

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Mark Shepherd a prisoner at HMP & YOI Parc on 22 January 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*



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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 I oversee can improve their work in the future.

Mr Mark Shepherd died on 22 January 2018 of an internal haemorrhage at HMP & YO1 Parc. He was 42 years old. I offer my condolences to Mr Shepherd's family and friends.

I am satisfied that Mr Shepherd received a good standard of care at Parc and that his death could not have been foreseen. When he was found unresponsive in his cell, the emergency response was good and we commend the staff for their actions.

However, I am disappointed to have to repeat a recommendation we made to Parc in 2016 about checking on the welfare of prisoners when unlocking cells.

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**  
**Acting Prisons and Probation Ombudsman**

**October 2018**

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# Summary

## Events

1. On 16 October 2017, Mr Shepherd was recalled to prison and admitted to HMP Cardiff. He had a history of alcohol and substance misuse and was given opiate replacement medication. He had hepatitis C (a viral infection which affects the liver) and leg ulcers which required regular dressings. On 14 November Mr Shepherd transferred to HMP &YOI Parc.
2. Mr Shepherd was seen regularly by nurses at Parc, who changed the dressings on his leg and monitored his well-being.
3. On 22 January, Mr Shepherd's door was unlocked at around 8.30am. The officer who unlocked his cell did not speak to Mr Shepherd and went on to unlock other cells. At 8.34am, another officer found Mr Shepherd unresponsive on his cell floor, with blood around his face. He called for help and cardiopulmonary resuscitation (CPR) was started immediately. Paramedics arrived and continued CPR, but Mr Shepherd was pronounced dead at 9am.
4. The staff involved in the emergency response were debriefed after the incident and offered support. The Director and a prison chaplain visited Mr Shepherd's mother on the morning that he died to break the news of his death.

## Findings

5. We agree with the clinical reviewer that the care Mr Shepherd received was equivalent to that which he could have expected to receive in the community and his death was not foreseeable or preventable. We commend the officers who initiated CPR appropriately.
6. We are, however, concerned that the officer who unlocked Mr Shepherd's cell on the morning of his death did not check on his well-being. We made a recommendation to Parc about this in 2016 and it is disappointing that this issue has come up again.

## Recommendation

The Director should ensure that officers understand their responsibilities for checking on the wellbeing of prisoners when unlocking their cells and ensuring that there are no immediate issues that need attention.

## The Investigation Process

7. 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.
8. The investigator obtained copies of relevant extracts from Mr Shepherd's prison and medical records.
9. The investigator interviewed four members of staff by telephone in March and April 2018.
10. NHS England commissioned a clinical reviewer to review Mr Shepherd's clinical care at the prison.
11. We informed HM Coroner for Bridgend and Glamorgan Valleys of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.
12. One of the Ombudsman's family liaison officers contacted Mr Shepherd's mother to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. She did not respond to our letter.
13. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

# Background Information

## HMP & YOI Parc

14. HMP Parc is a medium security private 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. 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 within the prison at night. Appropriate emergency equipment is located across the prison, all operational staff are first aid trained and most know how to use defibrillators.

## HM Inspectorate of Prisons

16. The most recent inspection of Parc was conducted 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 2017, the IMB reported that healthcare was able to achieve high standards in chronic disease management whereas targets have been missed for acute care.

## Previous deaths at HMP Parc

19. Mr Shepherd was the sixteenth prisoner to die at HMP YOI Parc since 2015. There were four self-inflicted deaths during this time and Mr Shepherd was the twelfth prisoner to die of natural causes. We have raised the issue of checking the welfare of prisoners when unlocking their cells in a previous investigation at Parc.

## Key Events

20. On 16 October 2017, Mr Shepherd was recalled to prison and admitted to HMP Cardiff. In his reception healthcare screening it was noted that he had a history of substance abuse and was taking a maintenance dose of subutex (for opiate replacement treatment) in the community, which was continued in prison. He said that he had a high alcohol intake before coming into prison, but was not showing signs of withdrawal. Mr Shepherd was diagnosed with hepatitis C (a virus that affects the liver) and had leg ulcers which required regular dressings.
21. On 25 October, a nurse noticed that Mr Shepherd was having difficulty walking around the wing and thought he looked jaundiced. She discussed her concerns with a GP and they agreed that a period of assessment in the healthcare unit would be beneficial. Mr Shepherd refused the offer and said he did not feel unwell. A prison GP reviewed Mr Shepherd the next day and found he was not jaundiced. She prescribed anti-depressants for his low mood. On 3 November, she changed Mr Shepherd's opiate maintenance treatment to methadone at his request.
22. On 14 November, Mr Shepherd transferred to HMP Parc and his reception screening noted his history. On 20 November, he was seen in the substance misuse clinic and appeared to be limping. Mr Shepherd said he was worried he might have an infection in his leg, and he had previously had sepsis due to a leg infection. A prison GP prescribed antibiotics at the request of a nurse.
23. Mr Shepherd was reviewed regularly to have his leg dressings changed and to monitor the wounds on his legs so was seen frequently by healthcare staff. He repeatedly failed to attend a variety of health care clinics at HMP Parc and did not follow advice given to manage his liver disease.
24. On 17 January 2018, a nurse saw Mr Shepherd in a mental health clinic. She found him low in mood because his leg ulcers were taking a long time to heal. She started a care plan to monitor his mood.

