



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at HMP Parc
in February 2014**

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 investigation report into the death of a man, who was found dead in his cell at HMP Parc in February 2014. He was 36 years old. A post-mortem examination was unable to find a definitive cause of death, but it appears to have been a sudden unexpected death in epilepsy. I offer my condolences to his family and friends.

Healthcare Inspectorate Wales reviewed the clinical care the man received at HMP Parc. The prison cooperated fully with the investigation.

The man was sentenced to five years in prison in May 2010 and had been at Parc since October that year. During his time at Parc, he had several seizures. He was referred to the hospital for investigations as it was suspected that he was suffering from epilepsy. However, he refused treatment and a diagnosis of epilepsy was never confirmed.

The investigation found that, despite the man's frequent refusal to accept treatment, healthcare staff provided a good level of care throughout his time at Parc. I agree with Healthcare Inspectorate Wales that the standard of healthcare he received at Parc was at least equivalent to that he could have expected to receive in the community. However, I am concerned that a number of hospital appointments were cancelled because of a lack of escort staff, a problem that we have identified in a previous investigation at Parc.

Most regrettably, the prison mishandled the arrangements for informing the man's next of kin about his death. This led to the family of another prisoner with the similar name, mistakenly being told that their family member had died. This caused them immense distress and meant that his family learnt of his death from other sources, before the prison was able to rectify its error.

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

October 2014

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SUMMARY

1. The man was sentenced to five years imprisonment in May 2010 and moved to Parc in October 2010. On admission to prison, he said he had no medical problems and was not taking any medication.
2. During his time at Parc, the man had periods of low mood and doctors prescribed antidepressants. On 17 February 2012, his prison sentence ended and he was detained under immigration powers. He remained at Parc while the immigration authorities sought his deportation.
3. In December 2012, the man's cellmate told staff that the man had suffered seizures during the night, but he denied this. The prison doctor referred him for a neurology appointment at the hospital. During 2013, he experienced four episodes of seizures. Each occurred during his sleep and was witnessed by his cellmates. He had no recollection of the seizures.
4. In April 2013, the man had an ECG and blood tests and the results were recorded as normal. His neurology hospital appointment was still outstanding, but the prison GP considered it was likely that he had generalised epilepsy. He prescribed epilepsy medication, which he began taking. He then stopped taking the medication and denied that he had ever had any seizures. He said his ill health was caused by stress. The neurology appointment was arranged and cancelled three times, at least twice because of a lack of prison escorts.
5. Eventually, on 21 August, a neurology specialist saw the man, who continued to say that he had never had any seizures. The hospital arranged an MRI scan in October, which he was unable to attend as there were no escorts available. He refused to attend for a rescheduled scan in November. A follow up neurology appointment in December was cancelled because of lack of escorts. He attended a rearranged appointment with the neurologist in January 2014, but there is no record of what happened at that appointment.
6. At the beginning of February, an officer found the man collapsed in his cell. An ambulance was called immediately and officers and nurses attempted resuscitation. Paramedics arrived at 7.25am and continued emergency treatment. However, at 7.49am, they confirmed that he had died. A post-mortem examination was inconclusive but indicated that it was likely that he had had suffered from a sudden unexpected death in epilepsy.
7. After the man's death, the prison mishandled the arrangements for notifying his family and confusion with another prisoner with a similar name led to the wrong family being notified. His family heard of his death from another source and had to contact the prison for confirmation.
8. Healthcare Inspectorate Wales found that the standard of healthcare the man received at Parc was at least equivalent to that he could have expected in the community and we agree. However, we are concerned at the number of times the prison cancelled hospital appointments. The mishandling of the arrangements to inform his family was unacceptable. We make two recommendations.

