Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Aaron Nunes, a prisoner at HMP Parc, on 21 February 2016

A report by the Prisons and Probation Ombudsman

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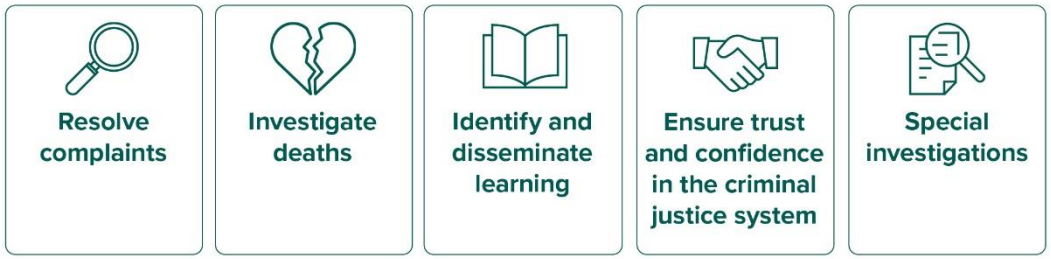
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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 Aaron Nunes died in hospital of septic shock and diabetic ketoacidosis on 21 February 2016 while a prisoner at HMP Parc. This was caused by necrotising fasciitis (a rare but serious bacterial infection) and insulin-dependent diabetes mellitus. Mr Nunes was 27 years old. We offer our condolences to Mr Nunes' family and friends.

Mr Nunes had had Type 1 diabetes since childhood. We investigated his death with the help of a clinical review commissioned by Health Inspectorate Wales (HIW) and in our report, issued in November 2017, the then Ombudsman found that the management of Mr Nunes' diabetes had deteriorated because he failed to regularly monitor his own blood glucose levels or follow advice from health professionals. The report concluded, on the basis of the clinical review, that the diabetes and dental care Mr Nunes had received at Parc was equivalent to that he could have expected to receive in the community. An inquest held in December 2017 concluded that the direct cause of Mr Nunes' death was his failure to manage his own health adequately.

However, following representations from solicitors acting on behalf of Mr Nunes' mother, we agreed to reinvestigate his death and HIW commissioned two new clinical reviews.

This report is the outcome of our reinvestigation. It identifies a large number of significant failings in the diabetic and dental care Mr Nunes' received at Parc and concludes that his death would have been preventable if he had received dental and diabetic healthcare of an acceptable standard.

I am extremely troubled by the many clinical failures described in this report. HM Prisons and Probation Service, NHS Wales and G4S, who run Parc, will need to ensure, as a matter of urgency, that they cannot recur. There were also some non-clinical concerns which the Director will need to address.

I apologise for the shortcomings of our original investigation and the delay in issuing this final report. I recognise that this will have caused Mr Nunes' mother additional distress and I am writing to her to apologise in person.

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 **May 2024**

Contents

Summary

Events

1. On 14 January 2015, Mr Aaron Nunes was recalled to custody. He was moved to HMP Parc on 1 June.

2. Mr Nunes had been diagnosed with Type 1 diabetes as a child and was dependent on insulin injections to manage his condition. He did not comply with his insulin medication regime at Parc and was frequently aggressive to healthcare staff when they told him how important it was that he should test his blood sugar and ketone levels to manage his diabetes and prevent diabetic ketoacidosis. (DKA, a potentially life-threatening condition).

3. Between June 2015 and February 2016, Mr Nunes was admitted to hospital with suspected DKA on 14 occasions and discharged himself on several occasions against medical advice. When he returned to Parc after being hospitalised, Mr Nunes was frequently not assessed by a GP and his blood sugar and ketone levels were not reviewed by healthcare staff.

4. In November and again in December, staff managed Mr Nunes under suicide and self-harm monitoring and support procedures (known as ACCT) as they considered that his failure to take responsibility for his health was a form of self-harm.

5. In November and December, Mr Nunes complained of toothache and was given painkillers. Healthcare staff suspected he may have a dental abscess. They made him an appointment with a prison dentist on 18 January 2016, which Mr Nunes failed to attend.

6. On 5 February, Mr Nunes complained of toothache again. A prison dentist saw him on 8 February but could not examine him properly as Mr Nunes was unable to open his mouth wide enough because of pain and swelling. The dentist prescribed antibiotics and planned to review him on 15 February.

7. On 10 February, Mr Nunes received his antibiotics, two days after they had been prescribed. He did not attend his dental appointment on 15 February, and no follow-up dental appointment was made.

8. On 17 and 18 February, Mr Nunes complained to nurses about pain from his abscess. On 18 February, a nurse left instructions that he should be given antibiotics overnight, but this did not happen as there was no one qualified to prescribe antibiotics. On 19 February, a dental therapist assessed him but was unable to examine him as he could not open his mouth. She booked an appointment for him to see the dentist on 22 February.

9. On 20 February, Mr Nunes felt unwell. Healthcare staff noted that he was at a considerable risk of DKA, and he was taken to hospital. This was Mr Nunes' fifteenth admission to hospital. Mr Nunes insisted on discharging himself although a hospital doctor told him he risked dying if he did so. When he returned to Parc, no one from the healthcare team assessed him.

10. Later that day, Mr Nunes did not collect his medication and did not attend a GP appointment. He was not seen by anyone from healthcare.

11. On 21 February, roll checks were carried out at about 5.30am and 7.00am and no concerns were raised about Mr Nunes. At 8.40am, an officer unlocked Mr Nunes' cell door, but did not look into the cell to complete a welfare check.

12. At 9.04am, an officer found Mr Nunes unresponsive in his cell. He raised the alarm, and an ambulance was called at 9.14am. At 9.34am, paramedics arrived at Mr Nunes' cell. They took him to hospital at 9.44am.

13. Mr Nunes' condition deteriorated in hospital, and he died at 10.45pm with his family present.

Findings

14. Parc could not offer the clinical care and observation required to meet Mr Nunes' complex healthcare needs safely. His death would have been preventable if he had received dental and diabetic healthcare of an acceptable standard.

15. Lack of expertise meant that healthcare staff failed to identify the seriousness of Mr Nunes' condition and mistakenly considered that he was to blame for his frequent hospital admissions. Prison staff took their lead from healthcare staff.

Dental care

16. Mr Nunes' dental care was unsafe and subject to a catalogue of failings. His dental infection remained untreated for 43 days. Subsequent dental care fell well below acceptable professional standards and resulted in a serious failure to meet the duty of care to him.

17. Mr Nunes' death from necrotising fasciitis (NF) arising from his mismanaged dental infection would have been preventable if he had been treated appropriately and in a timely manner.

18. Dental record keeping at Parc did not meet the standards set by the General Dental Council (GDC) and was not fit for purpose for the provision of safe dental care.

19. The system for booking dental appointments at Parc was inefficient. Although Mr Nunes had an acute dental infection and was an immune-compromised Type 1 diabetic patient, there were long delays before he received dental appointments.

20. Inadequate communication between dental and healthcare staff resulted in a series of missed opportunities to refer Mr Nunes for urgent dental treatment or to highlight that he had an acute dental infection requiring emergency treatment.

21. When Mr Nunes missed his dental appointments, no one from the dental or healthcare team checked why he had failed to attend or arranged an alternative appointment, and his acute dental infection was left unmonitored for unacceptably long periods.

22. There was no provision for emergency dental care out-of-hours on weekdays, weekends or Bank Holidays.

23. The unacceptably long delay in dispensing Mr Nunes' antibiotics contributed to his dental infection developing into NF, which was one of the causes of his death.

24. The absence of a working x-ray machine resulted in a lost opportunity to identify the cause of Mr Nunes' dental infection at an earlier stage.

25. Time for Teeth, the dental provider, had not provided its dental staff at Parc with specialised training in prison dental care and this contributed to the failure to provide Mr Nunes with safe and effective dental care.

26. When Mr Nunes was eventually seen in the dental clinic, he was seen only once by a dentist and once by a dental therapist.

27. The quality of dental care and treatment that the dentist provided Mr Nunes on 8 February fell significantly below the standards expected of a qualified dental surgeon.

28. The dental therapist did not provide Mr Nunes with appropriate dental treatment on 19 February and as a result his dental care immediately before his death was severely compromised. Her scope of practice and level of competence meant that she should never have been expected to see or treat dental emergencies without supervision.

Diabetic care

29. Clinical staff at Parc lacked experience and knowledge of acute diabetes complications and, as a result, the diabetic care Mr Nunes received was inappropriate and not equivalent to that he could have expected to receive in the community.

30. In a number of respects the actions of healthcare staff at Parc fell below the standards expected by the General Medical Council (GMC) and Nursing and Midwifery Council (NMC). This had a detrimental effect on Mr Nunes' health.

31. There were numerous occasions when healthcare staff omitted to administer Mr Nunes' insulin. Their failure to respond with the necessary urgency when this happened was the result of inexperience and lack of knowledge about acute diabetes complications.

32. It was important that Mr Nunes' insulin was administered immediately before or after eating a meal, but he was unable to do this because of the discrepancy between the times the medication hatch was open and the times that prison meals were served. This restricted Mr Nunes' ability to use his insulin correctly.

33. Mr Nunes often had difficulty accessing blood sugar and ketone level testing strips and accessing a working blood sugar testing meter.

34. Staff mistakenly believed that a blood sugar test was required before every insulin injection.

35. When Mr Nunes returned to prison from hospital after his many admissions, healthcare staff took no clinical observations and did not record his blood sugar and ketone levels.

36. The accumulation of these errors led to a critical and acute deterioration in Mr Nunes' health.

37. Healthcare staff failed to recognise and investigate Mr Nunes' diabetic gastroparesis and did not request that diabetes specialists visit him in prison, ask for advice on treatment or transfer him to a prison with facilities better able to manage this complex condition. This was a significant contributor to Mr Nunes' repeated admissions to hospital and impacted adversely on his health.

38. When Mr Nunes was unwell, healthcare staff failed to assess, observe and examine him adequately, using tools such as NEWS and sepsis screening, and frequently failed to monitor his blood sugar and ketone levels. Clinical note-taking was too brief and fell below the expected standards from the GMC and NMC.

39. Healthcare staff failed to recognise Mr Nunes' poor understanding of his condition and put an inappropriate onus on him to care for himself. It was unrealistic and irresponsible to expect him to manage his complex diabetic condition without adequate clinical support. Mr Nunes' erroneous self-care was a major, inadvertent cause of his repeated episodes of DKA. Staff should have identified this, and Mr Nunes should have been offered the support of diabetes specialists and a structured education programme.

40. Healthcare staff also failed to recognise that Mr Nunes' poor compliance with his diabetes regime was due to diabetes burn out and his poor understanding of his condition, rather than being intentional self-neglect. As a result, Mr Nunes' mental health problems remained unresolved and inadequately managed, and this contributed significantly to his poor diabetes control and recurrent hospital admissions. If these problems had been addressed earlier, it may have prevented his death.

41. Many of the nurses dealing with Mr Nunes were mental health or learning disability nurses and were therefore working outside of their clinical competence as far as Mr Nunes' diabetes was concerned. This did not meet NMC standards and resulted in Parc providing an unsafe environment for Mr Nunes.

42. In the absence of any formal healthcare multidisciplinary team meetings or a senior clinician taking responsibility for Mr Nunes' care, no one formulated a comprehensive care plan for Mr Nunes.

