Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul McLean, a prisoner at HMP Parc, on 9 October 2018

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 Paul McLean died in hospital on 9 October 2018 of pneumonia with sepsis after having an epileptic seizure and taking psychoactive substances (PS) at HMP Parc on 22 July. Mr McLean was 37 years old. I offer my condolences to Mr McLean's family and friends.

Mr McLean suffered from epilepsy, had mental health issues, self-harmed and was taking illicit drugs while in custody. I am very concerned that staff missed several opportunities to identify that Mr McLean took PS at Parc and to offer support accordingly.

I am also concerned that there was a delay in calling an ambulance when staff found Mr McLean fitting in his cell on 22 July. The prison should review its internal emergency response procedures and its protocols with the Welsh Ambulance Service.

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

Sue McAllister, CB
Prisons and Probation Ombudsman **April 2020**

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Summary

Events

1. On 12 February 2018, Mr Paul McLean was remanded to HMP Cardiff for making threats to kill. Mr McLean had epilepsy and had recently been discharged from a secure psychiatric hospital where he had been diagnosed with a personality disorder.

2. On 24 May, Mr McLean had a seizure in his cell after taking PS and spent three days in hospital. Mr McLean had two other seizures and self-harmed while at Cardiff. He took PS and staff submitted intelligence security reports about his substance misuse.

3. In June, Mr McLean was sentenced to two years and eight months.

4. On 11 July 2018, Mr McLean moved to HMP Parc. A reception nurse started an epilepsy care plan and suicide and self-harm monitoring because she was worried about him. Mr McLean refused to consent to sharing medical information and to engage with healthcare or substance misuse services, but remained subject to suicide and self-harm monitoring during his 12 days at Parc.

5. On 22 July at 9.53pm, Mr McLean had an epileptic seizure in his cell and an officer radioed an emergency medical code. Healthcare staff gave him medication to try to control the seizure, but it did not work. The control room officer called an ambulance about ten minutes later, but the ambulance service did not dispatch the ambulance immediately. The ambulance arrived at the prison at 11.35pm, by which time Mr McLean had been fitting for one and a half hours.

6. On 23 July, at 12.10am, Mr McLean was transferred to hospital, where he remained critically ill and was pronounced dead on 9 October at 6.30pm.

7. A toxicology report found that Mr McLean had taken PS before his seizure, that eventually led to his death.

Findings

Substance Misuse

8. Mr McLean did not want to engage with the substance misuse service at Parc. He knew the health risk of taking PS, but continued to take them.

9. The substance misuse assessment on 12 July did not consider Mr McLean's substance misuse history and was not sufficiently thorough. We consider this was a missed opportunity to engage Mr McLean.

Drug Strategy

10. Parc had a comprehensive drug strategy at the time of Mr McLean's death, but staff missed several opportunities to identify that he was taking PS, despite him being subject to suicide and self-harm monitoring. We are particularly concerned

that staff did not reflect Mr McLean's substance misuse needs in his ACCT caremap and that security intelligence reports were not actioned.

Emergency response

11. Officers did not call an ambulance for about ten minutes after the emergency radio code on 22 July, a critical delay. There was a further delay of 90 minutes because the ambulance service controller did not prioritise the call, a matter that falls outside of our remit but which the Director of Parc will need to take up with the ambulance service.

Recommendations

- **The Head of Healthcare should ensure that routine substance misuse assessments fully explore the prisoner's substance misuse history.**

- **The Director should ensure that:**

  - **the prison's supply and demand reduction strategies are properly implemented to help reduce the availability and abuse of drugs, including PS;**

  - **staff are vigilant to signs of drug use and take appropriate action; and**

  - **prisoners with relevant substance misuse intelligence are subject to frequent drug-testing.**

- **The Director and Head of Healthcare should ensure that:**

  - **staff manage prisoners at risk of suicide or self-harm in line with national instructions, including that case managers complete ACCT caremap actions adequately and record their progress; and**

  - **staff include the substance misuse team to manage risks for prisoners with a history of substance misuse.**

- **The Director and the Head of Healthcare should:**

  - **agree a protocol with the Welsh Ambulance Service Trust to ensure they understand the prison context and that staff who request ambulances might not have immediate detailed information about the patient; and**

  - **ensure that all prison and healthcare staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, as outlined in the local Medical Emergency Response Code Protocol, so that there is no delay in calling an ambulance.**

The Investigation Process

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

13. On 19 December 2018, the investigation was suspended pending disclosure of post-mortem and toxicology reports.

14. On 3 May 2019, the investigation was re-allocated to another PPO investigator. On 24 September 2019, the investigation was resumed. On 30 October 2019, he interviewed five members of staff at Parc.

