

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Richard Allen, a prisoner at HMP Parc, on 15 August 2020

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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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 Richard Allen died on 15 August 2020 from unknown causes at HMP Parc. Traces of psychoactive substances (PS) were found at post-mortem, and the pathologist said he could not exclude that PS had played a part in Mr Allen's death. Mr Allen was 40 years old. I offer my condolences to Mr Allen's family and friends.

Mr Allen had a history of drug misuse but there were no known incidents of him using drugs at Parc. While I am concerned that Mr Allen was able to access PS at Parc, I am aware that the prison has taken measures to tackle the availability of PS at the prison.

Mr Allen was found dead on the floor of his cell at just before 9.00am. Staff had delivered a breakfast pack to him around 90 minutes before, but they had not checked on him. It is possible that Mr Allen could have been found sooner if staff had carried out a welfare check as they should have done.

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

Elizabeth Moody
Deputy Prisons and Probation Ombudsman

November 2021

Contents

Summary	1
The Investigation Process	2
Background Information	3
Key Events	5
Findings.....	7

Summary

Events

1. In July 2018, Mr Richard Allen was sentenced to seven and a half years in prison for driving offences and possession of Class B drugs. He was moved to HMP Parc on 29 March 2019.
2. Just before 9.00am on 15 August 2020, an officer found Mr Allen unresponsive on the floor of his cell. Staff and ambulance paramedics carried out cardiopulmonary resuscitation (CPR) but this was unsuccessful. Mr Allen was declared dead at 9.14am.
3. While at Parc, Mr Allen was not known to use drugs. However, staff found paper impregnated with psychoactive substances (PS) in his cell following his death. Some prisoners told staff that Mr Allen used drugs in his cell at night.
4. The post-mortem examination was unable to establish the cause of Mr Allen's death. Toxicology tests showed that Mr Allen had traces of PS in his urine. The pathologist could not say that PS had caused Mr Allen's death but also said he could not rule out that it had played a part.

Findings

5. The clinical reviewer concluded that the healthcare that Mr Allen received at Parc was good and equivalent to that which he could have expected to receive in the community.
6. While we are concerned that Mr Allen was able to access PS in prison, we note that Parc has introduced measures to tackle the availability of PS.
7. We are concerned that staff did not carry out a welfare check when they delivered a breakfast pack to Mr Allen shortly after 7.30am. The officer unlocked the cell door just enough for the pack to be put in the cell and did not see Mr Allen or try to get a response from him. It is likely that Mr Allen was on the floor of his cell at this time and that staff missed an opportunity to intervene earlier.
8. Staff were wearing body-worn video cameras when they responded to the emergency but no one turned theirs on. Staff should have recorded the incident.

Recommendations

- The Director should amend Parc's written local unlock policy to make it clear that a welfare check should be conducted during the delivery of breakfast packs.
- The Director should ensure staff switch on their body-worn cameras during an emergency incident and that control room operators remind staff to do so during an incident.

The Investigation Process

9. 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.
10. The investigator obtained copies of relevant extracts from Mr Allen's prison and medical records.
11. Health Inspectorate Wales (HIW) commissioned a clinical reviewer to review Mr Allen's clinical care at the prison.
12. The investigator interviewed one member of staff in March 2021. The interview was conducted by telephone because of COVID-19 restrictions.
13. 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.
14. The PPO's family liaison officer contacted Mr Allen's family to ask if they had any matters they wanted us to consider. His sister contacted the PPO through her solicitor. She did not have any questions but asked for a copy of our report.
15. The initial report was shared with Mr Allen's sister through her solicitor. She did not make any comments.
16. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS asked for a correction to clarify that the corruption prevention unit is part of the security department (para 43). In discussion with HMPPS, the first recommendation has also been amended to make it more specific and to align it with national policy. The HMPPS action plan is annexed to this final report.

Background Information

HMP Parc

17. HMP Parc is a medium security private prison run by G4S. It holds around 1,600 prisoners and young adults who are either on remand or convicted. It also has a unit for up to 60 young people under 18.
18. 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. Three healthcare staff are located in the prison at night.

HM Inspectorate of Prisons

19. The most recent inspection of Parc was in November 2019. Inspectors found that most health services remained reasonably good, although secondary mental health provision was poor. Many prisoners described access to health services and treatments as being problematic, but inspectors found an appropriate range of primary care services, with short waiting times for most, including the GP. Support for patients with long-term conditions had improved as a result of enhanced staffing. Since their last inspection in January 2016, a comprehensive drug supply reduction policy had been developed and a range of measures to reduce the availability of drugs, including body and post scanners, had been introduced, and this was having positive results. The supply reduction policy was part of a wider treatment and support drug strategy.