THE INVESTIGATION PROCESS

9. The investigator issued notices informing staff and prisoners at HMP Parc of the investigation and inviting anyone with relevant information to contact her. Ten prisoners responded.
10. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. She and the clinical reviewer interviewed 14 members of staff and eight prisoners at HMP Parc during April. Two prisoners provided written statements.
11. Healthcare Inspectorate Wales reviewed the man's clinical care at the prison.
12. We informed HM Coroner for Bridgend and Glamorgan Valleys District of the investigation who provided the post-mortem report. We have sent the Coroner a copy of this investigation report.
13. Our investigation was suspended from 5 March 2014, because the man's cause of death could not be confirmed. The post-mortem examination report was still inconclusive about the cause of death, but we continued with the investigation on 23 April, when this was received.
14. One of the Ombudsman's family liaison officers contacted the man's sister, who acted as the family representative, to explain the investigation. The family were concerned about how they had been informed of his death. We have addressed this issue in the investigation report.
15. The family received a copy of the draft report. The solicitor representing his family wrote to us and raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.
16. The prison considered our draft report and recommendations, which they have accepted. The prison has also submitted an action plan in respect of our recommendation, which is included at the end of this report.

HMP & YOI PARC

17. HMP & YOI Parc, which opened in 1997, is run by G4S. It holds more than 1,400 convicted men and young adults on remand or convicted. It also has a unit for around 60 young people under 18. There is a 14 bed unit (the assisted living wing) for older prisoners with increased health needs.
18. G4S provides 24 hour primary general and mental healthcare services at Parc and St John's Medical Practice provides 24 hour GP cover.
19. Healthcare emergencies and those in need of specialist care are transferred to the hospital.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Parc was in July 2013. Inspectors found that the prison was safe and, overall, prisoners were well cared for. The standard of health services was assessed as good with an impressive new healthcare unit. There were some concerns about waiting times for hospital appointments.

Independent Monitoring Board

21. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recently published annual report for the year to May 2013, the IMB commented that the number of recent deaths in custody reflected an increasing older population. They said that, the prison was to be complimented for the way it cared for prisoners with complex health and mental health problems and their families.

Previous deaths at HMP Parc

22. The man was the twelfth prisoner to die from natural causes at Parc since the beginning of 2012. We have previously raised the issue of cancelled hospital appointments because of insufficient escort staff.

KEY EVENTS

23. The man, who was from Somalia, was sentenced to five years in prison for sexual offences on 14 May 2010 and sent to HMP Cardiff. In October 2010, he transferred to HMP Parc. His prison record indicated that he had given his brother's details as his next of kin.
24. The man's electronic prison record began in October 2011, when it was noted that he had previously had a CT scan of the head four years previously, but the reasons for this were not known. He had also been stabbed four years previously and it was noted that he had a history of drug abuse.
25. From 3 December 2011, the record shows that prison doctors and mental health nurses saw the man frequently as he reported feeling stressed and low in mood and had trouble sleeping. Doctors prescribed antidepressants.
26. When the man's prison sentence ended on 17 February 2012. He remained at Parc as an immigration detainee as the immigration authorities sought his removal from the UK.
27. On 3 December, the man's cellmate reported that the man had had seizures during the night. He denied this. The next day, a prison GP reviewed him and referred him to a consultant neurologist at the hospital to investigate the apparent seizures.
28. During the night of 20 January 2013, the man's cellmate told staff that the man had had two seizures. When a nurse examined him, he was confused. He was unable to recall the day of the week, month or year and she referred him to see a doctor. A nurse visited him in his cell that day and she said for his safety he would need to move to a shared cell on the ground floor. He agreed to the move. The records are not clear whether he saw a doctor or not.
29. The man's cellmate raised the alarm during the night of 2 February, as he believed the man was having another seizure. A nurse went to see him and found him responsive. She asked that day staff should inform the doctor. On 11 February, he told a doctor that he was finding things hard in prison, in particular sharing a cell. He said his problems would be solved if he had a single cell as he preferred to be alone. The doctor diagnosed an ongoing episode of mixed anxiety and depressive disorder. He prescribed antidepressant medication. He did not move to a single cell at that time.
30. On 22 March, the neurology department at the hospital asked for confirmation that the man, who was on their waiting list, still needed a neurology appointment. On 2 April, the prison confirmed that the appointment was still needed and an appointment was made for 29 May.
31. During the night of 13 April, the man's cell mate raised the alarm again when he appeared to be having another seizure. A nurse attended and noted that he was not able to be roused and was smacking his lips and snapping his teeth. This continued for ten minutes until he slowly recovered. A nurse diagnosed epilepsy and noted that he was not taking any medication for this.