43. ACCT procedures were not designed to address Mr Nunes' specific diabetes-related difficulties. ACCT monitoring was no substitute for adequate clinical care planning and clinical leadership, including effective Supported Living Plans (SLPs) and Clinically Vulnerable and Older Persons meetings (CVOPs).

44. Although a SLP was opened, it was of a poor standard and had little or no impact on the care delivered to Mr Nunes by healthcare or operational staff. The CVOP meetings were informal and unstructured and did not provide an opportunity for effective care planning.

45. There was an unacceptable delay in Mr Nunes accessing his antibiotics on 18 February as nurses did not have the authority to dispense them and did not contact the out-of-hours GP.

46. Mr Nunes' mother could have significantly contributed to his care if healthcare staff had involved her more. Failure to do so was detrimental to his overall diabetes care.

47. There is no evidence that Mr Nunes was obtaining illicit drugs when he went to hospital. However, there was evidence that he may have been using psychoactive substances (PS) in prison. Healthcare staff should have been more proactive in raising the dangers of drug use with Mr Nunes and attempts should have been made to identify or exclude drug misuse as a possible contributor to his poor compliance and disengagement with his complex diabetes management.

Events of 20 and 21 February

48. When Mr Nunes returned from hospital on 20 February after discharging himself against medical advice, he was not given antibiotics or insulin and healthcare staff did not see him for 28 hours until he was found unresponsive in his cell the next day. This was a gross breach in the duty of care.

49. If Mr Nunes had been given antibiotics and insulin, this might have managed his infection and prevented the development of severe DKA. Healthcare staff should also have supervised him closely, including carrying out hourly observations and recording his vital signs.

50. The officer who unlocked Mr Nunes on 21 February did not look into the cell or complete a welfare check on Mr Nunes as he should have done in line with national policy. Another officer found Mr Nunes unresponsive in his cell 25 minutes later. Although it is unlikely that the delay of 25 minutes made any difference to the outcome for Mr Nunes, such a delay may be critical in other medical emergencies.

51. After the code blue medical emergency was called, there was a delay of around 10 minutes before the control room called an ambulance. Although this is unlikely to have affected the outcome for Mr Nunes, in other emergencies, any delay could be critical.

52. When Mr Nunes was taken to hospital on 21 February after being found unresponsive in his cell, his mother was not informed by the prison until about three hours later.

Recommendations

53. Health Inspectorate Wales (HIW) have made a number of detailed recommendations about dental care and healthcare in their reviews, which the Director and Head of Healthcare at Parc will need to address.

54. We have made five high level recommendations below, as well as some 'housekeeping' and non-clinical recommendations.

- **The Chief Executives of HMPPS, NHS England and NHS Wales should write to the Ombudsman setting out what they have done to satisfy themselves that the dental services provided by Time for Teeth (TfT) in prisons in England and Wales are safe and fit for purpose, including that:**
  - a dedicated dental software system, which meets the professional standards set out by the General Dental Council, operates alongside SystmOne in prison dental surgeries;
  - there is an efficient appointments system to book dental appointments promptly;
  - dental emergencies are prioritised for urgent care;
  - failed dental appointments are followed up and rescheduled promptly so that emergency patients are not lost in the system;
  - patients at a higher risk of complications are flagged;
  - regular updates on patients causing concern are recorded and acted on;
  - prisoners have access to out-of-hours emergency dental cover equivalent to the level of safety and accessibility available in the community;
  - prescriptions, particularly those for antibiotics for acute infections, are dispensed within hours;
  - all surgery equipment, especially diagnostic equipment, is regularly serviced and is fit for use, as required by statutory regulations;
  - effective processes are in place to communicate critical patient information between the dental and healthcare teams and within the dental team;
  - prison dental staff receive specialist training to ensure competence in prison dental care; and
  - clinical sessions set out in the contract / SLA include the presence of a dental surgeon in the dental clinic at specified times to deal with emergencies as they arise.
- **The Chief Executive of NHS Wales should ensure that prison dental surgeries in Wales are subjected to the same level of scrutiny and inspection as community dental surgeries.**
- **The HMPPS Executive Director for Wales and the Chief Executive of NHS Wales should write to the Ombudsman setting out what they have done to satisfy themselves that the nurse-led healthcare service provided at Parc by G4S Medical Services is safe and fit for purpose, including that:**
  - there is an appropriate staff mix so that registered general nurses lead the care and those with specialist expertise, such as mental health nurses, support them within their competence;
  - staff make accurate and timely records in line with GMC and NMC standards;

- prisoners with complex care needs are promptly considered for transfer to a prison with a 24-hour inpatient facility;
- a senior clinician is responsible for leading and coordinating the care for prisoners with complex conditions;
- effective care plans are created and implemented; and
- therapeutic psychological services are available.

➢ **The Chief Executive of NHS Wales should investigate whether Parc followed the PGD regulations and whether the use of verbal instructions by GPs for nurses to dispense prescription-only medicines from the out-of-hours medication cupboard complies with regulations.**

➢ **Health Inspectorate Wales should consider whether the dentist and the dental therapist should be referred to their professional bodies with a view to considering their fitness to practice.**

Housekeeping recommendations

- The Director and the Head of Healthcare at Parc should:
  - liaise with the local Health Board to ensure that newly arrived insulin-dependent diabetic prisoners are assessed on their understanding of diabetes management and self-care so that appropriate care is provided in line with prisoners' needs; and
  - commission an outreach service from the community diabetes team to ensure that nursing staff are adequately trained and know when to seek advice from secondary services.
- The Director and the Head of Healthcare at Parc should ensure that all prisoners are assessed by the healthcare team on their return from hospital.
- The Director and the Head of Healthcare at Parc should ensure that hospital discharge summaries for prisoners are received in a timely manner and, if this does not happen, that requests are followed up promptly.
- The Head of Healthcare at Parc should ensure that CVOP meetings are clinically multidisciplinary, that effective care plans are created and implemented, and that the meetings are accurately minuted.
- The Director and the Head of Healthcare at Parc should ensure that SLPs are properly completed and shared with operational staff and are taken into account when providing care to prisoners.
- The Head of Healthcare at Parc should ensure that the prison pharmacist:
  - regularly reviews the medication needs of prisoners who use insulin and that insulin prescriptions are ordered promptly; and
  - ensures there are adequate supplies of lancets and blood testing strips for all prisoners who use insulin.

Non-clinical issues

- The Director at Parc should ensure that prisoners with substance misuse issues are supported and that efforts to tackle the availability of illicit substances are prioritised.
- The Director at Parc should ensure that staff manage prisoners at risk of suicide and self-harm in line with national policy, in particular staff should:
    - assess risk based on all relevant information, including that held in medical records;
    - mark caremap actions as completed only once they have been actioned fully; and
    - ensure that caremap actions are created and reviewed in line with national guidance and are specific, meaningful and time-bound, aimed at reducing prisoners' risks; and
    - obtain appropriate clinical input where appropriate before deciding to stop ACCT procedures.
- The Director at Parc should ensure that staff:
    - involve the prisoner's next of kin in their care where appropriate, in line with PSI 64/2011; and
    - ensure that the next of kin are promptly informed when a seriously ill prisoner is taken to hospital.
- The Director at Parc should ensure that Parc's instructions to staff about roll checks are consistent.
- The Director at Parc should ensure that when a cell door is unlocked, staff satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.
- The Director at Parc should ensure that control room staff call an ambulance immediately they receive a medical emergency code.

Learning lessons

- The Head of Healthcare at Parc should share this report with Nurses A, B and C and discuss the ombudsman's findings with them.
- The Director should share this report with CM A and Officers A, B and C and arrange for a senior manager to discuss the Ombudsman's findings with them.

The Investigation Process

55. We investigated Mr Nunes' death, with the help of a clinical reviewer appointed by Healthcare Inspectorate Wales (HIW) and issued a draft report to stakeholders in December 2016. The solicitors representing Mr Nunes' mother raised a number of concerns about our investigation and conclusions. In November 2017, we issued a final report into Mr Nunes' death, and addressed the issues raised by the solicitors in separate correspondence.

56. HM Coroner for South Wales Central Area held an inquest in November/December 2017. The jury concluded:

> "Mr Nunes sadly passed away due to the failure to manage his own health adequately … We the jury came to the final conclusion that despite insufficient provision of care under G4S during the period of the 20th to 21st of February 2016, Mr Nunes' management of his own health is the direct cause of death."

57. Mr Nunes' mother's solicitors continued to raise concerns about our investigation and in February 2018 we made some additions to our final report. However, in response to further concerns, the Acting Prisons and Probation Ombudsman asked a senior investigator and an Assistant Ombudsman to review our original investigation and subsequent report. The Acting Ombudsman then asked them to reinvestigate the circumstances of Mr Nunes' death.

58. We also asked HIW to carry out a further review of Mr Nunes' clinical care at Parc. HIW appointed two new clinical reviewers to review the general clinical and dental care provided.

59. The investigator reviewed documentation obtained during the original investigation and obtained other relevant documents. He re-interviewed four members of staff and interviewed a further five members of staff, including three from the prison's dental team. He carried out some of the interviews jointly with the clinical reviewers.

60. We told HM Coroner that we were re-investigating Mr Nunes' death and the investigator reviewed some of the evidence given during the inquest into his death. We have sent the Coroner a copy of this new report.

61. In November 2018, the investigator met Mr Nunes' mother and he has updated her through her solicitors throughout the course of the re-investigation. Mr Nunes' mother and her solicitors have raised numerous concerns, which we have addressed in the Findings section of this report and in the two clinical reviews.

Background Information

HMP Parc

62. HMP Parc is a medium security prison near Bridgend in South Wales. The prison is run by G4S Care and Justice Services and holds around 1,600 men and young adults convicted or on remand. It also has a unit for around 60 young people under 18.

63. At the time of Mr Nunes' death, G4S Medical Services provided primary physical and mental health care services at Parc and the Abertawe Bro Morgannwg University Health Board provided secondary mental health services. There were 24-hour general healthcare and palliative care facilities, but no inpatient facilities. A local General Practitioner practice provided GP services, including a daily clinic and out-of-hours cover. There were three healthcare staff available in the prison at night.

64. Time for Teeth (TfT) provided all dental services at Parc under a service level agreement (SLA) which started in 2012 and expired on 31 December 2015, although it continued to remain in place until it was renewed in 2017.

65. The original SLA stipulated that six dental sessions a week took place at the prison, with the renewed SLA providing eight dental sessions a week. The SLA made no provision for out of hours emergency dental cover during the weekdays, weekends or Bank Holidays. Healthcare staff and the GP service provided out-of-hours emergency dental cover at Parc. Specialist referrals for secondary dental care were available at the Princess of Wales (POW) Hospital in Bridgend.

HM Inspectorate of Prisons (HMIP)

HMIP inspection: January 2016

66. A HMIP inspection of Parc took place in January 2016. Inspectors reported that experienced clinical managers and lead nurses provided effective clinical leadership, but that significant recruitment and retention problems affected secondary health screening. Inspectors reported that support for prisoners with complex health needs, including life-long conditions, was generally good and that the lead GP had developed comprehensive case management that had contributed to improved outcomes for prisoners with complex epilepsy, which was being expanded to prisoners with diabetes. However, inspectors reported that prisoners remained overwhelmingly negative about prescribing, access to services, mental health support and the quality of care.