Independent Monitoring Board

20. 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 were pleased with improvements in healthcare staffing and coordinated efforts which had reduced non-attendance at clinical appointments. They noted that tackling drug supply into the prison was an ongoing high priority for management.

Previous deaths at HMP Parc

21. Mr Allen was the 15th prisoner to die at Parc since August 2018. Eight of the previous deaths were from natural causes, three were drug-related and three were self-inflicted. Following the three drug-related deaths, we made recommendations to Parc about reviewing its local drug strategy to tackle the availability of PS.

Psychoactive substances (PS)

22. Psychoactive substances (formerly known as '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.

23. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that 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.

Key Events

24. In July 2018, Mr Richard Allen was sentenced to seven and a half years in prison for various driving offences and possession of Class B drugs. He was moved to HMP Parc on 29 March 2019.
25. Mr Allen had a history of misusing illicit drugs both in prison and the community. He also had a history of trading his prescription drugs. At Parc Mr Allen was given a range of prescription-only medications for schizophrenia, depression and pain relief. One of these was stopped after an incident in December 2019, when a nurse caught him trying to conceal the drug rather than taking it. In the follow up consultation with a prison GP in January 2020, the doctor described him as exhibiting drug seeking behaviour.
26. However, while at Parc Mr Allen was not known to be linked to any other incidents involving illicit drugs. He told staff that he had matured and no longer used drugs. However, after his death some prisoners told a prison officer that they knew he used drugs at night.
27. Besides collecting his prescribed medications and receiving treatment for a burn, Mr Allen had little contact with healthcare staff at Parc. Although he had no known physical health problems for which he was receiving treatment at the time of his death, he was extremely overweight. In the 16 months he spent at Parc, his weight increased by 30 kilograms and when he died, he had a body mass index (BMI) of 41.5 (the NHS define a BMI of 40 and above as severely obese).

Friday 14 and Saturday 15 August 2020

28. CCTV recordings show that at 5.53pm on 14 August 2020, a Prison Custody Officer (PCO) opened Mr Allen's cell door and looked in on him. There were two roll checks later that evening, where officers looked through the cell observation panel.
29. On 15 August, there was a roll check at 5.30am and another at 6.58am by a PCO. In his statement, a PCO said Mr Allen was in bed in his usual position.
30. At 7.37am, the PCO unlocked Mr Allen's cell door and a prisoner put his breakfast items into the cell. The door was only opened far enough to do this, and no visual check of Mr Allen was made.
31. At 8.57am, while unlocking the cells on Mr Allen's landing, another PCO noticed that Mr Allen was face down on the floor with his head towards the door. She immediately went in, checked for a pulse and then left the cell to call for help from a colleague who was on the landing below. She also called a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties that alerts healthcare staff and prompts the control room to call of an ambulance).
32. She then went back into the cell and tried to turn Mr Allen onto his back in preparation for resuscitation. However, because of Mr Allen's size she was unable to do this until she had the help of two healthcare staff who arrived shortly after. Mr Allen was not showing signs of rigor mortis (stiffness of the limbs that

normally sets in around two to six hours after death), but had marked signs of livor mortis (the darkening of skin due to a pooling of blood at the lowest points of the body after death) when he was turned over.

33. Staff started cardiopulmonary resuscitation (CPR) and attached a defibrillator, but it did not detect a shockable rhythm at any point. Paramedics were on the wing in less than 15 minutes after the code blue was called. They declared Mr Allen dead at 9.14am.
34. There was no obvious cause of death at this point. There was nothing found in Mr Allen's cell at the time that would indicate that he had used drugs, but when his cell was searched prior to being cleared on 19 September, officers found paper impregnated with PS.

Contact with Mr Allen's family

35. A prison chaplain was appointed as family liaison officer (FLO), and she along with the Deputy Director contacted Mr Allen's father on the day he died. This was done by telephone because of COVID-19 restrictions. In the following days, The FLO maintained contact with Mr Allen's father and arranged for Mr Allen's property to be sent to him.
36. Parc contributed to the costs of Mr Allen's funeral in line with national instructions.

Support for prisoners and staff

37. On the day of Mr Allen's death, the Duty Director showed good consideration for the officers who had been first on the scene and ensured they had support following the incident. After Mr Allen's death, notices were issued for staff and prisoners informing them where they could get support if they were affected by his death.

Post-mortem report

38. The post-mortem examination was unable to determine the cause of Mr Allen's death. The pathologist noted there was fat and fibrous tissue around Mr Allen's heart but was reluctant to diagnose arrhythmogenic cardiomyopathy (where heart muscle cells die and are replaced with fatty and fibrous scar tissue) because of Mr Allen's weight. Toxicology tests found traces of PS in Mr Allen's urine but not in his blood. The pathologist could not say whether PS had caused Mr Allen's death but said that he could not exclude that the drug had played a part.