An on call doctor advised that, if he had another seizure, he should go to hospital. Staff moved him to a cell with a camera so they could observe him. Later the same morning, he had another seizure which lasted for over 40 minutes. He was taken to hospital by ambulance.

32. The man returned from hospital the same day. A prison GP saw him and noted that this was apparently his second seizure that day and there was a slow recovery phase. He said he shared concerns about his safety and noted that the hospital had carried out an ECG and blood tests, the results of which were normal. He recorded that the likely diagnosis was generalised epilepsy and prescribed medication.
33. On 13 April, a healthcare administrator completed a supported living plan (SLP) with the man. This is a written plan that is kept on a prisoner's wing so that all staff are aware of a prisoner's condition and how to manage them safely. To minimise the risk of injury, prisoners with epilepsy are usually required to share a ground floor cell and have their epilepsy monitored.
34. On 16 April, the man assaulted his cellmate. Later that day, he was moved to a camera cell and then subsequently to the segregation unit. The next day, he told a nurse that he had missed two doses of his epilepsy medication and she arranged for him to receive his medication immediately. On 24 April, he returned to the wing. As a result of the assault, the cell sharing risk assessment was reviewed and he was assessed as high risk of violence towards a cellmate so was not able to share a cell. On 28 April, he told a nurse that he wanted to stop taking his medication. His reasons are not recorded. The nurse made an appointment for him to see the doctor about this, but he did not attend.
35. On 21 May, the pharmacist noted that the man denied that he had had any seizures and said he did not need any medication. She referred him to the doctor. Later that day, a doctor tried to encourage him to continue taking his epilepsy medication but he refused. He again said that he did not need the medication as he was coping with prison life. The doctor said that the diagnosis was unclear but it was possible that he had epilepsy. He said the man should keep taking the medication until the investigations were complete as otherwise he could have a fit and injure himself or die. He said that he understood the risks but it was his decision not to take the medication.
36. The man did not attend appointments at the prison's epilepsy clinic on 23 May and a neurology appointment at hospital on 29 May. The records are not clear why he did not attend these appointments.
37. A doctor saw the man on 18 June. He said that he had not had any fits lately and would continue to decline to take medication as he believed his symptoms were stress related. His rearranged neurology hospital appointment for 19 June was cancelled, due to a lack of prison escorts. The appointment was rescheduled for 3 July. This appointment was also cancelled due to insufficient escorts when another prisoner with an urgent appointment took priority. An appointment was made for 21 August.
38. On 7 July, the prison epilepsy clinic compiled a record of the man's seizures which noted that he had last had seizures two months previously. He said

that he thought the triggers were the noisy wing and when he felt angry. He said that he had fallen and hit his head during a seizure, it is not clear when this had happened, but he maintained that he did not need any medication. He said that he wanted to move to a cell on the upper floor, but a doctor told him that this was not possible until the situation with his likely diagnosis of epilepsy was established.