67. Inspectors reported that prisoners with mild to moderate mental health needs were not always assessed promptly, and that primary mental health provision was inadequate as prisoners had no access to clinical psychology or psychiatry and did not receive the ongoing support they needed.

68. Inspectors said medicines were given at clinically appropriate times but that many administration records were incomplete, and it was unclear if prisoners had

received their medication. Inspectors reported that medicines held for administration under patient group directives (PGDs) were not audited regularly.

69. Inspectors reported that TfT provided equivalent dental services but waiting times were too long at around eight weeks. Inspectors said prisoners requiring routine appointments were triaged by a dental nurse within one to three weeks and saw a dentist around six weeks later. Inspectors reported that emergency dental provision was adequate, that the dental facility was excellent and clinical governance was good.

70. Inspectors reported that prisoners monitored under suicide and self-harm procedures felt supported and cared for and that prisoners in crisis, who required higher levels of support, were held in the safer custody unit. Inspectors reported that ACCT documentation was very good.

71. Inspectors reported that the ready availability of psychoactive substances (PS) was having a severely negative influence in the prison and that over half of prisoners told them that it was easy to obtain drugs. Inspectors reported that the prison had failed to meet its mandatory drug testing target but was actively addressing supply reduction and that the process for identifying managing and reducing violence were good with interventions to support victims of violence.

HMIP inspection: November 2019

72. HMIP carried out a further inspection of Parc in November 2019. Inspectors reported that, overall, the prison was fulfilling its core purposes well but there was room for improvement. Inspectors reported that the quality of ACCT documents was mixed and caremaps lacked detail.

73. Inspectors described access to health services and treatments as problematic but found an appropriate range of primary care services, including from GPs, and that care for patients with long-term conditions had improved because of enhanced staffing. However, inspectors reported that there was insufficient capacity in the secondary mental health team to deliver appropriate care and treatment for prisoners with complex needs, that there were no occupational therapists and there was minimal psychology input.

74. Inspectors reported that the prisoner 'in possession' medication policy needed to be reviewed as risk assessments focused on the individual and were not reviewed for each new medicine (such as antibiotics). Inspectors reported that this affected the provision of effective treatment. HMIP reported that prisoners reported a delay in receiving directly-ordered prescriptions, but they considered that the delays were not unreasonable. Inspectors also reported that the supervised administration of medicines took place at set times which meant that dosage schedules could not be adhered to. However, they found that some provision was available for administration at lunchtime and at night.

75. HMIP reported that TfT had an experienced team who provided an appropriate range of treatments, including a dental nurse who assessed prisoners to ensure that clinical priorities were identified, and routine appointments and ongoing treatments were arranged on time. HMIP reported that access to dental provision was good, and that equipment was appropriately maintained.

Independent Monitoring Board

76. 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 their report for the year to July 2016, the IMB reported that they considered that Parc was well managed. The IMB reported an ongoing problem with high numbers of prisoners not attending healthcare appointments because of a lack of staff to escort them.

77. In their most recent report for the year to February 2019, the IMB reported that the prison remained well managed and that positive changes had been introduced to reduce the level of non-attendance at healthcare appointments.

Previous deaths at HMP Parc

78. In the 12 months before Mr Nunes' death, six prisoners died at Parc: five of the deaths were from natural causes and one was self-inflicted.

79. In three of our previous investigations, we made similar but not identical recommendations to those that we make in this report. These included addressing the lack and quality of formal care plans for those with chronic disease, delays in administering medication, the failure of staff to liaise with secondary care services and the need for those known to use illicit substances to be referred to the prison's substance misuse team for support. In one investigation, we also made recommendations about weaknesses in the management of ACCT procedures, about the need for staff to satisfy themselves about a prisoner's wellbeing during unlock, and about the need to address both the supply and demand for illicit drugs at Parc.

80. There have been 27 deaths at Parc since Mr Nunes' death: 17 were from natural causes, five were self-inflicted and five were drug-related. In most of these cases we have found that the healthcare the prisoner received was equivalent to that he could have expected to receive in the community. However, in the case of five deaths (in October 2016, November 2017, October 2018 and January and August 2019) we found that the standard of healthcare was below that in the community – in some cases, well below – and in our report on a death in July 2018, we recommended that that healthcare introduce a protocol for managing prisoners who frequently refuse treatment and/or discharge themselves from hospital.

Type 1 diabetes

81. Type 1 diabetes, or insulin-dependent diabetes, is an autoimmune disease that causes the destruction of the insulin-producing cells in the pancreas, meaning that the body is not able to produce enough insulin to regulate blood glucose (blood sugar) levels. The condition can develop at any age. Because Type 1 diabetes causes the loss of insulin production, it requires regular insulin administration, usually by injection.

82. Type 1 diabetes is a serious condition which can result in significant risks and complications. These can occur if blood sugar levels go too low or too high and if insulin injections are missed. Complications can include hypoglycaemia (low blood

sugar levels) which can result in symptoms including sweating, fatigue, dizziness, hunger, confusion, convulsions and loss of consciousness, and hyperglycaemia (high blood sugar levels) which can cause the life-threatening condition of diabetic ketoacidosis (DKA)).

83. DKA happens when the body starts to run out of insulin. This causes harmful substances called ketones to build up in the body and can be life-threatening if not promptly identified and treated. Symptoms of DKA include needing to urinate more frequently, dehydration, stomach pain, breath that smells of pear drops, deep breathing, tiredness, confusion and passing out.

84. Ketones are measured at four levels: 1 (normal), 2 (medium), 3 (high) and 4 (possible DKA). People with level 2 or higher should contact healthcare specialists and for those with a level of 4, emergency medical attention is essential.

85. Symptoms of Type 1 diabetes are significantly reduced if individuals maintain good control of their blood sugar levels by regular testing and administering insulin when appropriate. Flexible insulin therapy usually involves self-injecting multiple daily doses of insulin, with the doses adjusted based on taken or planned exercise, intended food intake and other factors, including current blood glucose, which the insulin user needs to test on a regular basis. This self-management needs the insulin user to have the skills and confidence to manage the regime. One of the most important roles of healthcare professionals providing diabetes care to adults with Type 1 diabetes is to ensure that systems are in place to provide informed, expert support, education and training for insulin users. Regular attendance at diabetic clinics is also essential.

86. Diabetes is hard to manage, and it is common for people with Type 1 diabetes in particular to suffer from 'diabetes distress'. The symptoms of this include:

- feeling angry about diabetes and frustrated about the demands of managing it
- worrying about not taking enough care of your diabetes but not feeling motivated to change
- avoiding going to appointments or checking your blood sugars
- regularly making unhealthy food choices
- feeling alone and isolated.

87. Having diabetes distress for a long period can lead to 'diabetes burnout' when the patient stops taking care of themselves, including skipping insulin doses.

Assessment, Care in Custody and Teamwork

88. Assessment Care in Custody and Teamwork (ACCT) is the Prison Service's care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

89. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. There should be

regular multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT should not be closed until all the actions on the caremap have been completed. A post-closure review should take place after the closure of the ACCT to identify whether any issues or concerns have been identified since the closure of the ACCT and, if so, to consider whether to re-open the ACCT. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011

Psychoactive Substances (PS)

90. PS (formerly known as 'new psychoactive substances (NPS)' or 'legal highs') are a serious problem across the prison estate. They can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and causing 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 PS to precipitate or exacerbate the deterioration of mental health, and they are linked to suicide and self-harm.

Key Events

91. A more detailed account of the key events is attached at Annex 1.

92. Mr Nunes had served several sentences in young offender institutions and prison, most recently for drug offences and affray. On 14 January 2015, he was recalled to custody and in May, he received a further 12-month sentence. He was moved to HMP Parc on 1 June.

Diabetes

93. Mr Nunes had been diagnosed with Type 1 diabetes as a child. His mother supported him in managing his diabetes in the community by monitoring his blood sugar levels and administering his insulin, even into adulthood.

94. Mr Nunes did not comply with his insulin medication regime at Parc. He was frequently aggressive to healthcare staff when they told him how important it was that he should test his blood sugar and ketone levels to manage his diabetes and prevent diabetic ketoacidosis. (DKA, a potentially life-threatening condition.) Mr Nunes also raised issues with healthcare staff about not having access to equipment to test his blood sugar and ketone levels.

95. Between June 2015 and February 2016, Mr Nunes was admitted to hospital with suspected DKA on 14 occasions and discharged himself on several occasions against medical advice. Staff suspected he might be deliberately making himself ill so he could collect illicit drugs in hospital and bring them back into prison. When he returned to Parc after being hospitalised, Mr Nunes was frequently not assessed by a GP and his blood sugar and ketone levels were not reviewed by healthcare staff.

96. In September 2015, healthcare staff started to ask Mr Nunes to sign medical disclaimers if he refused to take his insulin. During September alone, Mr Nunes signed 14 medical disclaimers. In September and October, Mr Nunes failed to attend three GP appointments, a hospital appointment and four nurse-led clinic appointments.

97. In November and December, staff held two multidisciplinary case conferences to discuss Mr Nunes' poor diabetes management and his refusal to attend hospital for further assessment. His mother attended the second case conference.

98. In November and again in December, staff started suicide and self-harm monitoring and support procedures (known as ACCT) as they considered that Mr Nunes' failure to take responsibility for his health was a form of self-harm. The second period of ACCT management ended on 29 December. In December, he was assessed by a mental health nurse.

99. On 14 December, Mr Nunes was seen by a GP for the last time. He failed to attend three GP appointments in December and in January 2016. No follow-up appointments were arranged.

100. Between 8 January and 12 February 2016, healthcare staff saw Mr Nunes regularly for diabetes reviews. They noted that he had been reminded of the importance of

managing his diabetes but that he continued to refuse to check his blood sugar and ketone levels and was often abusive towards staff when they reminded him. Healthcare staff made no changes to how they managed his healthcare.

Toothache

101. In November and December 2015, Mr Nunes complained of toothache. An appointment was made for him to see a prison dentist on 18 January 2016 for a suspected abscess, but he failed to attend. On 5 February, Mr Nunes complained again. A prison dentist saw him on 8 February but could not examine him properly as Mr Nunes was unable to open his mouth wide enough because of pain and swelling. The dentist prescribed antibiotics and planned to review him on 15 February.

102. On 10 February, Mr Nunes received his antibiotics, two days after they had been prescribed. He did not attend his dental appointment on 15 February, and no follow-up dental appointment was made.

103. On 17 and 18 February, Mr Nunes complained to nurses about pain from his abscess. On 18 February, a nurse instructed that he should be given antibiotics overnight, but this did not happen as there was no one on duty who was qualified to prescribe them.

104. On 19 February, a dental therapist assessed him but was unable to examine him as he could not open his mouth. She noted that Mr Nunes had not been given antibiotics and that she needed to discuss this with the prison GP. She booked an appointment for him to see the dentist on 22 February.

105. On 20 February, Mr Nunes felt unwell in the early hours. Healthcare staff noted that he was at a considerable risk of DKA, and he was taken to hospital by taxi. This was Mr Nunes' 15th and penultimate admission to hospital. Mr Nunes insisted on discharging himself from hospital although a hospital doctor told him he risked dying if he did so. When he returned to Parc, no one from the healthcare team assessed him.

106. Later that morning, Mr Nunes did not collect his medication and did not attend a GP appointment. Nurses noted that they had been told by prison officers that he could not be bothered to get out of bed. He was not seen by anyone from healthcare.