15. Healthcare Inspectorate Wales commissioned a clinical reviewer to review Mr McLean's clinical care at the prison.

16. We informed HM Coroner for South Wales Central of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

17. The first investigator contacted Mr McLean's family, to explain the investigation and to ask if she had any matters they wanted the investigation to consider. They asked for the investigation to consider:

    - Mr McLean's epilepsy and mental healthcare at prison;
    - Mr McLean's substance misuse at prison; and
    - the prison's actions on tackling illicit drugs.

    We have addressed those issues in this report.

18. The investigator sent a copy of the initial report to Mr McLean's family. They did not make any accuracy comments.

19. The prison service also received a copy of the initial report. They made minor accuracy comments which have been addressed. Their response to our recommendations and action plan is annexed to this report.

Background Information

HMP Parc

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

21. G4S Medical Services provide primary physical and mental health care services. There is 24-hour general healthcare and palliative care facilities. A local GP practice provides GP services, including a daily clinic and out-of-hours cover. Substance misuse services are provided by Abertawe Bro Morgannwg University Health Board. Three healthcare staff are located in the prison at night.

HM Inspectorate of Prisons

22. The most recent inspection of Parc was in November 2019. The findings have not yet been published.

23. The previous inspection took place in January 2016. Inspectors found that more needed to be done to address not only levels of violence, but the sense among prisoners that they were in an unsafe prison. They said that that the seemingly ready availability of psychoactive substances (PS), was having a severely negative influence on the safety and stability of the prison, and recommended that the prison should increase the range of support for prisoners using PS.

Independent Monitoring Board

24. 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 2019, the IMB reported that incidents of violence and self-harm continued to be of concern and that many of these incidents were drug related. The IMB described the influx and distribution of drugs as very high.

25. The IMB also found that the mental health pathway for access to primary care services was now embedded and working well, with a dedicated mental health nurse appointed to complete daily group work.

Deaths at HMP Parc

26. Mr McLean was the ninth prisoner to die at HMP Parc since October 2016. Five of the previous deaths were from natural causes, one was self-inflicted and two were drug-related. Since Mr McLean's death, there have been 12 further deaths at Parc: seven from natural causes, one drug-related and the other four deaths were apparently self-inflicted.

27. In two of the previous deaths in November 2017 and June 2018, we found that the prisoners had taken PS at some point before they died. We have made previous recommendations about improving the operation of ACCT procedures and how staff respond to prisoners using PS.

28. We have found that ACCT caremaps did not sufficiently address the prisoner's substance misuse issues in previous investigations and we have had concerns about the prison's drug strategy on PS.

Assessment, Care in Custody and Teamwork (ACCT)

29. Assessment, Care in Custody and Teamwork (ACCT) is the is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process 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. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Psychoactive Substances (PS)

30. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

31. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at the time NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

32. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements.

Key Events

HMP Cardiff

33. On 12 February 2018, Mr Paul McLean was remanded to HMP Cardiff for making threats to kill. He was sentenced on 21 June 2018 to two years and eight months imprisonment.

34. Mr McLean had spent two and a half years at a hospital (a mental health hospital) in Abergavenny - he was discharged on 9 February 2018. Doctors initially diagnosed Mr McLean with paranoid schizophrenia and a personality disorder, but they eventually discharged him with a diagnosis of personality disorder. At Cardiff, healthcare staff and the mental health team reviewed Mr McLean regularly and created a care plan for his epilepsy.

35. On 7 March, Mr McLean had a seizure in his cell, but recovered without medical intervention. On 20 March, a nurse attended another in-cell seizure and gave Mr McLean diazepam (a drug to treat seizures). When he had recovered, the nurse told him to rest and asked officers to monitor him.

36. On 18 April, Mr McLean cut his left arm and an officer started ACCT monitoring for him. At his first ACCT review, Mr McLean told an officer that he had self-harmed because he had "run out of vaping oils and was struggling to cope with the non-smoking policy". On 26 April, staff concluded ACCT monitoring for Mr McLean, as he said that he was feeling better and did not have any thoughts of suicide and self-harm.