Findings

Clinical care

39. The clinical reviewer concluded that overall, the standard of healthcare Mr Allen received at Parc was equivalent to that which he could have expected to receive in the community.

Availability of illicit drugs at Parc

40. While we cannot say for sure, it would appear likely that PS played a part on Mr Allen's death.
41. Following three drug-related deaths in 2018, Parc revised their local drugs strategy in October 2019, to include a focus on PS use and a rapid response service for PS incidents. This includes an immediate follow up visit from the substance misuse team to prisoners involved in PS incidents.
42. The drugs searching strategy was reviewed in January 2020 to see if more use could be made of technology to detect incoming drugs. Body scanners are now used in the admissions area and Rapiscan machines check all incoming mail for traces of drugs.
43. Parc have also collaborated with the police to reduce the supply of drugs. Several arrests were made towards the end of 2020, in connection with prison visitors involved in attempts to bring drugs into Parc. The security department also includes a corruption prevention unit.
44. Two full-time substance misuse nurses are employed to ensure the substance misuse history of all new admissions is explored and recorded. Staff have been reminded to report all suspected or actual incidents of illicit drug use and of safeguarding actions for those suspected of drug use, including drug testing.
45. Mr Allen's substance misuse history was in his record. It was known that he had been involved in illicit drugs before he came to Parc. However, he was randomly tested for drugs at Parc on 30 August 2019 and returned a negative result. He was not tested again, and although the COVID-19 pandemic caused a halt to all random drug tests, staff had no suspicions about drug use by Mr Allen.
46. This was the first death at Parc since 2018 potentially involving PS and since those previous deaths, Parc has taken positive steps to reduce the supply of PS and other drugs, including the scanning of incoming mail which has previously been an entry point for PS across the prison estate. It is not known how Mr Allen obtained the PS that was found in his cell and in his body at post-mortem. It is disappointing that Mr Allen was able to access drugs which possibly had an impact on his death. However, we are satisfied that he was secretive about this and there were no known opportunities for the prison to intervene in his case. Therefore, we make no recommendation.

Unlock procedures

47. Prison Service Instruction (PSI) 75/2011 on residential services says that:

“Reports from the Prisons and Probation Ombudsman on deaths in custody have identified cases in which a prisoner has died overnight ... but staff unlocking them have not noticed that the prisoner had died. This is not acceptable...”

“...there needs to be clearly understood systems in place for staff to assure themselves of the wellbeing of prisoners during or shortly after unlock ...Where prisoners are not necessarily expected to leave their cell, staff will need to check on their wellbeing, for example, by obtaining a response during the unlock process.”

48. Parc’s local policy says:

“During unlock staff should physically check the presence of the occupants in every cell. Staff must ensure that they have a positive response from the prisoners occupying the cell, either through verbal communication or physical movement being observed. The purpose of this check is to confirm the wellbeing of the prisoner is not in any doubt and they are present where they should be.”

49. On 15 August, Mr Allen’s cell was unlocked at 7.37am by a PCO but no check was made on him before the cell was locked again. An internal inquiry was conducted by Parc into the incident. While other officers said they understood that welfare checks should be carried out when breakfast packs were delivered to prisoners, the PCO who unlocked the cell for the delivery of the breakfast pack, said that he thought that a welfare check was needed only when cells were unlocked to enable prisoners to leave their cells and did not apply to the delivery of the breakfast packs.

50. In the post-mortem report, the pathologist expressed surprise that there had been only 90 minutes between Mr Allen being believed to have been alive and being found dead. The pathologist indicates that the state of Mr Allen’s body when found suggested he had been dead for longer than 90 minutes. It is highly likely therefore that Mr Allen was on the floor of his cell when the breakfast packs were delivered and that staff missed an opportunity to intervene much earlier. There is also the possibility that Mr Allen was on the floor of his cell when the PCO carried out the roll check at 6.58am, but we cannot say for sure.

51. The PPO is satisfied that Parc have taken appropriate disciplinary action in this case. However, although we have been told that morning briefings on the wing include directions to conduct welfare checks when delivering breakfast packs, it would be helpful for this to be included in written guidance. We recommend:

The Director should amend Parc’s written local unlock policy to make it clear that a welfare check should be conducted during the delivery of breakfast packs.

Body-worn cameras

52. Although some officers involved in the emergency response on 15 August were wearing body-worn cameras, none were turned on. It is understandable that in the heat of the moment, officers forget to engage their cameras. However, this

needs to be reinforced as valuable evidence of incidents can be lost if not deployed. We recommend:

The Director should ensure staff switch on their body-worn cameras during an emergency incident and that control room operators remind staff to do so during an incident.

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