39. On 8 August, a healthcare assistant saw the man to complete an epilepsy assessment. He signed a disclaimer to say that he wanted to be in a single cell and would not take any medication for his epilepsy. In case of an emergency, he gave his uncle's contact details as his next of kin. The assessment noted that he did not have a diagnosis and there was no history of epilepsy in his family. He gave her some background information and said that he had not had a seizure for three to four months. He told her that his first seizure was when he was 32 years old and lasted for ten minutes and that three weeks later he had had another ten minute seizure. He said his seizures occurred when he was stressed, lying in bed and he had a quick recovery that did not require hospital treatment. He said he was not taking any epilepsy medication.
40. On 21 August, a specialist registrar in neurology saw the man at hospital. The registrar said that he was uncooperative and at first denied having any seizures, despite the accounts in his medical record. However, he said that he had an episode in December 2012, but this had been due to insomnia and stress about his continued detention. For his medical history he said he was a smoker and denied any illicit drug use, birth trauma, convulsions as a child, previous brain infections or significant brain injuries. The registrar planned to try and rule out any potential underlying triggers of possible epilepsy and arranged for him to have an ECG, an MRI scan and a test to record the electrical activity in his brain (EEG). He would see him in the clinic again in approximately five months.
41. From 7 October 2013, the man was located in a cell 15 which is a standard single cell, without a camera. He was still considered a high risk of violence to a cellmate.
42. The man was scheduled to have his MRI scan on 23 October, but there were no prison escorts available. The MRI scan was rescheduled for 20 November but he then refused to attend. On 19 December, the prison cancelled his follow up neurology appointment because six other prisoners had appointments that day, the maximum number of escorts. The neurology hospital appointment was rescheduled for 9 January 2014. He attended that appointment but there is no record of what happened in his prison medical records.

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43. The man was in a standard single cell on the ground floor landing on Delta wing. At 7.00am, the roll count began when officers check to make sure the correct numbers of prisoners are in their cells. Officer A was conducting the check on the ground floor and Officer B on the second floor.

44. Officer A opened the observation panel of the man's cell door, switched the light on and saw him lying on the floor. He shouted to Officer B to ask if he slept on the floor as some prisoners prefer to do this. When Officer B told him he did not, he immediately opened the cell door. He could not get a response from him and asked Officer B to radio a code blue emergency. (This indicates a prisoner is unconscious or has breathing difficulties and should result in the control room calling an ambulance automatically.) Records show that an ambulance was called at 7.03am. Officer A said that he moved him flat on the floor. He was unable to find a pulse so he started cardiopulmonary resuscitation. Nurses arrived at the cell a few minutes later and continued the resuscitation attempt.
45. Paramedics arrived at the cell at 7.25am and continued emergency treatment. However, at 7.49am, they pronounced the man dead.

Liaison with the man's next of kin

46. The prison appointed a prison chaplain to act as the family liaison officer. He said that he checked the prison database for the man's address and found that his brother was recorded as his next of kin. From his telephone contacts list, there was a record of a telephone number which he had rung from prison and he took a note of this.
47. The records were not clear and a check of local maps showed that the address recorded for the man's brother was incorrect. However, the chaplain found a similar street name and decided to visit that address.
48. The man was a Muslim and the chaplain contacted the prison's Imam to ask him to attend also. He gave the Imam the man's name, prison number and cell number, and the Imam said that he knew him.
49. The Director of Parc, the chaplain and the Imam went to what they believed to be the man's family home. When they got there it was apparent this was not the correct address and no one knew him there. The Imam then telephoned the number obtained from the telephone contacts list. The Imam told us that a young female had answered and told him that she had no knowledge of the man. The man's sister told us that her niece had answered the phone that morning and did not fully understand the caller. The caller had asked her niece about her brother, and she had replied that he was asleep in his room, which her niece's brother was.
50. As the man's family were known at the mosque, the Imam contacted Muslim community leaders. They confirmed that they knew his family and they would make arrangements for them to meet at the mosque so they could break the news to his family there. At 11.10am, the Imam informed a person, who he was told was the man's brother, that his brother had died. As they were leaving the mosque, the chaplain said to the Director that he was not sure if they had informed the right family.
51. At around 12.30pm, the chaplain went back to his office to make notes about the visit. The Imam was also present, making arrangements for a memorial service for the man to be held at the prison. The chaplain received a telephone call from an officer on Delta wing to say that a prisoner was

distraught as he had telephoned his family and they had told him that they had just been informed that he had died.

52. At 1.15pm, the Imam received a telephone call from the man's sister, who said that her aunt had telephoned to check that he was all right as she had heard there had been a death at Parc. She had then telephoned the prison to ask about her brother and she was asked to verify a number of details. She said after about three or four calls another prison chaplain had confirmed that it was her brother who had died. At 3.30pm, the prison chaplain and an operational manager visited the family and apologised for the confusion about the meeting at the mosque with the wrong family. The Director apologised to the other prisoner and his family.
53. The prison chaplain remained in contact with the man's family but they did not want the prison to be involved in his funeral arrangements. Parc offered financial assistance towards the costs of the funeral in line with national guidance.

