Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ronald Moran a prisoner at HMP Parc on 1 February 2017

A report by the Prisons and Probation Ombudsman
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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 Ronald Moran died in hospital on 1 February 2017 of a brain haemorrhage while a prisoner at HMP Parc. He was 68 years old. I offer my condolences to Mr Moran's family and friends.

I am satisfied that Mr Moran received a good standard of care for his chronic health conditions, equivalent to that which he could have expected in the community. I am pleased that prison managers expeditiously granted Mr Moran release on special licence when it became clear he was dying.

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 **August 2017**

Contents

Summary

Events

1. On 20 December 2010, Mr Ronald Moran was sentenced to 20 years in prison. He was transferred to HMP Parc on 1 February 2011.

2. Mr Moran suffered from a number of health problems including chronic kidney disease, rheumatoid arthritis and numbness and pain in his right arm and leg due to a problem in his neck. He was a smoker and had limited mobility.

3. Mr Moran saw nurses several times a day to help with his social care. They would check that he took his medication, had adequate nutrition and hydration and that his hygiene needs were met.

4. In September 2015, Mr Moran had a major stroke. He spent 12 months in hospital before being returned to Parc. On his return, he received 24 hour nursing care to help him take his medication, eat and ensure all his personal needs were met as he was immobile.

5. On 27 January 2017, nurses noted Mr Moran was drowsy and had low oxygen saturation levels. They arranged for him to be admitted to hospital. Hospital staff diagnosed bleeds on the brain. Prison managers authorised Mr Moran's release on temporary licence the same day. Mr Moran died in hospital on 1 February at 5.30pm.

Findings

6. Healthcare Inspectorate Wales (HIW) concluded that Mr Moran received a good standard of care for his chronic illnesses.

7. When Mr Moran's condition deteriorated, healthcare staff assessed him promptly and sent him to hospital quickly. Managers also acted quickly in authorising Mr Moran's release on special temporary licence. We are satisfied that Mr Moran received a good standard of care at Parc, equivalent to that which he could have expected to receive in the community. We do not make any recommendations.

The Investigation Process

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

9. The investigator obtained copies of relevant extracts from Mr Moran's prison and medical records.

10. Healthcare Inspectorate Wales (HIW) reviewed Mr Moran's clinical care at the prison.

11. We informed HM Coroner for Cardiff and Vale of Glamorgan District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

12. The investigator contacted Mr Moran's family, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They did not respond.

13. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Parc

14. HMP Parc is a medium security prison run by G4S, which holds around 1,600 convicted men and young adults on remand or convicted. It also has a unit for around 60 young people under 18.

15. Integrated Services, a branch of G4S, provides 24-hour primary general and mental healthcare services at Parc and St John's Medical Practice provides 24-hour GP cover.

HM Inspectorate of Prisons

16. 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.

17. 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

18. 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 health provision could be explained by a lack of access to healthcare services rather than the quality of the service.

Previous deaths at HMP Parc

19. Mr Moran was the seventh prisoner to die from natural causes at Parc since January 2016. There were no significant similarities between Mr Moran's death and these previous deaths.

Key Events

20. On 20 December 2010, Mr Ronald Moran was sentenced to 20 years in prison for sexual offences and sent to HMP Forest Bank. On 1 February 2011, he was transferred to HMP Parc.

21. Mr Moran suffered from a number of medical conditions, including chronic kidney disease, rheumatoid arthritis and numbness and pain in his right arm and leg due to a narrowing of the spinal canal in his neck. He was a smoker and had limited mobility. Mr Moran saw healthcare staff frequently to receive medications and for monitoring of his conditions.

22. In September 2015, Mr Moran had a major stroke, which left him disabled and bed bound. He remained in hospital for 12 months before he was transferred back to Parc on 29 September 2016. He remained bed bound and required regular and frequent nursing care.

23. On his return to Parc, the healthcare manager completed a social care review. She arranged for a chair and hoist to be located near Mr Moran's cell and ensured there was a spare airflow mattress in stock in case it was needed. She arranged for healthcare staff to see Mr Moran daily to help him take his medication and help with personal care activities (including using a catheter). Mr Moran was on a 24 hour open cell door policy to allow healthcare staff access and this also allowed other prisoners to socialise with him.