Events of 21 February 2016

107. On 21 February, roll checks were carried out at about 5.30 and 7.00am and no concerns were raised about Mr Nunes. At 8.40am, an officer unlocked Mr Nunes' cell door but did not look into the cell to complete a welfare check.

108. At 9.04am, an officer found Mr Nunes unresponsive in his cell. The officer raised the alarm, and an ambulance was called at 9.14am. At 9.34am, paramedics arrived at Mr Nunes' cell. Mr Nunes was stabilised, and he was taken to hospital at 9.44am.

109. Mr Nunes' condition deteriorated in hospital, and he died at 10.45pm, with his family present.

Contact with Mr Nunes' family

110. Mr Nunes was taken to hospital at 9.44am on 21 February 2016. At 12.15pm on 21 February, the prison appointed a chaplain as the family liaison officer. She immediately telephoned Mr Nunes' mother to tell her that Mr Nunes had been taken to hospital.

111. Around three hours later, the chaplain went to the hospital to meet Mr Nunes' mother and to offer her support. She asked Mr Nunes' mother how she would like to be told of any change in Mr Nunes' condition. She said the chaplain should contact her by telephone. The chaplain left the hospital at approximately 6.00pm but returned at 10.20pm after she was told that Mr Nunes had deteriorated. She conducted a prayer service and was with his family when Mr Nunes died at 10.45pm.

112. The following day, the chaplain and a prison manager visited Mr Nunes' mother at her home to offer their condolences and support.

113. The prison offered a contribution to the costs of Mr Nunes' funeral in line with national instructions, though his family declined the offer.

Support for prisoners and staff

114. On 29 February, a senior prison manager held a hot debrief for the staff involved in the emergency response and the bed watch to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support. A week later, the manager debriefed the staff involved in the bed watch and she again offered them support.

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

Post-mortem report

116. The post-mortem examination concluded that Mr Nunes' death had been caused by septic shock and DKA, caused by necrotising fasciitis of the left temple and insulin-dependent diabetes mellitus.

117. Septic shock occurs when the blood pressure drops to a dangerously low level as the result of an infection and causes organ failure. People with diabetes have an increased risk of developing septic shock. Necrotising fasciitis is a rare but serious bacterial infection in which toxins are released that damage nearby tissue.

118. The toxicology report found PS in Mr Nunes' blood but noted that it was not possible to ascertain when they were last used or what role they may have played in his death.

Mr Nunes' mother's statement to the Coroner

119. In a statement to the Coroner, Mr Nunes' mother said that there had been no real problems with Mr Nunes' diabetes treatment when he had been in previous prisons, and that it was only after he arrived at Parc that he began to complain about access to his insulin. She said this worried her and she tried to contact the healthcare team many times to discuss her son's care.

120. Mr Nunes' mother said that when she met the complex case manager and a prison manager in November 2015, she was told that her son might be being bullied to pick up drugs from hospital. Mr Nunes mother said she did not think this made any sense as if this was the case, she would have been expected to have been searched by his escorts in hospital, which had never happened.

121. Mr Nunes' mother told the inquest that she had persuaded him to stay in hospital many times in the past when he had wanted to discharge himself. She said he required support with managing his diabetic regime and that she would have to tell him when it was time to take his insulin. She said she did not think her son fully understood the details of his diabetic regime and found it hard to adjust to his new insulin regime.

122. Mr Nunes' mother said that she was certain that her son was becoming more ill. She said that she was told in December that she would be contacted if he was admitted to hospital, but this never happened, apart from on the day that he died. She said that if she had been contacted, she might have been able to stop him discharging himself.

123. She said that on the day Mr Nunes died, she was not told that he had been admitted to hospital until around 12.30pm, three hours after he had been found unresponsive in his cell. She said she understood the hospital had asked the prison to contact her.

124. Mr Nunes' mother said her son liked everything in order and was very clean. She said that when she saw her son's cell after his death, it was awful, and she did not believe her son had lived like that.

Accounts of other prisoners

125. After Mr Nunes' death over fifteen prisoners provided statements.

126. A prisoner who shared a cell with Mr Nunes, said that towards the end of January, Mr Nunes had a swollen face from toothache and cried a lot as he was not able to eat properly. He said Mr Nunes told staff but that nothing was done about it. He said that Mr Nunes would beg staff to help him and would cry himself to sleep. He said that on one occasion when responding to a cell bell, a member of staff said to him, "You again. You are always crying like a baby." The prisoner said he asked for a cell transfer on 19 February, as he felt no longer able to share a cell with Mr Nunes because he was so unwell.

127. A friend of Mr Nunes said he had never seen Mr Nunes so ill as in the time leading to his death. He said he told staff about his concerns, but no one took any notice. He said officers ignored Mr Nunes and would just lock him behind his cell door

when he became frustrated about his health and did not appear to care about his welfare. He said officers would laugh and make jokes about Mr Nunes.

128. A prisoner said officers treated Mr Nunes as if there was nothing wrong with him and would call him a baby. Another prisoner said that healthcare staff and officers at the prison neglected Mr Nunes. He said that Mr Nunes could not eat properly because of the swelling caused by the abscess. A third prisoner said he complained to staff about the treatment Mr Nunes was getting. He said staff would say Mr Nunes was crying like a baby and would tell him to "man up".

129. A prisoner said in his statement that towards the end of his life, Mr Nunes would break down and cry in the middle of the wing and that this was out of character for someone who was strong. He said Mr Nunes could not eat for around about 10 days before his death because of toothache and the abscess in his mouth and that no one took him seriously.

130. Statements from other prisoners gave accounts of witnessing Mr Nunes in pain, with his face swollen and often crying in pain. Many expressed concerns in their statements that they did not think Mr Nunes received appropriate treatment during his time at Parc.

Findings

131. HIW commissioned two clinical reviews as part of our re-investigation, one to address Mr Nunes' dental care and the other his general clinical care. We have summarised the main issues identified in these reviews in our findings below. More detail on these and other issues is contained in Annexes 2 and 3.

132. HIW have made a large number of recommendations. Although we do not repeat them all here, they will all need to be addressed by the relevant parties.

Provision of dental care at HMP Parc

Overall conclusion

133. The post-mortem report concluded that one of the causes of Mr Nunes' death was necrotising fasciitis (NF) of the temple.

134. HIW said that the most common cause of NF affecting the head or neck is a dental infection in patients with weakened immune systems, such as those with diabetes, and linked Mr Nunes' dental abscess to his NF. HIW said that early recognition is critical for successful treatment as the infection can spread very rapidly and lead to organ failure and death.

135. As it appears that the NF had a dental origin, we have considered whether the dental care Mr Nunes received was appropriate, timely and equivalent to that he could have expected to receive in the community.

136. HIW concluded that Mr Nunes' dental care was unsafe and subject to a catalogue of failings with systems not fit for purpose. They noted that Mr Nunes' dental infection remained untreated for 43 days and that subsequent dental care fell well below acceptable professional standards and resulted in a serious failure to meet the duty of care to him.

137. HIW concluded that the whole dental team mismanaged Mr Nunes' dental infection and said NF would not have developed if the dental infection been appropriately managed. They found that Mr Nunes' death from NF arising from his mismanaged dental infection would have been preventable if he had been treated appropriately and in a timely manner.

138. We have examined the various concerns in more detail below.

Record keeping

139. HIW noted that SystmOne (the electronic medical record system used by prison healthcare staff) were the only records of Mr Nunes' dental care at the prison. No separate or additional dental notes or radiographs were identified during the investigation by either Parc or Time for Teeth (TfT), the prison's dental provider, and a dedicated dental software system, as used in community dental surgeries, was not being used.

140. The dental therapist told the investigator that all dental records at Parc were kept on SystmOne but that brown cards, stored manually, were used for charting teeth. The dentist told the inquest that he did not keep handwritten records. Tft agreed that SystmOne was not a robust system for recording dental records and said they had raised their concerns about this with G4S.

141. HIW found that it was not possible for SystmOne to record the dental information required for charting, a process used to note the description and condition of a patient's teeth, treatment plans and treatment provided. HIW concluded that dental record keeping at Parc did not meet the standards set by the General Dental Council (GDC), the dental professional regulatory body, and was not fit for purpose for the provision of safe dental care.

Timely dental appointments

142. The HIW found that there were long delays before Mr Nunes received dental appointments:

- On 27 December, healthcare staff identified that Mr Nunes may have a dental abscess. A dental referral was made through a Task on SystmOne, and a dental appointment was subsequently made for 18 January, 22 days later. HIW said that this was an unacceptable delay, given Mr Nunes' poorly-controlled diabetes and suspected dental infection. They noted that this would not have happened in the community. HIW also noted that there was no record on SystmOne to explain why healthcare staff used the lengthy Task appointment system rather than making an immediate emergency referral to the dental clinic, where a dentist would be present on 29 December.

- On Friday, 5 February 2016, Mr Nunes was not offered an emergency referral to the dental clinic, even though three calls had been made to ask for pain relief and there was a dentist present in the prison that day. Mr Nunes was not seen by a dentist until Monday, 8 February 2016.

143. HIW concluded that the system for booking dental appointments at Parc was inefficiently organised and that poor communication between healthcare and dental staff resulted in delayed appointments for acute dental care.

Failed appointments

144. TfT said there was a high failure rate of prisoners attending dental appointments in prisons in England and Wales. HIW noted that there were no systems in place at Parc to deal with failed prisoner appointments.

145. Mr Nunes failed to attend two of his dental appointments, the first on 18 January for his suspected dental abscess, and a follow-up appointment on 15 February to monitor the progress of his infection. HIW noted that Mr Nunes had an acute dental infection at the time of both missed appointments. On both occasions, no one from the dental or healthcare team checked why he had failed to attend, or his state of health and wellbeing. HIW also found that no one arranged an alternative appointment as there was no co-ordinated management of the appointment system, and that this resulted in Mr Nunes being lost in the system for unacceptably long

periods of time, during which his infection was not monitored. HIW concluded this was a failure in the duty of care.

Out of-hours provision for emergency dental care

146. HIW noted that there was no provision for emergency dental care at Parc out-of-hours on weekdays, weekends or Bank Holidays. They concluded that this fell well below the standard of care expected in the community and put Mr Nunes' safety at serious risk.

Delay in dispensing medication

147. HIW found that on at least four occasions, Mr Nunes' dental medication, including antibiotics, was dispensed late or not at all:

- There were delays in providing pain relief to Mr Nunes when he complained of toothache.
- Although the dental referral of 27 December indicated that Mr Nunes was on an antibiotic regime, there is no record that antibiotics were dispensed.
- When Mr Nunes was prescribed antibiotics on 8 February 2016, they were not dispensed until 10 February, two days later. HIW concluded that this delay was inappropriate and unacceptable given the seriousness of Mr Nunes' dental infection.
- Although a further antibiotic was prescribed at around 8.00pm on 18 February, it was not dispensed until the following day at around 11.30am, over 15 hours later, because of system failures and poor communication. This unacceptable delay occurred because nurses did not have the authority to dispense the antibiotics from the Patient Group Directive cupboard, and HIW noted that nurses did not contact the on-call GP to enable them to dispense the antibiotics.

148. HIW said that the efficacy of antibiotics is dependent on them being dispensed as soon as possible after prescription and that the unacceptably long delay in dispensing Mr Nunes' antibiotics was a contributory factor to Mr Nunes' dental infection exacerbating and developing into NF which was one of the causes of his death.

