisps. She suggested to him that he should make a list of the foods he liked and those he was unable to have due to his Jewish faith. Healthcare staff also ordered a special mattress, recommended by the hospital specialists, to relieve the pressure on his wounds.

20. On 6 November, the man was interviewed by a forensic psychiatrist. During the interview, he discussed his family history and the breakdown of the relationship with his family. He said that he had suffered from the sores for around eight years and had seen a wound specialist, at UHW, but did not mention receiving any treatment. He described his mood as "alright" but also spoke of attempting suicide in September 2008. He said that he had taken an overdose of pain killers but then felt sick and called an ambulance.

21. When asked about his life before he entered custody, the man said that he had lived alone in a rented house since 1995, after having to sell his own property. He regretted losing his fortune and described himself as having no friends. He

said he did not cook for himself. The psychiatrist recorded that there was evidence of self-neglect and lack of motivation. It was concluded that more information was required from the local health authority before the possibility of anti-depressant medication could be considered. The psychiatrist planned to review him in a week.

22. The healthcare team at Parc continued to try and obtain his medical records from Cardiff Royal Infirmary. Some information they received indicated that on 15 September 2008 he had been admitted to Whitchurch Hospital in Cardiff as a result of drinking bleach, but later discharged. The prison was also told that the man had been extremely violent in the past towards NHS staff and non-compliant with treatment offered to him.

23. On 20 November, a psychiatric review was completed which recorded that he was settled and feeling better. The man said that he spent the majority of his time watching television and that he liked football and soap operas. Although he was still having physical health problems, he was more mobile. He told the psychiatrist that he wanted to move on and start his life again. It was decided that the man did not require anti-depressants at that time but this should be kept under review and he would be seen again in one to two months.

24. During the remainder of November and the early part of December, healthcare staff continued to encourage him to tend to his personal hygiene but he often declined. His wounds were dressed in accordance with the care plan but again there were times when he would refuse to have this done, despite the possible consequences being explained to him. The clinical reviewer mentions this in their report, and says that “slow improvements were noted to the wounds, but there was still some infection noted on 22 December. No swab was taken and he was not given antibiotics to try and treat the infection.”

25. During the night of 24 December, it was recorded in the man’s medical record that he had become verbally abusive and aggressive in his nature, but that this was not his normal character. The nurse who made the entry, also highlighted possible underlying infection as the cause of this behaviour and that there was a need for a blood test to be carried out. The clinical reviewer has said in their report that “there is no evidence in the medical record that wound swabs or blood was taken for investigation to eliminate a medical cause for the man’s confusion.”

26. On 30 December, the man made an application to see a member of the IMB who visited him that afternoon. The man told the IMB that on 23 December he had been forced to have his hair and beard cut by one of the nursing staff. He alleged that he had been told that he would be held down by the orderly to have his hair cut if he refused. (An orderly is a prisoner who is placed in a position of trust and is employed to carry out tasks for which he is given a bonus payment. They are also referred to as red bands or trusties.).

27. The IMB member was concerned by what they had been told. They immediately reported the complaint to the Duty Director, who went to see the man later that day. The IMB were also told that an investigation would take

place into the allegations. The Duty Director subsequently wrote to the IMB to explain that he had spoken to the man regarding missing property and had also asked him about the allegation regarding his haircut. The Duty Director told the IMB in his memo that the man had said that he did not wish to pursue the complaint as long as he received new clothing on his release. When my investigator visited Parc he spoke at length with the IMB about the allegations made by the man. The IMB were concerned that the prison did not appear to have taken the allegations seriously and that no investigation had taken place. The only apparent action was that the healthcare orderly had been removed from the wing for the remainder of that day but was reinstated the following day.

28. The day after making the complaint to the IMB, the man was reviewed by the doctor and considered to be fit for normal location. My investigator asked nursing staff whether the decision to move him out of the healthcare wing had been influenced by the complaint he had made. He was told that this had not been the case, and the doctor had considered that the man no longer needed to be an inpatient. The man was moved from the healthcare wing and located on a normal houseblock. The care plan recorded that he was to attend the healthcare wing every other day to bath and have his dressings changed.

29. There is little recorded information about how he interacted with staff and prisoners on the residential wing. His medical record shows that he went to healthcare as planned to wash and have his wounds dressed.

30. The man was readmitted to the healthcare wing on 6 January 2009 as there had been a deterioration in his wounds, and a revised care plan was put in place. On 8 January, it was recorded that he should not be seen alone as he had attempted to lunge at staff and had become aggressive.

31. At 4.00pm on 9 January, a nurse went to unlock him for association and found him lying on the floor of his cell. (Association is when prisoners have time out of their cells to make telephone calls, use the shower, interact with each other, or watch television.) The nurse immediately shouted for assistance from other nursing staff who were close by and called a code red via her radio. (Various coding systems are used in prisons to alert staff to emergencies, with code red usually indicating a medical emergency involving bleeding.)