37. On 10 May, an officer requested healthcare assistance because Mr McLean was not feeling well. A nurse recorded that Mr McLean was standing, walking around in a circle, but did not respond to questions and his pupils were not reactive. Mr McLean started to salivate from his mouth and tried to speak but his speech was slurred. The nurse called a code blue (an emergency call which indicates that a prisoner is unconscious or having difficulty breathing). Mr McLean recovered shortly after that. The nurse asked officers to keep an eye on Mr McLean as she thought he had taken PS.

38. On 14 May, an officer searched Mr McLean's cell. Mr McLean resisted the search and the officer and a second officer restrained him. The officer's found a weapon in Mr McLean's cell. (There is no record that they found drugs.) Mr McLean was placed on report for this finding and was taken to the segregation unit. He was found guilty at a disciplinary hearing and punished with 14 days cellular confinement.

39. On 24 May, Mr McLean had another seizure in his cell. Two nurses went to the cell. Mr McLean told the nurses that he had taken PS from another prisoner. The nurses thought that PS could have triggered the fit. Mr McLean's condition deteriorated, he became unresponsive and was transferred to hospital where he spent three days. Also, on 24 May, an officer submitted an intelligence security report recording that Mr McLean had asked another prisoner for a vape charger which he gave him before his seizure. When the officer searched the cell, he found the vape charger, which had been dismantled and thrown in the bin. The officer spoke to another prisoner who told him that Mr McLean had been using

his prescription medication and purchases from the prison shop to pay for illicit drugs.

40. On 29 May, an officer recorded that Mr McLean refused to provide a urine sample for an intelligence-led mandatory drug test (MDT). The officer submitted an intelligence security report where he noted that officers suspected that Mr McLean was involved in illicit substance misuse. The officer recorded that Mr McLean was charged with disobeying a lawful order, but the charge was not proceeded with. There is no record of another intelligence-led MDT on Mr McLean or of any other action to address his substance misuse issues.

41. On 4 June, Mr McLean cut his arm because nobody from his family came to visit him when he was in hospital, and he said he was "fed up". An officer started ACCT monitoring for Mr McLean. The ACCT remained opened for five days.

42. On 10 June, an officer recorded that another prisoner, appeared to have been bullying Mr McLean. The prisoner was found with some of Mr McLean's personal possessions, including his trainers. There were two other intelligence reports submitted at Cardiff which mentioned that the prisoner continued threatening Mr McLean. Intelligence assessments suggested that prisoners were taking advantage of Mr McLean's vulnerabilities, including his substance misuse.

HMP Parc

43. On 11 July 2018, Mr McLean moved to HMP Parc as part of his sentence progression. Officers recorded in his Person Escort Record (PER, a document that travels with prisoners when they move between police stations, courts and prisons) that Mr McLean had a history of self-harm and suffered from epilepsy and mental health issues. In reception, Mr McLean told an officer that he did not have any thoughts of suicide or self-harm. Mr McLean was assessed as high risk to share a cell with other prisoners because he had a previous history of threats to staff and mental health issues.

44. The same day, Mr McLean told a nurse during the initial health screen that he did not have any problems with drugs or alcohol, had not been bullied and had not self-harmed. She however, reviewed Mr McLean's records and noted his history of suspected PS use and self-harm. She also noted that Mr McLean had epilepsy and a history of mental health issues. She assessed that Mr McLean was at risk of suicide or self-harm and described his behaviour as "bizarre". She recorded that she was very concerned about Mr McLean's presentation and started ACCT monitoring.

45. She also referred Mr McLean to the epilepsy clinic and the primary mental health team. She started a Supporting Living Plan to support his healthcare issues and included locating Mr McLean in a ground floor cell and monitoring his epilepsy. Mr McLean was taking sodium valproate (a medication to control epileptic seizures), which staff did not give to him "in possession". This meant that he could not keep it in his cell and had to take every dose at the wing's medication hatch under supervision.

46. On 12 July, an Operational Manager (OM) and a nurse chaired the first ACCT case review. Mr McLean told them that he did not have any thoughts of suicide

or self-harm and did not want to be on ACCT. The OM and the nurse assessed that Mr McLean's risk of suicide and self-harm continued to be raised given his recent history of self-harm and mental health issues. They agreed to continue ACCT monitoring until his mental health had been assessed. The OM and nurse decided staff should observe Mr McLean twice per hour in the morning and in the evening and have two conversations with him in the morning and one at night. They did not include any other actions in the ACCT caremap and did not identify any substance misuse issues.