Maintenance of dental equipment

149. HIW noted that an extra-oral (OPG) x-ray machine is a valuable diagnostic tool, especially when a patient cannot open his mouth because of infection or trauma, as was the case for Mr Nunes. Although there was an extra-oral OPG machine in the dental clinic on 8 February 2016, it had not been maintained and was not in working order. HIW concluded that the absence of a working extra-oral x-ray machine resulted in a lost opportunity to identify the cause of Mr Nunes' dental infection at an earlier stage.

Communication

150. HIW noted that Mr Nunes' dental care was unequally shared between healthcare and dental staff. SystmOne recorded that Mr Nunes required dental attention 28 times at Parc, but he was only treated by dental staff twice. Although the dental clinic at Parc was in the same building as the healthcare department, there was only one occasion (19 February) when there was direct communication between healthcare and dental staff and only three occasions when there was indirect communication using Tasks.

151. HIW found there was no effective communication between healthcare staff and dental staff about patients needing extra care, no effective "flagging" between dental staff of patients in need of extra vigilance, and no policies or protocols in place about the handover of care from dental to healthcare staff.

152. HIW concluded that there was a failure to provide safe and timely dental care for Mr Nunes because of inadequate communication between dental and healthcare staff, which resulted in a series of missed opportunities to refer him for urgent dental treatment or to highlight that he had an acute dental infection requiring emergency treatment.

Training

153. Public Health England's survey of dental services in adult prisons in England and Wales carried out in 2014, found that the prison population has poorer physical, mental and social health, as well as higher levels of substance misuse. The survey also identified poor levels of oral health in prison, four times higher than the general population. As a result, Public Health England recommended specialised training programmes for dental clinicians working in prisons.

154. HIW found no evidence that TfT provided its dental staff at Parc with a specialised training programme in prison dental care and concluded that this contributed to the failure to provide Mr Nunes with safe and effective dental care.

Failings in the dental treatment provided

155. HIW noted that the prison's healthcare team, who were not dentally trained, provided analgesia for Mr Nunes dental pain, treating the symptoms rather than the cause of his pain. The review also noted that when Mr Nunes was eventually seen in the dental clinic, he was seen only once by a dentist and once by a dental therapist.

<u>The dentist</u>

156. HIW identified several failings in the standard of care provided the prison dentist when he saw Mr Nunes on 8 February, including that:

- He failed to search SystmOne for any previous dental notes. Earlier notes were available which would have provided a basis for the probable cause of Mr Nunes' dental infection and would also have shown that he had missed an appointment

on 18 January and had not been seen for 43 days since his original referral to the dentist on 27 December.

- His notes fell below the standard of record keeping expected of a dental surgeon. They were not accurate, clear, concise or complete and failed to record the significance of Mr Nunes' symptoms.
- He charted the suspected infected tooth as being on the right side, rather than the left where there was facial swelling.
- He failed to identify and highlight Mr Nunes' trismus (inability to open the mouth completely) and failed to note the significance of this and the facial swelling in an immune-compromised Type 1 diabetic patient.
- He failed to carry out an extra-oral examination to note the nature and extent of swelling of Mr Nunes' lymph glands in response to an infection.
- He failed to refer Mr Nunes to secondary care for an extra-oral radiograph (OPG) to help identify the cause of the dental infection as the prison x-ray machine was not working.
- He only prescribed amoxicillin but should have prescribed it in combination with metronidazole, in line with the standard antibiotic protocol. He did not record why he deviated from normal antibiotic protocol.
- He failed to ensure that Mr Nunes' facial swelling and trismus were reviewed within the week. There was a dentist in the prison on 12 February who could have referred Mr Nunes for specialist care if his symptoms had got worse.
- He failed to note why he did not refer Mr Nunes for secondary care for specialist treatment.

157. HIW concluded that the quality of dental care and treatment that the dentist provided Mr Nunes on 8 February fell significantly below the standards expected of a qualified dental surgeon.

The dental therapist

158. A dental care professional was employed as a dental therapist and provided dental treatment to patients at Parc under the supervision of a qualified dental surgeon. She did not have the authority to prescribe antibiotics as she was not included on the Patient Group Directive (PGD). She told the investigator that although she was qualified to take x-rays, she felt it was outside her scope and had never independently taken one for a prisoner at Parc.

159. The dental therapist saw Mr Nunes once on 19 February. HIW identified several significant failings in the standard of care provided by her, including that:

- If she checked previous records, she would have noted that Mr Nunes had presented as an emergency on 8 February with a swollen face and unable to open his mouth. Mr Nunes' dental symptoms had not improved for 11 days. HIW said that this should have alerted the dental therapist to the fact that Mr Nunes' dental infection had been neglected for a dangerously long period. However, she

treated Mr Nunes as a new dental emergency. HIW said that this was a significant failure in the standard of care expected of a qualified dental professional.

- She failed to carry out a thorough extra-oral examination to record the nature and extent of the swelling, the degree of trismus and any significant swelling of the lymph glands.
- There is no record that she considered an emergency referral to secondary care, and she failed to note her reasons for not referring him.
- Her dental notes fell far below the standard of record keeping expected of a qualified dental therapist.

160. HIW concluded that the dental therapist's scope of practice and level of competence meant that she should never have been expected to see or treat dental emergencies without supervision. However, on 19 February, she treated Mr Nunes alone and unsupervised. HIW concluded that she was incapable of providing Mr Nunes with appropriate emergency dental care and that the failure to refer him immediately to secondary care for specialist investigation and treatment was a major breach in her duty of care to Mr Nunes.

161. HIW also said that, given there was no emergency dental provision at weekends at Parc, and TfT failed to fully assess the risk of not having a qualified dentist present, particularly on a Monday and Friday, able to make professional decisions, diagnose and carry out the full range of dental treatment required. HIW concluded that a dental therapist who needed to work under the supervision of a dentist was therefore not an appropriately qualified staff member for the clinic.

162. HIW concluded that the dental therapist did not provide Mr Nunes with appropriate dental treatment and that his dental care immediately before his death was severely compromised. This was the result of placing inappropriately qualified dental staff on the rota before a weekend when no dental services were available for emergency care.

163. We recommend:

Health Inspectorate Wales should consider whether the dentist and the dental therapist should be referred to their professional bodies with a view to considering their fitness to practice.

164. We note that TfT provide dental services in a number of other prisons in England and Wales. We make the following recommendation:

The Chief Executives of HMPPS, NHS England and NHS Wales should write to the Ombudsman setting out what they have done to satisfy themselves that the dental services provided by Time for Teeth in prisons in England and Wales are safe and fit for purpose, including that:

- **a dedicated dental software system, which meets the professional standards set out by the General Dental Council, operates alongside SystmOne in prison dental surgeries;**

- **there is an efficient appointments system to book dental appointments promptly;**
- **dental emergencies are prioritised for urgent care;**
- **failed dental appointments are followed up and rescheduled promptly so that emergency patients are not lost in the system;**
- **patients at a higher risk of complications are flagged;**
- **regular updates on patients causing concern are recorded and acted on;**
- **prisoners have access to out-of-hours emergency dental cover equivalent to the level of safety and accessibility available in the community;**
- **prescriptions, particularly those for antibiotics for acute infections, are dispensed within hours;**
- **all surgery equipment, especially diagnostic equipment, is regularly serviced and is fit for use, as required by statutory regulations;**
- **effective processes are in place to communicate critical patient information between the dental and healthcare teams and within the dental team;**
- **prison dental staff receive specialist training to ensure competence in prison dental care; and**
- **clinical sessions set out in the contract / SLA include the presence of a dental surgeon in the dental clinic at specified times to deal with emergencies as they arise.**

Prison dental surgery inspections

165. HIW have the statutory authority to inspect all NHS and private dental surgeries in the community in Wales but have no authority to inspect prison dental surgeries, which are left to regulate themselves. HIW concluded that the dental services at Parc fell far below the standards in the community. We make the following national recommendation:

The Chief Executive of NHS Wales should ensure that prison dental surgeries in Wales are subjected to the same level of scrutiny and inspection as community dental surgeries.

Provision of general clinical care

Diabetic care

Overall conclusion

166. HIW found that clinical staff at Parc lacked experience and knowledge of acute diabetes complications and that as a result the diabetic care Mr Nunes received

was inappropriate and not equivalent to that he could have expected to receive in the community. HIW concluded that this had a detrimental effect on Mr Nunes' health and that the actions of healthcare staff at Parc fell below the standards expected by the General Medical Council (GMC) and Nursing and Midwifery Council (NMC).

167. We have examined the specific concerns in more detail below.

Insulin regimes

168. HIW noted that when Mr Nunes was in hospital at the end of August 2015, his insulin regime was changed, and hospital staff told healthcare staff at Parc that he should be supervised when he administered his new insulin regime. Parc misinterpreted this and removed Mr Nunes' insulin from his possession so that he had to attend the medication hatch to receive it. He then administered his insulin himself in an adjacent corridor.

169. HIW said that this would have made it impossible for healthcare staff to observe Mr Nunes' injecting technique or the quantity of insulin he was injecting, and this defeated the purpose of removing the insulin from his possession. HIW noted that Mr Nunes had areas of lipohypertrophy (fatty lumps under the skin caused by repeatedly injecting insulin into the same site) which healthcare staff had not recognised. This condition is a common cause of poor blood sugar control because insulin injected into these lumps does not work properly. If healthcare staff had observed Mr Nunes more closely when he administered his insulin, they could have prevented him from injecting in these areas and monitored the levels of insulin he used.

170. HIW noted that Mr Nunes signed over fifteen medical disclaimer forms when he refused to have his blood sugars tested before his insulin injections. HIW said that a blood sugar test should not be required before every insulin injection and concluded that Parc's policy of requiring Mr Nunes to sign medical disclaimers appeared to be more about healthcare staff's concerns about their legal risk than about providing him with appropriate care.

171. HIW also noted that between 20 August 2015 and 6 January 2016, when Mr Nunes did not keep and administer his insulin, there were numerous occasions when healthcare staff omitted to administer his insulin, something that should only happen in exceptional circumstances. HIW noted that during this period, Mr Nunes was admitted to hospital on seven occasions and for the first three weeks of November, he missed nearly a quarter of his doses of insulin.

172. HIW identified several occasions when healthcare staff did not respond appropriately when Mr Nunes missed an insulin dose. For example:

- On 2 September 2015, Mr Nunes told a nurse that he was annoyed that he had not been given his evening dose of insulin. The nurse did not record why Mr Nunes' insulin had been omitted and did not check his ketone levels, even though his blood sugar levels were high, although she did seek advice from the offsite on-call prison GP. HIW said that the use of rapid-acting insulin may have been clinically appropriate at this point. However, the GP advised no action and HIW said that this was a clinically inappropriate decision which would have

caused Mr Nunes' blood sugar levels to rise further, causing him to become dehydrated and unwell. HIW concluded that this decision, which demonstrated a lack of knowledge about the management of diabetes, might have been a precursor to the development of DKA.

- On 17 November Mr Nunes was not given his insulin as his prescription chart had run out. HIW said that that the impact of missing a dose of insulin would have led to hyperglycaemia, which might have led to Mr Nunes' admission to hospital four days later. HIW said that this could have been avoided if his insulin had been administered correctly.

