Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Alan Davies a prisoner at HMP Parc on 13 December 2016

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Alan Davies died on 13 December 2016 of multiple organ failure while a prisoner at HMP Parc. He was 75 years old. I offer my condolences to Mr Davies' family and friends.

I am satisfied that Mr Davies received a good standard of care at the prison, equivalent to that which he would have expected in the community. The healthcare team were proactive in dealing with his refusal to receive treatment and medication.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **April 2017**

Contents

Summary

Events

1. On 11 October 2016, Mr Alan Davies was sentenced to eight years in prison for sexual offences and was sent to HMP Parc.

2. Mr Davies had a complicated medical history, which included type 2 diabetes, chronic kidney disease, raised blood pressure and other age related conditions.

3. When Mr Davies arrived at Parc, he told a nurse that he wanted to die and that he would refuse all medical care, medicine and food. Prison staff placed Mr Davies on Assessment, Care in Custody and Teamwork (ACCT) procedures to support him and to determine his level of risk.

4. Mr Davies required dialysis three times a week. On 13 October, when Mr Davies' wife and son attended a meeting with prison and healthcare staff at Parc, they persuaded him to accept treatment and take his medication. After that meeting, Mr Davies went to hospital three times each week for his dialysis. Prison staff stopped ACCT procedures on 22 November.

5. At 3.10pm on 25 November, a nurse saw Mr Davies after he returned from his dialysis. He said he felt unwell and was short of breath. She found his blood pressure slightly raised and his blood oxygen level was low but rising when she asked him to take breaths. She asked a doctor to review Mr Davies. The doctor said that he had a chest infection and prescribed amoxicillin (an antibiotic).

6. At 6.46pm that day, prison staff called a code blue medical emergency (which indicates that a prisoner is unconscious or not breathing) as Mr Davies was short of breath and feeling unwell. A nurse gave Mr Davies oxygen, although his blood oxygen level dropped when this was removed. A doctor saw Mr Davies and advised that he be taken to hospital. Paramedics arrived and took over his care.

7. Mr Davies was admitted to hospital. On 27 November, Mr Davies was moved to the intensive care unit and put on a ventilator. His condition worsened and, at 2.30pm on 13 December, hospital staff turned off the ventilator. He died of multiple organ failure at 3.30pm.

Findings

8. The clinical care Mr Davies received whilst at Parc was equivalent to that which he would have expected in the community. After Mr Davies agreed to receive his treatment he attended hospital for dialysis three times a week and took his prescribed medication.

9. Staff appropriately managed Mr Davies under ACCT procedures, which they regularly reviewed, and arranged a meeting with Mr Davies' wife and son where they encouraged him to start accepting treatment.

10. While we would have expected the prison to have formally informed other prisoners of Mr Davies' death in case they were affected by it, overall the prison managed his end of life well and we make no recommendations.

The Investigation Process

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

12. The investigator obtained copies of relevant extracts from Mr Davies' prison and medical records.

13. Healthcare Inspectorate Wales (HIW) reviewed Mr Davies' clinical care at the prison. HIW interviewed one member of staff at Parc.

14. We informed HM Coroner for Bridgend and Glamorgan Valleys District of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.

15. The investigator wrote to Mr Davies' wife to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.

16. The initial report was shared with the Prison Service. The Prison Service pointed out a factual inaccuracy and this report has been amended accordingly.

Background Information

HMP Parc

17. HMP Parc is a medium security private prison run by G4S, which holds around 1,750 men and young adults both on remand and convicted. It also has a unit for around 60 young people under 18.

18. G4S Medical Services provides 24-hour primary general care. Abertawe Bro Morgannwg University Health Board provides mental healthcare services and St John's Medical Practice provides 24-hour GP cover.

HM Inspectorate of Prisons

19. The most recent inspection of Parc was in January 2016. Inspectors found that significant chronic recruitment and retention problems affected secondary health screening. They said there were easily accessible automated defibrillators, which ensured prompt emergency care.

20. In their survey of prisoners, significantly fewer prisoners than in comparator prisons said the quality of health provision was good. Inspectors noted that support for prisoners with complex health needs, including life long conditions was generally good.

Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to February 2016, the IMB found that the prison was well managed. The Board said that the HMIP survey results about poor health provision were because of lack of access to Healthcare rather than the quality of the service.

Previous deaths at HMP Parc

22. Mr Davies was the sixth person to die of natural causes at HMP Parc since January 2016. There has been one death since. There are no significant similarities with these previous deaths.

Assessment, Care in Custody and Teamwork

23. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

24. On 11 October 2016, Mr Alan Davies was sentenced to eight years in prison for sexual offences and sent to HMP Parc.

25. Mr Davies had a complicated medical history, which included Type 2 diabetes, chronic kidney disease, raised blood pressure and other age related conditions.

26. At an initial health assessment, a nurse examined Mr Davies and noted he had insulin treated Type 2 diabetes. He required dialysis three times a week for his kidney disease but Mr Davies told her that he wanted to die and that he would refuse all medical care, medicine and food. Staff placed him on suicide and self-harm prevention procedures, known as Assessment, Care in Custody and Teamwork (ACCT), and reviewed him regularly each day. He was located in the safer custody unit (a small residential unit providing full time support for up to 12 prisoners thought to be at high risk of serious and immediate self harm).

27. A prison GP did not see Mr Davies on 11 October, but arranged for his medication for his existing medical conditions. A nurse spoke to him later about his refusal to attend the hospital for his dialysis. She tried to get him to attend his appointment but he said he had spoken to his wife about this and had also discussed his own funeral arrangements.

28. On 12 October, Mr Davies did not attend the hospital for dialysis and he refused his medication. The healthcare team created a care plan for his refusal to take medication and receive treatment. Mr Davies told a prison GP that he understood that dialysis kept him alive. The GP felt that Mr Davies' understanding around his treatment showed mental capacity, though he wanted a psychiatrist to assess him. Staff from the mental health in-reach team saw Mr Davies later that day and agreed that he needed to be assessed by a psychiatrist.

29. Later that day, prison and healthcare staff carried out an ACCT review. Mr Davies agreed to have his vital signs monitored. He also signed a medical disclaimer form for refusing to attend his dialysis treatment that day. Staff continued to hold regular reviews of the ACCT.

30. On 13 October, Mr Davies attended a meeting with a nurse and the complex case manager. Mr Davies' wife and son also attended and they encouraged him to accept his dialysis treatment and other medication. At the end of the meeting, Mr Davies decided to accept treatment. He then took his medication, which included his insulin. As Mr Davies accepted his treatment, the mental health in-reach team cancelled the need for a psychiatrist's assessment.

31. The following day, Mr Davies attended hospital for dialysis. Two prison officers escorted him but they did not use any restraints.

32. Mr Davies moved from the safer custody unit to the assisted living and older prisoners' unit. He had daily access to a nurse and attended his dialysis appointments each Monday, Wednesday and Friday. On each occasion, prison officers escorted Mr Davies but they did not use any restraints.

33. On 7 November, a nurse saw Mr Davies in his cell. He told her he felt dizzy after getting dressed and going to the toilet. She checked his blood oxygen level, which was normal, and his blood pressure, which was high (163/106). She arranged for healthcare staff to measure his blood pressure regularly over the next few weeks. On 15 November, a nurse found that Mr Davies' blood pressure had dropped, although was still slightly raised (121/93).

34. On 22 November, prison staff closed Mr Davies' ACCT.

Events from 25 November 2016

35. At 3.10pm on 25 November, a nurse saw Mr Davies after he returned from his dialysis. He said he felt unwell and was short of breath. She found his blood pressure was slightly raised (159/89) and his blood oxygen level was low but rising when asked to take breaths. She asked the GP to review Mr Davies.

36. At 4.00pm, a prison GP locum saw Mr Davies, who said that he had been short of breath and feeling unwell for over a week. The GP diagnosed a chest infection, prescribed amoxicillin (an antibiotic) and planned a review if he did not improve.