47. The same day, a substance misuse worker, assessed Mr McLean for substance misuse services. Mr McLean denied having taken any drugs in custody and did not want to engage with substance misuse services. She assessed that Mr McLean had low to medium substance misuse needs. She planned a further appointment five days later, but Mr McLean did not attend. The substance misuse team did not review Mr McLean again at Parc.

48. On 13 July, the security department logged the security intelligence report from HMP Cardiff about Mr McLean's substance misuse, generated in May. The Head of Security told the investigator that the intelligence report was re-submitted at Parc because there were outstanding actions that had been "rolled over" from Cardiff, including cell searches and mandatory drug testing.

49. On 18 July, a nurse reviewed Mr McLean's epilepsy. The nurse recorded that Mr McLean was not experiencing any side effects of sodium valproate. She recorded that Mr McLean denied any substance misuse issues, but she noted in the medical records that he had taken PS at Cardiff and that it was a trigger for his epilepsy. She recorded that Mr McLean's epilepsy was severe and life threatening. Mr McLean refused to give consent for the release of his community medical records, refused to sign his Supported Living Plan and refused further information about epilepsy. He also did not want to be referred to the substance misuse team.

50. On 19 July, the OM and a nurse chaired Mr McLean's second ACCT case review. The OM recorded that Mr McLean appeared tired and his speech was slurred. The OM asked Mr McLean whether he had taken any drugs and he said that he had not. The nurse warned Mr McLean that if he appeared to be under the influence of drugs at the medication hatch, he would be tested for drugs and his medication could be stopped. She pointed out that mixing illicit substances with his epilepsy medication was very dangerous. The OM and nurse kept the level of observations at two observations per hour. The ACCT caremap was not updated with any other actions. They planned for a further case review on 23 July. No one spoke to the substance misuse team and nobody from the substance misuse team was invited to any of the ACCT case reviews.

51. On 20 July at around 9.30pm, Mr McLean pressed his cell bell. An officer responded. Mr McLean said that he thought that he was going to have a seizure. The officer called a nurse but as Mr McLean remained watching television in his cell and appeared fine, staff took no further action.

52. On 22 July from 12.24am until 9.53pm, three officers recorded 46 observations in Mr McLean's ACCT on-going record. They described what Mr McLean was doing on each occasion, such as watching television or writing in his cell. At 8.27pm,

an officer recorded that Mr McLean was sleeping. In total, staff recorded about 560 ACCT observations about Mr McLean in the 12 days he was at Parc. Despite this close monitoring, officers did not record any suspicious behaviour or substance misuse.

Events on 22 July

53. On 22 July at 9.53pm, Mr McLean pressed the alarm and an officer attended within four minutes. Mr McLean told the officer that he was "having a seizure". The officer recorded that Mr McLean did not show any signs of having a seizure and was walking in his cell. The officer telephoned a nurse and told her what Mr McLean had said. She told the officer that she would check the medical records and Mr McLean's history before coming to the wing but asked her to tell her immediately if there were any changes in Mr McLean's condition.

54. At 10.07pm, Mr McLean started to have a prolonged seizure. He lost consciousness and was continuously having convulsions. An officer radioed a code blue emergency. At 10.12pm, three nurses got to Mr McLean's cell. After consulting with the on-call GP, they gave Mr McLean rectal diazepam. The medication did not stop the seizure.

55. At 10.17pm, an Operational Support Grade (OSG) called the ambulance and a minute later passed the call to a nurse who was in Mr McLean's wing. The investigator listened to the conversation. The nurse told the ambulance controller that Mr McLean was not managing his airway and was having an epileptic seizure. She asked again for an ambulance. The controller told the nurse that an ambulance was going to be dispatched but did not prioritise the call, as they should have done. This caused a considerable delay in the ambulance service dispatching the ambulance.

56. At 11.35pm, the ambulance arrived at the prison and paramedics reached Mr McLean's cell. At this point Mr McLean had been continuously fitting for around an hour and 30 minutes. Paramedics injected Mr McLean with diazepam, which started to control the seizure.

57. On 23 July, at 12.10am, Mr McLean was transferred to a hospital in Bridgend, where he remained critically ill. Doctors placed Mr McLean in an induced coma and diagnosed him with significant brain injury and a reduced supply of oxygen in his brain (cerebral hypoxia). Mr McLean remained in hospital until 9 October 2018 when, at 6.30pm, a doctor pronounced Mr McLean had died. Mr McLean never recovered from his epileptic seizure.