- On 22 November, the diabetic lead nurse noted that Mr Nunes was vomiting, his blood sugar and ketone levels were very high and that he was very tearful and blamed the nurse for his condition as she had not given him his insulin earlier that day. HIW found that the omission of Mr Nunes' insulin was clinically negligent, and that the subsequent failure to monitor his blood sugar demonstrated a further lack of care.

- In the early hours of 27 November 2015, Mr Nunes was distressed and told a nurse that his ketones were raised, and he felt nauseous. The nurse told Mr Nunes she would try to get him reviewed later that day. HIW concluded that this was clinically negligent and that the nurse should have contacted the duty on-call GP immediately to discuss an action plan and possible hospital admission. HIW concluded that the nurse's lack of action had a detrimental impact on Mr Nunes' health and caused a delay in him receiving the correct treatment.

- At 8.30am on 2 December, healthcare staff became aware that Mr Nunes was feeling unwell. At 11.00am the prison GP told a nurse to give Mr Nunes a dose of anti-sickness medication, to check if he was positive for ketones and that if he was ketoic he might need hospitalisation. HIW noted that Mr Nunes' ketone levels were not checked until 7.30pm, over eight hours later, and said that this was an inordinate delay in assessing vital aspects of Mr Nunes' physical condition. HIW said that Mr Nunes' clinical signs indicated that he required hourly monitoring and that the delay in assessment allowed his condition to deteriorate further, once again needing hospital admission.

173. HIW also said that it was important that Mr Nunes' insulin was administered immediately before or after eating a meal, but that he was unable to do this because of the discrepancy between the times the medication hatch was open and the times that prison meals were served. HIW found that this restricted Mr Nunes' ability to use his insulin correctly.

174. HIW concluded that the accumulation of these actions led to a critical and acute deterioration in Mr Nunes' health. HIW also concluded that the lack of urgency by clinical staff in arranging the necessary monitoring and provision of insulin was the result of inexperience and lack of knowledge about acute diabetes complications.

175. HIW made a number of recommendations which the Director and Head of Healthcare will need to address, including the following issues:

Blood strip testing

176. HIW noted that on numerous occasions during his time at Parc, Mr Nunes had difficulty accessing blood sugar and ketone level testing strips and access to a working blood sugar testing meter.

177. HIW concluded that healthcare staff should have regularly checked that Mr Nunes' blood sugar testing meter was working properly, and that he could access the blood sugar level testing strips that he needed. Healthcare staff appeared unaware that Mr Nunes had not ordered supplies of test strips, and this showed a lack of supervision and poor support, especially when he had extreme sugar levels. HIW concluded that this was a failing in Parc's duty of care to Mr Nunes.

178. We recommend:

The Head of Healthcare at Parc should ensure that the prison pharmacist:

- **regularly reviews the medication needs of prisoners who use insulin and that insulin prescriptions are ordered promptly; and**
- **ensures there are adequate supplies of lancets and blood testing strips for all prisoners who use insulin.**

Gastroparesis

179. Mr Nunes first presented to staff with gastrointestinal symptoms in June 2015 and there were subsequently numerous entries in his clinical record about chronic episodes of vomiting, abdominal pain and other symptoms of diabetic gastroparesis. Prisoners who knew Mr Nunes also gave evidence of these symptoms in statements submitted after his death.

180. HIW noted that healthcare staff tried to manage Mr Nunes' symptoms with intermittent use of anti-sickness injections and oral medication. HIW said that when Mr Nunes had gastrointestinal symptoms, he was unable to eat and consequently his insulin requirements would have changed and his glycaemic control would have deteriorated, which would have contributed to his episodes of DKA.

181. HIW considered that healthcare staff at Parc failed to recognise and investigate Mr Nunes' gastrointestinal-related symptoms and did not request that diabetes specialists visited him in prison, ask for advice on treatment or transfer him to a prison with facilities better able to manage this complex condition.

182. HIW said that diabetic gastroparesis (a condition in which the stomach cannot empty itself of food, causing nausea, vomiting and weight loss) is usually identified, diagnosed and managed within secondary care settings and that it would not be expected that it could be diagnosed in a primary care setting. Secondary care experts would have been able to recommend appropriate therapies and strategies that would have minimalised the unpleasant symptoms.

183. HIW said that healthcare staff should have been able to recognise that their attempts to resolve Mr Nunes' symptoms of gastroparesis were not successful, but instead they continued to manage his gastric problems ineffectively without

specialist guidance. The NICE guidelines for the management of diabetic gastroparesis were not followed: there was no systematic approach to managing his symptoms, clinical reviews were not held in a timely manner and interventions were not reviewed. HIW considered that Parc's inadequate management of Mr Nunes' gastroparesis was not equivalent to the treatment which he could have expected to receive in the community. The clinical review said this was a significant contributor to Mr Nunes' repeated admissions to hospital and impacted adversely on his health.

184. The Head of Healthcare at Parc will need to address this issue.

Clinical assessments and record keeping

185. HIW found that from Mr Nunes' first contact with healthcare services at Parc and on numerous subsequent occasions, healthcare staff failed to assess, observe and examine him adequately, using tools such as NEWS and sepsis screening, and frequently failed to monitor his blood sugar and ketone levels during periods of illness.

186. HIW also found that healthcare staff's clinical note-taking was too brief and fell below the expected standards form the GMC and NMC.

Mr Nunes' poor diabetic health literacy

187. HIW found that Mr Nunes' had poor diabetic health self-management skills and concluded that healthcare staff put an inappropriate onus on him to care for himself.

188. HIW noted that when Mr Nunes was admitted to hospital at the end of August 2015, his diabetes treatment changed to a more complex basal-bolus regime. HIW said that the few days Mr Nunes spent in hospital would not have been sufficient to complete an in-depth education programme about the new insulin regime and that in the community, this change would have been followed by a structured education programme. This was not offered to Mr Nunes.

189. On 17 November, Mr Nunes experienced the first of two hypoglycaemic events during his time at Parc, which confirmed his poor awareness of hypoglycaemia, as set out in his hospital records. HIW concluded that prison healthcare staff treated this first episode of hypoglycaemia inadequately, and also failed to recognise Mr Nunes' ignorance about the condition or to put a plan in place to address this problem.

190. HIW also noted that in early December, when healthcare staff asked if he had taken his insulin, Mr Nunes said he had not because he had not eaten anything. HIW found that this was another example of Mr Nunes' poor health literacy as he believed inaccurately that if he had not eaten, he should not take his insulin. HIW found that Mr Nunes' inappropriate action was not deliberate but was the result of his poor understanding of self-care management strategies. HIW concluded that Mr Nunes' erroneous self-care was a major, inadvertent cause of his repeated episodes of DKA. The healthcare team should have identified and addressed this. HIW concluded that while Mr Nunes was at Parc healthcare staff should have referred him for specialist diabetic reviews.

191. HIW also noted that in January 2016, Mr Nunes signed an agreement that he would be responsible for controlling his diabetes by self-administering his insulin based on his blood sugar levels. HIW concluded that it was irresponsible of healthcare staff to expect Mr Nunes, who had diabetic gastroparesis, diabetes distress and burn out, lipohypertrophy, hypoglycaemic unawareness, recurrent episodes of DKA and poor health literacy to manage his complex diabetic condition without adequate clinical support.

192. Healthcare staff made numerous entries in Mr Nunes' medical notes saying that he did not respond to advice on managing his condition. HIW said that it is standard practice for a patient with compliance problems to be referred to secondary care for specialist opinion and management, and that it was a failing and lack of care by healthcare staff at Parc not to make repeated efforts to engage with secondary care. HIW considered that Mr Nunes' should have had face-to-face reviews with diabetes specialists which would have allowed him to develop a therapeutic relationship with healthcare professionals who were able to relate to his complex needs and advocate for him.

193. We are concerned that because healthcare staff did not have a good understanding of Mr Nunes' complex diabetic condition, they failed to recognise how ill Mr Nunes was and mistakenly blamed him for his repeated hospital admissions. Prison staff, not surprisingly, took their lead from healthcare staff.

194. We recommend:

The Director and the Head of Healthcare at Parc should:

- **liaise with the local Health Board to ensure that newly arrived insulin-dependent diabetic prisoners are assessed on their understanding of diabetes management and self-care so that appropriate care is provided in line with prisoners' needs; and**
- **commission an outreach service from the community diabetes team to ensure that nursing staff are adequately trained and know when to seek advice from secondary services.**

Mental health

195. Mr Nunes had been prescribed antidepressants during previous periods of custody and it was first noted that he may have mental health issues at Parc in June 2015. Over the following months, numerous entries about Mr Nunes' behaviour and attitude towards his diabetes management were made in his medical records. HIW considered that these behaviours and attitudes were clinical examples of diabetes distress and burnout, and that healthcare staff misinterpreted them as poor compliance and self-neglect.

196. HIW also noted that hypoglycaemia is known to cause unusual behaviour in some people, including tearfulness and unprovoked hostility and aggression.

197. HIW concluded that although diabetes burnout and hypoglycaemia may have been beyond the expertise of the primary and mental healthcare teams at Parc, they should have recognised that he had significant psychological problems.

198. HIW noted that although Mr Nunes was referred to the mental health team on 10 August, there is no evidence that this was actioned and there was no review scheduled to ensure that he was assessed until a brief mental health assessment on 29 December.

199. HIW noted that on 1 December, the prison GP diagnosed Mr Nunes with disabling anxiety and prescribed an antidepressant at twice the normal starting dose. Although the GP planned to see Mr Nunes weekly in the GP clinic, there is no evidence that this was ever arranged and therefore a medication review never took place to assess its impact. Mr Nunes stopped taking the medication for unexplained reasons. HIW concluded that starting Mr Nunes on too high a dose may have contributed to his discontinuation of the antidepressant.

200. HIW noted that the GP's entry of 1 December described a patient with complex health and psychological needs who required specialist treatment, but this was not arranged.

201. HIW concluded that Mr Nunes' mental health problems remained unresolved and inadequately managed. The reviewer considered that this contributed significantly to his poor diabetes control and recurrent hospital admissions, and that if these problems had been addressed earlier, it may have prevented his death.

202. HIW also noted that Mr Nunes failed to keep appointments with the prison GP. Healthcare staff did not identify this as a concern and did not take action to follow up why he did not attend. HIW considered that Mr Nunes' failure to attend GP appointments was another sign of his diabetes distress which went unnoticed.

203. HIW noted that HMIP's 2016 report noted that primary mental health services, which supported prisoners with mild to moderate mental health needs, were too limited and there was no clear care pathway. HMIP noted that nurses mainly completed primary care activities and had insufficient time to complete assessments promptly and manage their caseloads effectively. HMIP were also concerned that despite a high demand for mental health support, primary mental health provision was inadequate.

204. HIW concluded that healthcare staff failed to assess Mr Nunes' clinical condition effectively and to identify his diabetes distress and other psychological problems correctly. This prevented him from accessing the specialist support services he needed. HIW considered that the care Mr Nunes received was sub-standard, failed to deliver many of the standards set out in the Standards for Prison Mental Health Services – Quality Network for Prisons Mental Health Services, published in June 2015, and was not equivalent to treatment he could have expected to receive in the community.