### 21/22 January

25. On 21 January, Mr Shepherd was seen at 5.56pm for issue of his opiate replacement treatment. On 22 January, at 7am, Officer A said he looked into Mr Shepherd's cell while completing an early morning roll check. He told the investigator that he did not see anything untoward, that he completed the check and went to the wing office. At approximately 8.30am, he returned to Mr Shepherd's cell and unlocked the door. He did not speak to Mr Shepherd when he unlocked the door, and moved on to unlock the remainder of the landing.
26. Shortly afterwards, Officer B began the process of re-locking cells after movements from the wing had taken place. When he went to Mr Shepherd's cell he found him on the floor with blood around his face. He checked for a pulse and tried to move him but Mr Shepherd did not respond. He called a code blue emergency on his radio (which indicates a medical emergency when a prisoner is unconscious, not breathing or having breathing difficulties). The emergency was called at 8.34am and Officer A arrived shortly afterwards.

27. Officer A entered the cell and started cardiopulmonary resuscitation (CPR) by giving chest compressions. He said he did not give mouth-to-mouth because there was a lot of blood around Mr Shepherd's mouth. He said that Mr Shepherd was not cold and he thought that he might be able to save him.
28. A nurse was working on the wing and was called to the cell by an officer. A nurse paramedic arrived shortly after and entered the cell. He asked Officer A to continue CPR while he inserted an airway. The defibrillator advised that no shock be given. CPR continued until paramedics arrived at 8.50am. Mr Shepherd was pronounced dead by paramedics at 9am.

### **Contact with Mr Shepherd's family**

29. A prison chaplain was appointed as family liaison officer after Mr Shepherd's death. She accompanied the prison Director to visit Mr Shepherd's mother on the morning that he died to break the news of his death. She kept in regular contact with Mr Shepherd's mother and provided practical and emotional support.
30. The funeral took place on 14 February and the prison chaplain led the service. The prison contributed towards the funeral costs, in line with national policy.

### **Support for prisoners and staff**

31. After Mr Shepherd's death, an operational manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
32. The prison posted notices informing other prisoners of Mr Shepherd'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 Shepherd's death.

### **Post-mortem report**

33. The post-mortem report gave Mr Shepherd's cause of death as gastro-intestinal haemorrhage, ruptured oesophageal varices (ruptured veins) and cirrhosis of the liver due to hepatitis C.

# Findings

## Clinical care

34. We agree with the clinical reviewer that that the care that Mr Shepherd received at Parc was equivalent to that which he could have expected to have received in the community. She makes four recommendations, which can be found in the clinical review. We are satisfied that Mr Shepherd received a good standard of care and that his death could not have been predicted.
35. The nurse paramedic who attended the scene praised the skill and perseverance of the officers who started CPR. We also commend their actions.

## Unlocking cells

36. On 22 January, Officer A unlocked Mr Shepherd's cell, but did not speak to Mr Shepherd. He told the investigator that this was his usual practice because prisoners often do not like to be disturbed if they are sleeping. He said that after Mr Shepherd's death a notice was sent to staff reminding them that they should speak to prisoners when unlocking their cells, and to open their doors widely. He said that this is now what he does each time he unlocks cells in the morning.
37. In 2016, we made a recommendation to Parc about checking on the welfare of prisoners when unlocking cells and it is disappointing that this issue has arisen again. There was only a short time between unlocking his cell and Mr Shepherd being found, but it is possible that CPR could have been started earlier.
38. Although the Director issued a notice to staff after Mr Shepherd's death instructing them to obtain a response from prisoners when unlocking their cells, it is clear that more focus is required on this issue. We make the following recommendation:

**The Director should ensure that officers understand their responsibilities for checking on the wellbeing of prisoners when unlocking their cells and ensuring that there are no immediate issues that need attention.**

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