24. On 4 October, physiotherapist completed an assessment. He noted that Mr Moran was unable to sit up in bed independently and had very little potential to improve.

25. On 25 October, the healthcare manager held a multi disciplinary team meeting with an occupational therapist, social worker, social services team manager, mental health nurse, named nurse and wing manager. They discussed Mr Moran's dehydration and what equipment he would be able to use if he needed to summon help. They also said that the physiotherapist should continue working with Mr Moran to try to improve his hand grip.

26. Mr Moran frequently saw nurses and doctors to monitor and change his catheter. Prison GPs prescribed pain relief. He saw the physiotherapist on 15 November, and he recommended extra pillows for support for him to be able to grip small bottles with minimal assistance.

27. On 7 December, Mr Moran was unresponsive in his cell. A healthcare assistant called an emergency code blue (indicating a life threatening incident involving breathing difficulties) and carried out standard health checks. His blood pressure and pulse rate were normal and his temperature low (35.8). She checked his oxygen saturation level and noted that it ranged from 90% to 95%. Two nurses attended and gave Mr Moran oxygen through a nasal cannula, which stabilised his oxygen levels to 97%.

28. Ambulance staff attended and took Mr Moran to hospital. Hospital staff completed a chest x ray and discharged him the following morning as nothing was found.

2017

29. On 27 January 2017, a nurse completed a social care round. She saw Mr Moran at 5.30am to give him his medication. She noted he was very sleepy, so returned at 6.15am. When she tried to wake Mr Moran, he was shaking his head. She tried again at 6.45am and described his chest as "very bubbly". She noted his temperature was 37.1º, blood pressure 130/85 and oxygen saturation level 85%. She called an emergency code blue and administered oxygen. At 7.15am, she rechecked his observations. His temperature was 37.2º, blood pressure120/38, oxygen saturation remained unchanged at 84% on 15 litres of oxygen. She noted that his saturation ranged from 84% to 92%. Paramedics arrived at 7.23am and took Mr Moran to hospital at 8.21am. Hospital staff conducted a CT scan, which showed Mr Moran had extensive bleeds on his brain. Mr Moran died in hospital on 1 February at 5.30pm.

Release of temporary licence

30. Release on temporary licence (ROTL) can be granted for precisely defined and specific activities, which cannot be provided in the prison. A risk assessment is completed to ensure that the prisoner's temporary release does not present unacceptable risks. The Governor of the prison is able to grant the temporary licence and will decide on whether the prisoner is to be accompanied by staff.

31. On 27 January, the day Mr Moran was taken to hospital, prison managers authorised his release on temporary licence on the grounds that he was critically ill and immobile.

Contact with Mr Moran's family

32. The prison appointed an officer as the family liaison officer in October 2015 when Mr Moran had a stroke. At that time, Mr Moran did not have a nominated next of kin, but after discussions with the officer he said that he would like his sister to be his next of kin and to be informed he was in hospital. His sister was contacted and updated as requested.

33. On 27 January 2017, the officer contacted Mr Moran's sister and told her that her brother was ill and was in hospital. She asked to be updated by telephone of any developments. News of his death was broken on the day to Mr Moran's sister as arranged. The officer offered his condolences and discussed the funeral arrangements. The prison arranged and contributed towards Mr Moran's funeral, which was held on 28 February.

Support for prisoners and staff

34. After Mr Moran's death, a prison manager debriefed the staff involved in the hospital escort to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

35. The prison posted notices informing other prisoners of Mr Moran's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Moran's death.

Cause of death

36. The Coroner confirmed that the cause of Mr Moran's death was a spontaneous intracerebral bleed (bleed on the brain).

Findings

37. We are satisfied that Mr Moran's care and treatment at Parc was equivalent to that which he could have expected to receive in the community. The clinical reviewer found that Mr Moran received a high standard of care at Parc. His health conditions were appropriately monitored and treated by prison healthcare staff. Staff reacted promptly on both occasions when Mr Moran suffered a stroke. After his first stroke, Mr Moran was severely disabled and bed bound. Staff at Parc put in place a comprehensive care plan and coped very well with all his problems.

38. Managers acted swiftly and appropriately in authorising Mr Moran's release on special temporary licence when he became seriously ill.

39. We make no recommendations.

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