Post-mortem

54. On 4 February, an initial post-mortem report said the cause of death was unascertained and a supplementary report would be provided. On 19 March, the supplementary report commented that a detailed examination of the man's brain showed previous bruising but it was not possible to tell if a seizure had occurred around the time of death. The conclusion was that the cause of death was unascertained but, if his medical records established that he had epilepsy, his death would appear to fall within the definition of a sudden unexpected death in epilepsy (SUDEP).

ISSUES

Clinical Care

55. The man had a number of apparent seizures at Parc. Records show that he refused his medication and would not attend some hospital and clinic appointments. It is clear that he fully understood the consequences of his refusal. His mental capacity to take such decisions was frequently reviewed. Healthcare Inspectorate Wales (HIW) raise some issues about healthcare services which we do not repeat in this report, but which the Head of Healthcare will need to address.
56. Although the man refused to take his medication, Healthcare Inspectorate Wales (HIW) found that the care he received was at least equal to that he could have expected in the community. Nurses saw him frequently and he had regular mental health reviews. Doctors reviewed him and he had regular reviews at the prison epilepsy clinic even though he refused to accept that he might have epilepsy.
57. The supplementary post-mortem suggests that the man might have died from sudden unexpected death in epilepsy (SUDEP), when a person with epilepsy dies unexpectedly and no obvious cause of death can be found. HIW note that the risk factors for SUDEP include being a young male adult having sleep seizures, not taking medication and having seizures when alone. He was therefore at increased risk, particularly as he refused to take medication.

Cancelled hospital appointments

58. Healthcare Inspectorate Wales found that the procedure for ensuring that prisoners attended local hospital appointments was in disarray, as there were insufficient appointment slots allocated and insufficient escorts for those appointments. During their inspection, HM Inspectorate of Prisons were not assured that access to hospital appointments was reasonable, as there were no systems to monitor waiting times. We too have identified this problem in another case at Parc.
59. The doctor referred the man to a neurology specialist on 4 December 2012. It took some time for the hospital to organise this and the first appointment was not until 29 May. He did not attend the appointment and the records are not clear why, as there is only a handwritten note saying that it had been rearranged. The hospital rearranged the appointment to 19 June, but the prison cancelled it due to lack of escorts. The hospital rearranged it again for 3 July, but, once more, the prison cancelled the appointment because the escorts were required for another prisoner's urgent appointment.
60. The man eventually attended his neurology appointment on 21 August, eight months after the original referral. On 23 October, the prison cancelled an appointment for a brain scan as there were no escorts. In December, the prison cancelled a further hospital appointment as the maximum number of prisoners was out on escort. It is unacceptable that he missed at least four hospital appointments for these reasons. We have made a recommendation to Parc before about this issue and were told that processes would be

reviewed. When the prison cancel a prisoner's hospital appointment there should be fully documented reasons to justify it and cancellations for operational reasons should be avoided. Such cancellations risk prisoner's health and waste valuable NHS resources. The prison allows six slots for external appointments each day, three in the morning and three in the afternoon. The frequency of cancellations for lack of escorts or availability of slots suggests that this is insufficient, particularly for an expanding population with increasing health needs. We make the following recommendation:

The Director should ensure that sufficient staffing resources are allocated to hospital escorts to meet the health needs of the population, that hospital appointments are cancelled only as a last resort and at no detriment to a prisoner's health and that staff clearly record the reasons for such cancellations.