Transfer to a prison with 24-hour inpatient facility

205. During his time at Parc, Mr Nunes was admitted to hospital on 16 occasions for DKA or symptomatic hyperglycaemia with ketosis or dehydration. Of the 266 days that Mr Nunes was detained at Parc, he was in hospital for 46 of them and on eight occasions, he was re-admitted to hospital within a week of being discharged. Nine of Mr Nunes' admissions to hospital ended in him discharging himself against medical advice.

206. HIW said that this number and type of admissions in less than nine months was extraordinary and would be highly unusual even in specialist care settings. HIW considered that after Mr Nunes' second admission to hospital, a multidisciplinary healthcare team should have reviewed and created plans to address his healthcare needs. If, after the introduction of measures to prevent his further hospital admission, Mr Nunes was re-admitted to hospital, the multidisciplinary team should have concluded that it was unsafe for him to remain at Parc.

207. HIW considered that Mr Nunes should have been transferred to a prison with a 24-hour inpatient facility as Parc could not offer the clinical care and observation required to meet his complex healthcare needs. (HIW noted that the prison GP said he did not know that it was possible to transfer Mr Nunes.) HIW concluded that the failure to address Mr Nunes' repeated admissions to hospital meant that Parc was an unsafe environment for him, and that healthcare staff grossly breached their duty of care to Mr Nunes.

Nurse competency

208. Healthcare provision at Parc is a nurse-led service with nurses acting autonomously and with the GP service being advisory. Nurses refer and book prisoners for GP appointments.

209. HIW noted that over 50% of nurses at Parc were either registered mental health nurses or learning disability nurses. This meant that many nurses dealing with Mr Nunes' diabetes were undertaking the role of a registered general nurse and were working outside of their clinical competence as their training would not have equipped them with the knowledge and skills to deal with Mr Nunes' complex physical needs.

210. A nurse who failed to recognise the importance of Mr Nunes' clinical symptoms on 20 February was a learning disability nurse. HIW considered that this exemplified the poor general care that Mr Nunes received and the way in which inexperienced staff who lacked expertise in diabetes management made inappropriate clinical decisions.

211. Overall, HIW concluded that healthcare staff did not meet the standards of the professional regulators in Mr Nunes' routine and emergency clinical care. HIW considered that this was due to several factors: staff were working outside of their competence, the nursing skill-mix was inappropriate, there was a lack of knowledge about basic diabetes care, documentation was sub-standard, communication between professionals was poor, and there was a failure to administer antibiotics and insulin in a timely manner. Contributory factors included staff shortages and the absence of specialist services.

Assessments on return to prison from hospital

212. HIW noted that the failure to ensure that Mr Nunes was seen by a nurse in reception when he returned from hospital on 20 February was not a solitary episode. There were two previous occasions when this had happened. In addition, HIW found that whenever Mr Nunes returned to prison from hospital, healthcare staff took no clinical observations and did not record his blood sugar and ketone

levels. HIW also noted that on the nine occasions that Mr Nunes discharged himself from hospital, there was only one occasion when the reception nurse discussed him with a prison GP.

213. HIW said this did not meet NMC standards and concluded that these failings resulted in Parc providing an unsafe environment for Mr Nunes were a breach in duty of care. HIW said it appeared that healthcare staff viewed prisoners arriving back at the prison as an inconvenience which distracted from their other duties and that it was a task to complete as quickly as possible.

214. HIW also noted that on the many occasions Mr Nunes was discharged or discharged himself, there was only one occasion when healthcare staff received a hospital discharge summary for Mr Nunes when he returned. When a discharge summary was obtained, there was no evidence that a clinician saw it, took any clinical action or reviewed Mr Nunes.

215. At inquest, the Head of Healthcare said that not receiving discharge letters had been an historic issue with the POW Hospital which had improved. Despite this, we make the following recommendation:

216. We were told that it is now Parc's policy for every prisoner to see a member of healthcare staff when they return from hospital, and they have introduced a system to record how long it takes for a prisoner to see a nurse. Nevertheless, we recommend:

The Director and the Head of Healthcare at Parc should ensure that all prisoners are assessed by the healthcare team on their return from hospital.

The Director and the Head of Healthcare at Parc should ensure that hospital discharge summaries for prisoners are received in a timely manner and, if this does not happen, that requests are followed up promptly.

CVOP meetings

217. HIW said that, in the absence of any formal prison healthcare multidisciplinary team meetings or a senior clinician taking responsibility for Mr Nunes' care, the CVOP meetings would have been the only opportunity for clinical staff to formulate a comprehensive care plan for Mr Nunes. However, the CVOP meetings were simply an informal gathering of clinicians to share information and discuss difficult clinical cases on an ad hoc basis. HIW found there was no structure to the meetings, that care plans were not discussed, evaluated or monitored, that no formal, significant event analysis took place and that full and accurate minutes were not taken. The lead diabetes nurse did not attend many of these CVOP meetings and so was unable to provide continuity of care and expertise. As a result, Mr Nunes' care needs were never identified.

218. HIW noted, for example, that Mr Nunes' refusal to have his blood sugars tested was discussed at the CVOP on 21 September and it was agreed that a joint appointment should be made for Mr Nunes to see the GP and lead diabetes nurse. However, an appointment was not arranged for a further five weeks. HIW said that this was alarming and showed a lack of care when it was obvious that Mr Nunes was

experiencing extreme difficulties and had had seven hospital admissions. HIW considered that this would have adversely affected Mr Nunes' care.

219. HIW concluded that the CVOP meetings were inadequate and unable to fulfil a role as a co-ordinating and planning meeting, that they failed to provide support for prisoners at heightened risk and were irrelevant to Mr Nunes' care.

220. We make the following recommendation:

The Head of Healthcare at Parc should ensure that CVOP meetings are clinically multidisciplinary, that effective care plans are created and implemented, and that the meetings are accurately minuted.

Support Living Plans

221. The SLP is a process which allows the sharing of medical information with prison officers and is not a strategic care planning document.

222. An SLP was opened for Mr Nunes on 9 December, without his consent. Healthcare staff had considered opening an SLP on two previous occasions, but Mr Nunes had refused to agree. We consider that a SLP could usefully have been opened earlier without his consent.

223. However, when the SLP opened it was of a poor standard. The immediate action plan was poorly completed, issues appeared to have been confused with actions and actions noted were not subsequently recorded as having taken place. Few entries were made in the events summary, which was intended to update officers on Mr Nunes' wing and no entries were made at all between 11 and 22 December. The process was not multidisciplinary and did not involve officers on the wing. The review scheduled for 16 December did not take place, and there was no review between 22 December and 2 February and then the next view was planned for April. The SLP was not updated when Mr Nunes returned from hospital admissions, including on his return from hospital on 20 February.

224. We consider that the SLP did little to add to the delivery of Mr Nunes' care and was probably a distraction, being seen as another process to be followed. It developed into a tick box exercise which had little or no impact on the care delivered to Mr Nunes by healthcare or operational staff. We recognise that Mr Nunes was also being monitored under ACCT procedures for much of this time and that staff may have thought ACCT took precedence or offered more support. However, if staff considered that this was the case, they should have formally closed the SLP and recorded the reasons for doing so.

225. Mr Nunes was monitored under ACCT, CVOP, SLP and complex case meetings. We note that the SLP and complex case reviews appear to have fallen by the wayside despite Mr Nunes' ongoing issues, including non-compliance with testing regimes and taking his medication. The level of monitoring under different schemes is likely to have taken the focus of any one plan away from the other.

226. We recommend:

The Director and the Head of Healthcare at Parc should ensure that SLPs are properly completed and shared with operational staff and are taken into account when providing care to prisoners.

Patient group directives

227. HIW found that there was an unacceptable delay in Mr Nunes accessing his antibiotics on 18 February as nurses were unable to dispense the antibiotics from the Patient Group Directive (PGD) cupboard. The PGD in place at Parc at the time had been lost and there was no PGD in place during this investigation. In these circumstances HIW could not be satisfied that the PGD had complied with the terms of the relevant Welsh Health Circular or that nurses had been acting with legal authority when they dispensed antibiotics.

228. HIW was concerned that it appeared the purpose of the PGD in place at the time of Mr Nunes' death was to reduce the service costs in having to contact the out-of-hours on-call GP. This was an inappropriate use of PGDs. HIW made the following recommendation which will need to be addressed:

The Chief Executive of NHS Wales should investigate whether Parc followed the PGD regulations and whether the use of verbal instructions by GPs for nurses to dispense prescription-only medicines from the out-of-hours medication cupboard complies with regulations.

Events of February 2016

229. Mr Nunes was taken to hospital in the early hours of 20 February. He discharged himself against medical advice, although a hospital doctor told him that he was seriously ill and at risk of dying. When he returned to Parc at around 7.15am, he was not seen by a nurse as he should have been. This meant that the escort officers were not able to pass on critical care information to prison healthcare staff, he was not given antibiotics or insulin and healthcare staff did not see him for a further 28 hours until he was found unresponsive in his cell the next day.

230. The prison officers who escorted Mr Nunes to Parc said that it was the responsibility of reception staff to contact the healthcare team and ask for a nurse to assess a prisoner. However, the reception officer said the responsibility lay with escort staff. We are concerned that the process was unclear. However, the escort officers had heard what the hospital doctor had said to Mr Nunes before he discharged himself and, irrespective of whose responsibility it was, we consider that they should have ensured that Mr Nunes was seen by a nurse.

231. HIW concluded that healthcare staff's failure to assess Mr Nunes when he returned from hospital significantly contributed to the events that led to his death and was a gross breach in duty of care. HIW said that if Mr Nunes had been given antibiotics and insulin, this might have managed his infection and prevented the development of severe DKA.

232. The nurse on duty that day said she was never asked to assess Mr Nunes in reception. When asked why no healthcare staff went to see Mr Nunes on the wing, as he had not been seen in reception and had missed appointments with healthcare

staff that day, the nurse told the inquest that the healthcare team was short-staffed, Mr Nunes was known not to attend appointments and that prisoners could not be forced to attend appointments.

233. HIW was concerned that healthcare staff rearranged the GP review scheduled for 20 February to the following day. HIW considered that deferring the review was negligent as it would have been a critical opportunity to review the progress of Mr Nunes' infection and whether it risked developing into sepsis, with infection-related DKA.

234. HIW was also critical of the pejorative language used by the nurses on 20 February - that Mr Nunes was "unwilling to get out of bed" and "he could not be bothered again to come over" - and said that this was no excuse for failing to discharge their clinical responsibilities.

235. HIW also reported that entries in the medical records made by nursing staff on 20 February were confusing as they had been written retrospectively and contained multiple encounters. HIW said that as a result, the accounts given by nursing staff at interview were unclear as they could not recollect events.

236. HIW said that when Mr Nunes was locked in his cell at around 5.45pm on 20 February, healthcare staff should have supervised him closely, including carrying out hourly observations and recording his vital signs, oral input, urinary output and blood sugar and ketone levels, and supervising his insulin injections and antibiotic treatment.

237. Instead, he was left alone and was not clinically monitored for a further 15 hours. HIW considered that it was predictable that his health would continue to deteriorate in these circumstances, and concluded that, at some point during the night, Mr Nunes succumbed to DKA and sepsis and became incapacitated and too ill to call for assistance. HIW said that at this point that Mr Nunes' condition was no longer retrievable and his death was inevitable.