58. On 1 August, a nurse made a retrospective entry in Mr McLean's medical records. She noted that she had asked an officer on 23 July if any officer had found drugs in Mr McLean's cell. The officer told the nurse that she did not smell PS and that officers had found nothing. An hour later, however the nurse found a burnt pen cartridge, a vape cartridge lid with burnt substances and a piece of paper in the bathroom window of Mr McLean's cell (all items associated with substance misuse) which she placed in an evidence bag given to her by the officer. The items were never tested for drugs because the evidence bag was lost.

Post-mortem report

59. The post-mortem examination gave the following cause of death: pneumonia with sepsis, complicating prolonged agitation in a man admitted in status epilepticus (a prolonged seizure) having taken a synthetic cannabinoid (or PS).

60. The toxicology report dated 16 November 2018 on blood samples taken on 23 July 2018, detected PS, valproate (epilepsy medication) and diazepam (which healthcare staff gave him during the emergency response).

61. The supplementary post-mortem toxicology report dated 11 June 2019 detected morphine, fentanyl, valproate and zonisamide in Mr McLean's blood, all prescribed at hospital.

Contact with Mr McLean's family

62. On 23 July, a chaplain called Mr McLean's next of kin to tell him that Mr McLean was in hospital and in a critical condition.

63. On 24 July, the managing chaplain, visited Mr McLean in hospital. She also called Mr McLean's family. The chaplain offered to support his family during any future visits to Mr McLean in hospital. Mr McLean's next of kin asked Ms Tilt to phone her directly if Mr McLean died suddenly.

64. On 10 August, Mr McLean's life support was withdrawn. The managing chaplain kept in touch with Mr McLean's family by phone and email.

65. On 8 October, Mr McLean's condition deteriorated and the hospital informed Mr McLean's next of kin directly. Mr McLean's family went to the hospital and were with Mr McLean when he died on 9 October. The managing chaplain continued to offer support to Mr McLean's family thereafter.

Support for prisoners and staff

66. Ms Frost offered support to staff involved in the emergency response and ensured they had the opportunity to discuss any issues arising. The staff care team also offered support.

67. The prison posted notices informing other prisoners of Mr McLean'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 McLean's death.

Findings

Epilepsy

68. The clinical reviewer found that the clinical care provided to Mr McLean at Parc was good and equivalent to that he could have expected to receive in the community. The clinical reviewer found that healthcare staff adequately reviewed Mr McLean's epilepsy and his medication, and his epilepsy care plan was appropriate.

Substance Misuse

69. On 12 July, a substance misuse worker carried out a routine initial substance misuse assessment of Mr McLean. She assessed that Mr McLean had low to medium substance misuse needs, despite his extensive history of substance misuse.

70. On reviewing the assessment form, we noted that relevant questions about Mr McLean's history of substance misuse in custody were not completed and the clinical reviewer found that the assessment did not focus enough on PS, a significant risk factor in this case. We are not satisfied therefore that the initial assessment was sufficiently thorough. This was a missed opportunity to engage Mr McLean with substance misuse services and offer support accordingly.

    The Head of Healthcare should ensure that routine substance misuse assessments fully explore the prisoner's substance misuse history.

Drug Strategy

71. At the time of Mr McLean's death, Parc had a drug strategy policy issued in July 2017 and reviewed in June 2018. The policy acknowledged that the prison experienced significant levels of PS use, which resulted in increased emergency calls and hospital transfers. It also recognised that PS had caused violent and threatening behaviour and self-harm, as well as indirect consequences such as high levels of debt and associated violence.

72. The policy sets out measures to target PS trafficking, including use of the IEP scheme, the adjudication process, closed visit sanctions, adequate use of intelligence and use of the drugs testing (MDT), and aims to apply a balanced approach between disciplinary measures and treatment or support to prisoners with substance misuse issues.

73. Mr McLean was suspected of taking PS at Cardiff and the toxicology report found PS in Mr McLean's body after his death. Healthcare staff at Cardiff attended two emergency situations involving Mr McLean which were probably triggered by PS. One of them (on 24 May) was very serious. Intelligence indicating that Mr McLean was involved in the drug culture at Cardiff was passed to Parc. We are very concerned that despite this intelligence, staff at Parc missed several opportunities to identify that Mr McLean was taking PS and to support him accordingly, notably through his ACCT monitoring.

74. From 11 July to 22 July, officers recorded at least 560 ACCT observations in Mr McLean's ACCT on-going record. On 22 July alone, they recorded 46 observations from 12.24am until 9.53pm. Yet, officers made no entry in the ACCT's on-going record sheet related to substance misuse or suspicious behaviour. We are very concerned that, notwithstanding such number of observations, officers failed to notice that Mr McLean was using PS. After his seizure, officers did not discover the evidence of drug use in Mr McLean's cell, found later by a nurse.