32. A senior nurse and a second nurse went to the cell. The man was lying on his left side. There was blood around his mouth and he had also been incontinent of urine. In her statement, the second nurse said that the man was unresponsive, with no pulse or breath sounds and his pupils were fixed and dilated. The second nurse and a third nurse (who had also responded to the code red call), and the senior nurse commenced cardio pulmonary resuscitation (CPR). Defibrillator pads were placed on the man's chest. (Defibrillation is a method of delivering a therapeutic dose of electrical energy to the heart.) The machine indicated no shock and CPR resumed. Emergency paramedics arrived in healthcare at 4.13pm and inserted an airway into him while nursing staff continued to administer CPR. The paramedics gave the man adrenaline and intravenous fluids before taking over the CPR from the nursing staff.

Efforts to revive him continued until 4.21pm when he was pronounced dead by the paramedics.

**Actions after the man's death**

33. Following his death, the prison was unable to contact any next of kin. However, prison staff spoke to the rabbi in Cardiff who knew the family and he said that he would inform his mother and sister of his death. The rabbi said that they did not wish to be contacted or to be involved in any funeral arrangements. The prison arranged the funeral with the help of the rabbi and met all the costs.

34. The post mortem indicates that a life threatening bacterial infection was present in the man's wounds. However, no definitive cause of death had been recorded at the time of issuing this report and further toxicology results are awaited by the Coroner.

## ISSUES

### Healthcare provision

35. When the man arrived at Parc his health needs were quickly identified and a care plan put in place. The medical staff acted swiftly to try and obtain further medical information. The clinical reviewer also recognises this and the clinical review says that:

> "... Nursing staff were conscientious about obtaining the correct mattress and diet for the man and dressing his wounds, as prescribed. Improvements in his self caring, wounds and diet were noted in his medical record until 25 December, when he became confused. In hindsight the cause of the confusion should have been investigated more thoroughly by medical staff to eliminate a medical cause ..."

With regard to the medical records provided by Parc following his death, the clinical reviewer says that these were in good order but the review would have benefited from having copies of the pathology results of tests carried out at Princess of Wales Hospital on 4 November. The clinical reviewer also observes that, on the man's discharge from the hospital on 4 November, a handwritten note was sent with him and this should have been followed up by a typed discharge summary. In view of this, the reviewer makes the following recommendation which I endorse and the Director may wish to raise this at the Prison Health Partnership Board.

**The NHS should ensure that comprehensive, typed discharge summaries are sent to the prison following a prisoner's attendance at hospital.**

36. As noted, the post mortem indicates a life threatening bacterial infection was present in the man's wounds. This has caused concerns regarding the infection control in place in the healthcare wing at Parc. The reviewer makes the following recommendation which I endorse:

**The Head of Healthcare should perform an urgent review of infection control procedures in healthcare to ensure cross infection is always minimised.**

### Complaint of bullying made by the man

37. When he was seen by the IMB member, on 30 December he was very distressed and upset. The IMB were concerned that what had allegedly taken place constituted an assault and spoke to a senior manager. They were assured that a full investigation would take place but it later became clear that this did not happen. The IMB told my investigator they had gained the impression that Parc felt that, as the man had died, there was no need to take the complaint any further.

38. Following his visit to Parc, my investigator wrote to the Director, on 23 February 2009 to advise her what he had been told by the IMB and to ask what action the prison had taken in relation to the matter. The director responded on 30

March. In relation to the man's allegations about being physically threatened, the director confirmed that a formal investigation was to be carried out. She further explained that a formal investigation had not been instigated at the point he made his complaint as the concerns had not been brought to her attention or that of her deputy. The director gave the reasons as a breakdown of communication on all sides, for which she apologised.

39. It is clear that the prison should have carried out a more timely and thorough investigation into the serious allegations made by the man. However, I am satisfied with the action to be taken now by the director and judge that the prison has learnt from its failings. I therefore make no further recommendation on this matter.

**Conclusion**

40. The man had, by his own admission, not cared for himself for a number of years before entering prison, and this had affected his overall health. He had lived alone and, apart from visiting betting shops and going to buy takeaway food, had little contact with anyone else. When he came into the healthcare wing at Parc, this was likely to have been the most one-to-one contact he had enjoyed for some time. I have no doubt that he benefited from the care and support that he was offered.

41. The man's death was sudden and unexpected. The precise cause of death is not yet known, but it seems clear that – in general – his existing medical conditions were addressed promptly and appropriately by the prison. However, I note the clinical reviewer's recommendation about infection control. I also note their concern that the cause of the man's confusion should have been investigated more thoroughly to eliminate a medical cause.

## RECOMMENDATIONS

1. The NHS should ensure that comprehensive, typed discharge summaries are sent to the prison following a prisoner's attendance at hospital.

2. The Head of Healthcare should perform an urgent review of infection control procedures in healthcare to ensure cross infection is always minimised.