

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Jermin, a prisoner at HMP Parc, on 25 August 2019

A report by the Prisons and Probation Ombudsman

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*



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Summary

1. 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.
2. Our office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr David Jermin, who was 59 years old, died of metastatic prostate cancer on 25 August 2019 at HMP Parc. We offer our condolences to Mr Jermin's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Jermin received at HMP Parc was equivalent to that which he could have expected to receive in the community. She has made four recommendations which are outlined below.
5. We did not find any non-clinical issues of concern.

Recommendations

- The Head of Healthcare should ensure that all new prisoners at HMP Parc have their history of serious health issues documented in the medical records on admission to prison.
- The Head of Healthcare should ensure that all existing prisoners at HMP Parc have their history of serious health issues documented in their medical records.
- The Head of Healthcare should ensure that immediate steps are taken to assess, monitor and improve knowledge among healthcare staff about GP referrals and when one is needed.
- The Head of Healthcare should ensure that healthcare staff review the circumstances surrounding Mr Jermin's case and ensure that there is a process in place to follow up referrals for CT scans and postponed appointments in a timely manner.

Investigation Process

6. Health inspectorate Wales commissioned an independent clinical reviewer to review Mr Jermin's clinical care at HMP Parc. The clinical review is attached to this report as Annex 1.
7. The PPO investigator has investigated the non-clinical issues in Mr Jermin's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. The PPO family liaison officer wrote to Mr Jermin's next of kin, his wife, to explain the investigation. She did not respond.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out no factual inaccuracies.

Previous deaths at Parc

10. Mr Jermin was the 14th prisoner to die at Parc since November 2017. Of the previous deaths, seven were from natural causes, two were self-inflicted deaths and four were drug-related deaths. There are no similarities between our findings in the investigation of Mr Jermin's death and the other deaths.

Key Events

11. On 16 September 2014, Mr David Jermin was sentenced to six years in prison for historic sexual offences and assault. He was released on licence on 2 June 2017. Mr Jermin breached his licence conditions and was recalled to prison on 11 October 2018. He was sent to HMP Parc.
12. In November, Mr Jermin was diagnosed with prostate cancer with multiple metastases (spread of cancer) in his brain, lungs and bones.
13. On 3 December, prison staff started the process of applying for compassionate release on Mr Jermin's behalf. However, Mr Jermin told staff that he wanted to stay at Parc to receive end of life care. As a result, the compassionate release process was stopped.
14. On 31 January 2019, during a routine healthcare visit, healthcare staff noted that Mr Jermin had slurred speech and was unsteady on his feet. He was taken to hospital and admitted as an inpatient and was diagnosed with a bleed on the brain and a clot in his lung.
15. Mr Jermin was identified as being suitable for palliative care only. Hospital staff and prison staff considered that it was in Mr Jermin's best interests to receive palliative care at Parc. On 12 February, he was discharged from hospital and was returned to the prison.
16. The next day, a do not attempt cardiopulmonary resuscitation (DNACPR) order (which means that, in the event of cardiac or respiratory arrest, no attempt at resuscitation will be made; all other appropriate treatment and care will continue to be provided) was put in place.
17. On 1 April, Mr Jermin's wife asked if she could care for Mr Jermin at home. Mr Jermin agreed, and prison staff re-started the compassionate release process. However, on 19 April, Mr Jermin told healthcare staff that he wanted to stay at Parc for end of life care.
18. Mr Jermin's health deteriorated and on 25 August, it was confirmed that Mr Jermin had died.
19. There was no post-mortem examination but the Coroner gave Mr Jermin's cause of death as metastatic prostate cancer.

Lisa Burrell
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February 2020