37. At 6.46pm, an officer called a code blue medical emergency (that indicates a prisoner is unresponsive or having difficulty breathing) because Mr Davies was feeling unwell and was short of breath. The control room immediately called an ambulance. A nurse attended and noticed that Mr Davies' blood oxygen level was low (85%), and his respiratory rate and his blood pressure were high (39 beats per minute and 157/78 respectively). She gave Mr Davies oxygen and his blood oxygen level increased, though it dropped once the oxygen was taken away. A prison GP advised that Mr Davies go to hospital.

38. At 7.06pm, paramedics arrived and took over Mr Davies' care. They took Mr Davies to hospital, where he was admitted. Two prison officers escorted him and they did not use any restraints.

39. Mr Davies remained in hospital. On 27 November, hospital staff moved Mr Davies to the intensive care unit and placed him on a ventilator. Prison healthcare staff remained in contact with medical staff at the hospital and they maintained a record of his treatment and progress.

40. On 7 December, a senior prison manager authorised Mr Davies' release on temporary licence (ROTL – release granted for specific activities which cannot be provided in the prison). A prison officer stayed with him at the hospital. The ROTL application was reviewed every seven days.

41. Mr Davies' condition continued to decline and, at 2.30pm on 13 December, hospital doctors decided to turn off the ventilation to Mr Davies. He died an hour later at 3.30pm.

Contact with Mr Davies family

42. On 27 November, when it became apparent that Mr Davies' health was deteriorating, Parc appointed a chaplain as the family liaison officer. She spoke to Mr Davies' wife that day and helped to arrange for Mr Davies' wife and son to see him in hospital.

43. The chaplain maintained contact with Mr Davies' wife. At 3.00pm on 13 December, after being told that the ventilator had been switched off, she arrived at the hospital to see Mr Davies' wife and family but they did not want to see her. They gave no reason but she reassigned the family liaison officer role to a non-religious person, an officer.

44. At 6.30pm, the officer spoke to Mr Davies' wife and offered her condolences and support. Mr Davies' wife did not want a visit at that time and said she had her family for support.

45. Mr Davies' funeral took place on 4 January 2017. The prison contributed to the costs in line with national policy.

Support for prisoners and staff

46. After Mr Davies' death, two senior managers debriefed the member of staff who was at the hospital to ensure he had the opportunity to discuss any issues arising, and to offer support. The officer said that he was fine and declined the offer at that time.

47. The prison did not post notices informing other prisoners of Mr Davies' death, and offering support, though staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Davies' death. Prisoners were offered the opportunity to attend a memorial service for Mr Davies' where they were offered support if they required it.

Cause of death

48. The Coroner did not request a post mortem. The hospital recorded that Mr Davies died from multiple organ failure, septic shock and pneumonia arising from diabetes and chronic kidney disease.

Findings

Clinical care

49. The clinical reviewer was satisfied that the care Mr Davies received at Parc was equivalent to that which he could have expected to receive in the community. On the assisted living and older prisoners' unit he had daily access to a nurse.

50. We are satisfied that prison staff put Mr Davies on an ACCT when he told them he wanted to die and refused all medical care, medicine and food. They monitored and reviewed him regularly until the ACCT was closed. We are also pleased that healthcare staff arranged a meeting with Mr Davies, his wife and his son and they were able to persuade him to resume his treatment and medication.

51. After Mr Davies agreed to receive his treatment, he attended hospital for dialysis three times a week and he took his prescribed medication.

52. We also consider that the emergency response on 25 November was appropriate and that the prison's decision to release Mr Davies on temporary licence was good.

Actions following a death in custody

53. The prison admitted that they had not posted notices informing other prisoners of Mr Davies' death and offering them support. This decision had been taken because Mr Davies had not been at Parc long.

54. We note that prisoners were invited to attend a memorial service held for Mr Davies, where support was available, and that staff reviewed those prisoners at risk of suicide or self-harm. While we suspect that those prisoners who required support were ultimately provided with it, we are concerned that notices were not immediately posted and that this delayed the provision of support. We do not make a recommendation, though the Governor should address this issue and needs to recognise that it is good practice to post notices to prisoners offering support. We are pleased to see that the prison has since drafted such an additional notice for future use.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141