75. We also note that relevant drug-related intelligence was not passed to officers or actioned by staff. The Head of Security told the investigator that the intelligence generated at Cardiff should have been considered and actioned at Parc. This intelligence should have prompted staff action, but there was no follow up.

76. HMPPS's Drug Strategy, published in April 2019, highlights the important of drug testing in prisons to restrict the supply of drugs and identify those with drug misuse problems. It points out that prisoners who test positive can be subject to sanctions, as well as being supported to access treatment, and so testing is key to encourage prisoners to remain drug free and help them to maintain this. We make the following recommendation:

The Director should ensure that:

- **the prison's supply and demand reduction strategies are properly implemented to help reduce the availability and abuse of drugs, including PS;**
- **staff are vigilant to signs of drug use and take appropriate action; and**
- **prisoners with relevant substance misuse intelligence are subject to frequent drug-testing.**

ACCT management

77. Prison Service Instruction (PSI) 64/2011 on safer custody sets out the processes that should be followed when a prisoner is at risk of suicide and self-harm. Mr McLean had some risk factors, including a history of self-harm, substance misuse and mental health issues. Given his epilepsy, Mr McLean's substance misuse issues, including PS, was a key risk factor. On his arrival at Parc, a nurse started ACCT monitoring for Mr McLean as she was very concerned about his presentation and history.

78. On 19 July, staff noted during an ACCT case review that Mr McLean could have been under the influence of drugs. Despite this concern and Mr McLean's well-documented history of possible PS use, staff did not add any actions in the ACCT caremap to address this issue or follow up with the substance misuse team. Officers did not update the caremap. This was a significant missed opportunity to try to engage Mr McLean with substance misuse services or manage this significant risk factor.

79. PSI 64/2011 requires that ACCT caremaps reflect a prisoner's needs, level of risk and the triggers of their distress. They should aim to address issues identified in the ACCT assessment interview. They must be tailored to meet prisoners' individual needs and reduce risk. They must be time-bound and say who is responsible for completing the action. We make the following recommendation:

The Director and Head of Healthcare should ensure that:

- **staff manage prisoners at risk of suicide or self-harm in line with national instructions, including that case managers complete ACCT caremap actions adequately and record its progress; and**
- **staff include the substance misuse team to manage risks for prisoners with a history of substance misuse.**

Emergency response

80. PSI 03/2013, *Medical Emergency Response Codes*, contains mandatory instructions for efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that it should not be a requirement for a member of the healthcare team or a manager to attend the scene before an ambulance is called.

81. On 22 July, there was an unacceptable delay of ten minutes in calling the ambulance and a crucial further delay of 90 minutes in the ambulance arriving at the prison. The latter delay was due to the ambulance controller giving the wrong priority to the call, so the ambulance was not dispatched immediately.

82. We are concerned that an OSG, the control room officer, told the investigator that he did not call an ambulance until he was sure that a response officer or a member of the healthcare team had attended the wing. This was clearly contrary to national policy.

83. We are also concerned that after the OSG called the ambulance, he said that he radioed to ask an officer or a member of healthcare to move to the closest landline in the wing to provide the ambulance service's controller with basic information on Mr McLean. A nurse had to take the OSG's call shortly after she attended the emergency response. This was entirely inappropriate as it interrupted her treatment of Mr McLean. We are satisfied that the nurse clearly indicated to the ambulance controller that Mr McLean could not maintain his airway, so the call should have been prioritised from the outset. The clinical reviewer said that the ambulance's delay contributed to Mr McLean's death.

84. The Head of Healthcare told the investigator that the ambulance service does not send an ambulance until they receive some personal details about the patient. This creates another avoidable delay. PSI 3/2013 requires prisons to have agreed written emergency response protocols with the local ambulance trust so

that they understand the prison context to help eliminate such delays. The Head of Healthcare told the investigator that the prison had agreed such a protocol, but the prison could not find a copy. We make the following recommendations:

The Director and the Head of Healthcare should:

- **agree a protocol with the Welsh Ambulance Service Trust to ensure they understand the prison context and that staff who request ambulances might not have immediate detailed information about the patient; and**

- **ensure that all prison and healthcare staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, as outlined in the local Medical Emergency Response Code Protocol, so that there is no delay in calling an ambulance.**

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