Cell allocation

61. Parc's supported living plan indicates that a prisoner with epilepsy should share a cell (where appropriate), be allocated a ground floor cell, have appropriate work allocation and be subject to epilepsy reviews and monitoring. Apart from when he was in a cell with a camera for observation, the man shared a cell until he assaulted his cellmate on 16 April and went to the segregation unit. The information on his records suggest that he had deliberately attacked his cellmate because he did not want to share. After this, he was regarded as a high risk of violence towards a cellmate. From 7 October 2013, he lived in cell 15 on D wing, a standard single cell.
62. Ideally, the man would have shared a cell on the ground floor of D wing but his cell sharing risk assessment made this difficult. Other prisoners were naturally reluctant to share with him as he had made it clear he preferred to be on his own. He signed a disclaimer to say he wanted to be in a single cell and had chosen not to take medication which would have helped protect him from fits. The prison had a duty to protect other prisoners from violence and we are therefore satisfied that his allocation to a single cell was appropriate in the circumstances.

Informing Next of Kin

63. The man's next of kin details on his main prison record were not correct as the address recorded did not exist. The subsequent confusion resulted in another prisoner's family incorrectly being informed that their family member had died at the prison. This caused great distress to that family and the prisoner involved. It also meant that his family were not informed in the way they should have been. This was most unfortunate as the Director, the family liaison officer and the Imam had set out to inform his family in person, which is good practice.
64. The outcome of the confusion was calamitous for those involved, but need not have occurred. The investigator found an epilepsy assessment form in the man's medical record, which gave up to date contact details for his uncle, to be used in the event of an emergency. Healthcare staff told us that although such information is collected it is not shared with other prison staff as it is regarded as medical in confidence. While the assessment form contains some information that would be medical in confidence, the details of emergency contacts are not. There is little purpose in collecting such

information if it cannot be accessed by staff who will need it to contact a next of kin in an emergency. The most unfortunate outcome in this case underlines the need for the prison to make sure that next of kin details are up to date and accurate and that details are verified, particularly in cases where the deceased prisoner has a common name or one that is similar to other serving prisoners. We make the following recommendation:

The Director and Head of Healthcare should ensure that emergency contact details for prisoners' next of kin are shared, accurate and kept up to date and that the identity of a prisoner who dies is verified before informing their family.

RECOMMENDATIONS

1. The Director should ensure that sufficient staffing resources are allocated to hospital escorts to meet the health needs of the population, that hospital appointments are cancelled only as a last resort and at no detriment to a prisoner's health and that staff clearly record the reasons for such cancellations.
2. The Director and Head of Healthcare should ensure that emergency contact details for prisoners' next of kin are shared, accurate and kept up to date and that the identity of a prisoner who dies is verified before informing their family.

ACTION PLAN

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and <u>function responsible</u>	Progress (to be updated after 6 months)
1	The Director should ensure that sufficient staffing resources are allocated to hospital escorts to meet the health needs of the population, that hospital appointments are cancelled only as a last resort and at no detriment to a prisoner's health and that staff clearly record the reasons for such cancellations.	Accepted	<p>On any given day there is a determined number of operational resources allocated to hospital escorts. These provide for six hospital appointments each day, 3am and 3pm</p> <p>As and when emergency escorts are needed these take precedence over any planned hospital escorts. This is always done in conjunction with Healthcare; who prioritise the escorts for that day to ensure that appointments cancelled to accommodate the emergency are rebooked as soon as practicable, thereby minimising any detriment to a prisoner's health. Reasons for cancellations are recorded by Healthcare staff.</p> <p>When such an event occurs, every effort will be made to provide escorts from other operational resources.</p>	<p>Completed</p> <p>Director HMP & YOI Parc</p>	
2	The Director and Head of Healthcare should ensure that emergency contact details for prisoners' next of kin are shared, accurate and kept up to date and that the identity of a prisoner who dies is verified before informing their family.	Accepted	<p>Personal details relating to prisoners are maintained on Prison NOMIS. As staff are informed or become aware of changes to these details they are now updated accordingly.</p> <p>Prisoners are advised during the admission process and during Induction of the importance of accurate next of kin details. Each prisoner is also given a card emphasising the need for this information and how to advise of any changes.</p>	<p>Completed</p> <p>Director/ Head of Healthcare HMP & YOI Parc</p>	