238. We make the following recommendation:

The HM Prison and Probation Service (HMPPS) Executive Director for Wales and the Chief Executive of NHS Wales should write to the Ombudsman setting out what they have done to satisfy themselves that the nurse-led healthcare service provided at Parc by G4S Medical Services is safe and fit for purpose, including that:

- **there is an appropriate staff mix so that registered general nurses lead the care and those with specialist expertise, such as mental health nurses, support them within their competence;**
- **staff make accurate and timely records in line with GMC and NMC standards;**
- **prisoners with complex care needs are promptly considered for transfer to a prison with a 24-hour inpatient facility;**
- **a senior clinician is responsible for leading and coordinating the care for prisoners with complex conditions;**

- **effective care plans are created and implemented; and**
- **therapeutic psychological services are available.**

Non-clinical issues

Illicit drug use

239. Although Mr Nunes frequently denied drug use when healthcare staff asked him about it, post-mortem toxicology tests found that Mr Nunes had used psychoactive substances (PS) before his death.

240. In December, Mr Nunes' mother told staff that his cellmate might be giving him drugs and that she thought Mr Nunes might have been under the influence of drugs when she spoke to him. Staff also suspected that Mr Nunes may have been deliberately engineering hospital admissions to collect contraband items such as drugs. There is no evidence that this was the case, and we note that the HIW considers that Mr Nunes' frequent hospital admissions were the result of poor clinical care and Mr Nunes' own lack of understanding of how to manage his condition.

241. However, HIW said that the use of PS may have had an adverse impact on Mr Nunes' behaviour and diabetes management and considered that healthcare staff should have been more proactive in raising drug awareness and the dangers of drug use with Mr Nunes and that attempts should have been made to identify or exclude drug misuse as a possible contributor to his poor compliance and disengagement with his complex diabetes management.

242. We make the following recommendation:

The Director at Parc should ensure that prisoners with substance misuse issues are supported and that efforts to tackle the availability of illicit substances are prioritised.

Family involvement

243. Prison Service Instruction (PSI) 64/2011 on safer custody says that if a prisoner is refusing treatment, it is important to involve his family, if the prisoner consents.

244. Mr Nunes' mother had played a significant role in the care and management of Mr Nunes' diabetes since his childhood. She managed his medications and encouraged him to manage his blood sugar levels. She said she did not think her son fully understood the details of his new diabetic regime. She also told the inquest that she had previously been able to persuade him to stay in hospital many times when he wanted to discharge himself.

245. Although Mr Nunes' mother attended a meeting on 9 December, at which staff agreed to keep her informed and involved, there is no evidence that this happened and, although a further multidisciplinary review took place, she was not invited to it.

246. HIW considered that, although Mr Nunes' diabetes was very complex, his mother could have significantly contributed to his care if healthcare staff had involved her more. Her input should have been sought earlier when the healthcare team had difficulties in managing her son's diabetes. Failure to do so was detrimental to his overall diabetes care.

247. In addition, HIW noted that the agreement that Mr Nunes' mother would be contacted if he was admitted to hospital was not recorded in Mr Nunes' clinical record or in the notes of ACCT reviews. This meant that clinical staff were not aware of the arrangement.

248. When Mr Nunes was admitted to hospital on 20 February, with infection and at risk of DKA, Mr Nunes' mother was not told. The Head of Healthcare told the inquest that this was because the agreement did not include admissions to A&E. We are not persuaded by this argument. All of Mr Nunes admissions to hospital were serious. DKA is a life-threatening condition and his mother, as his next of kin, should have been told of his admission on each occasion. HIW concluded that if healthcare staff had contacted Mr Nunes' mother when he was taken to hospital on 20 February, she may have been able to persuade him to stay in hospital and the outcome may have been different for Mr Nunes.

249. We are also concerned that when Mr Nunes was found unresponsive in his cell on 21 February, his mother was not informed by the prison until about three hours after he had been taken to hospital.

250. We make the following recommendation:

The Director at Parc should:

- **involve the prisoner's next of kin in their care where appropriate, in line with PSI 64/2011; and**
- **ensure that the next of kin are promptly informed when a seriously ill prisoner is taken to hospital.**

Suicide and self-harm monitoring

251. Although Mr Nunes did not have a history of attempted suicide or of self-harm, staff monitored him twice under ACCT procedures – 26 November to 2 December and 11 to 22 December - due to his refusal to accept diabetes treatment, his poor self-management of his condition and his refusal to share a cell with another prisoner (who could have alerted staff if Mr Nunes became ill). Staff at Parc interpreted his actions as intentional self-neglect amounting to self-harm.

252. We recognise that PSI 64/2011 includes self-neglect as a risk that may be appropriately managed under ACCT procedures in some circumstances. However, Mr Nunes had no history of self-harm or attempted suicide and HIW considers that Mr Nunes' poor compliance with his diabetes regime was due to diabetes burn out and his poor understanding of his condition, rather than being intentional self-harm. In these circumstances, we share HIW's view that ACCT procedures were not designed to address Mr Nunes' specific diabetes-related difficulties.

253. We agree with HIW that a comprehensive healthcare plan, including an early SLP or CVOP, would have been more appropriate and effective in addressing Mr Nunes 'poor diabetic self-management and refusal to take medication, and we share HIW's concern that there was an inordinate delay in arranging any form of multidisciplinary care planning in the five months before ACCT procedures were first started.

254. HIW concluded that ACCT monitoring was no substitute for adequate clinical care planning and clinical leadership, including effective SLPs and CVOPs.

255. However, once an ACCT had been opened, it was important to manage it effectively and only close it when Mr Nunes' risk had reduced. We are concerned that that only junior nurses were present at Mr Nunes' ACCT reviews, and they could not provide expertise about Mr Nunes' healthcare needs. We are also concerned that Mr Nunes' mother was not involved and that, for the most part, staff failed to set and record clear and effective actions in Mr Nunes' caremaps, which might have helped reduce his risk by encouraging compliance with his diabetic regime and improving his interactions with staff, including healthcare staff. We consider that that both ACCTs were closed prematurely before the caremap actions had been completed and before the risks posed by Mr Nunes' failure to comply with his diabetic regime had been addressed or resolved.

256. We note that HIW considered that the failure to open an ACCT on 20 February was a gross breach in Parc's duty of care. We agree that the opening of an ACCT would almost certainly have led to the involvement of the healthcare team, increased clinical monitoring and appropriate medical interventions, including regular checks. Monitoring under ACCT would also most likely have resulted in the consideration of his location in the prison, including whether he should be moved to the safer custody unit, share a cell, or have a cell with CCTV. All of this would have increased Mr Nunes' chances of survival. However, we do not make a recommendation about this as we consider that effective healthcare monitoring would have better addressed Mr Nunes 'healthcare needs.

257. We make the following recommendation:

The Director at Parc should ensure that staff manage prisoners at risk of suicide and self-harm in line with national policy, in particular staff should:

- **assess risk based on all relevant information, including that held in medical records;**
- **mark caremap actions as completed only once they have been actioned fully; and**
- **ensure that caremap actions are created and reviewed in line with national guidance and are specific, meaningful and time-bound, aimed at reducing prisoners' risks; and**
- **obtain appropriate clinical input where appropriate before deciding to stop ACCT procedures.**

Roll checks

258. A roll check is primarily a security check to count prisoners to ensure that they are present in their cells, but it is also an opportunity for any immediate concerns about prisoners' safety to be identified and addressed.

259. G4S's Operational Policy Standard and Procedures 2.107 on roll counts, issued in October 2003, says,

> "Staff checking prisoners and young people in a cell or room must ensure a verbal response, or some movement. This is necessary to ensure the prisoner / young person is alive and well… If a prisoner or young person appears to be asleep and you are concerned then you should wake him in order to check."

260. Parc's Local Instruction 5.32 on Routine Roll Checks, issued in January 2012 and revised in September 2017, says that a roll check must be completed at 7.00am and that:

> "Every cell door will be opened, and a physical check of the prisoners conducted to ensue all prisoners are in the correct cell and that there are no health or safety issues, with the exception of routine roll counts conducted by night staff."

Local Instruction 5.32 was revised again in January 2019 and now says:

> "Every cell door will be opened, and a physical check of the prisoners conducted to ensure all prisoners are in the correct cell and that there are no health or safety issues, with the exception of routine roll counts conducted by night staff *and roll counts on patrol state*." [Change in italics.]

261. Officer A checked Mr Nunes at 7.09am and raised no concerns about Mr Nunes. The officer told the inquest he was not required to open the cell door to carry out a roll count but to check that Mr Nunes was in his cell.

262. We do not think it is reasonable to expect staff to wake prisoners during the night and early morning to check on their wellbeing, and we accept that during a prison's patrol / night state officers are not expected to open cell doors for security reasons. However, according to OPS 2.107, Officer A was required to get a response from Mr Nunes or see him move.

263. Although we accept that Officer A was not required to open Mr Nunes' cell door or check on his welfare and we make no criticism about this, Parc's local guidance is confusing and contradicts the requirements of OPS 2.107. We make the following recommendation:

The Director at Parc should ensure that Parc's instructions to staff about roll checks are consistent.

Unlock

264. At morning unlock, officers should take active steps to check on a prisoner's wellbeing. PSI 75/2011 on residential services says:

> "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...
>
> "[Differing] arrangements will depend on the local regime, but there need 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 well-being, for example by obtaining a response during the unlock process."

265. Parc were unable to give us a copy of the Director's Instruction to staff on unlocking prisoners which was in place at the time of Mr Nunes' death. However, we were provided with Parc's Director's Order 5.290, issued in January 2017, which 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."

266. Officer B unlocked Mr Nunes at 8.40am but did not look into the cell or complete a welfare check on Mr Nunes as he should have done in line with national policy. Officer A found Mr Nunes unresponsive in his cell 25 minutes after another officer had unlocked him. Although it is unlikely that the delay of 25 minutes made any difference to the outcome for Mr Nunes, such a delay may be critical in other medical emergencies. We make the following recommendation:

The Director at Parc should ensure that when a cell door is unlocked, staff satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.

Delay in calling an ambulance

267. PSI 03/2013 on medical emergency response codes requires staff to radio a code blue when a prisoner is found unresponsive or with breathing difficulties. This should trigger the control room to call an ambulance immediately. The PSI is clear that control room staff should not check with managers, healthcare staff or others at the scene before calling an ambulance but should be alert to updates and keep the ambulance service informed.

268. Although Officer A called a code blue at around 9.04am, the control room did not call an ambulance until around 9.14am. Although the 10 minute delay in this instance is unlikely to have affected the outcome for Mr Nunes, in other emergencies, any delay could be critical. We make the following recommendation:

The Director at Parc should ensure that control room staff call an ambulance immediately they receive a medical emergency code.

Learning lessons

269. The events set out in this report happened in 2016 and some of the staff involved in Mr Nunes' care will have moved on. Nevertheless, we consider it important that those who are still working in prisons in England and Wales should have the opportunity to reflect on what could have been done differently and the lessons to be learned. We therefore recommend that:

The Head of Healthcare at Parc should share this report with Nurses A, B and C and discuss the ombudsman's findings with them.

The Director should share this report with CM A and Officers A, B and C and arrange for a senior manager to discuss the Ombudsman's findings with them.

ANNEX 1

Key events

Background

1. Mr Aaron Nunes was diagnosed with Type 1 diabetes as a child. He learned to administer his own insulin injections and his mother supported him in managing his diabetes by monitoring his blood sugar levels and administering his insulin, even into adulthood.

2. Mr Nunes had served several sentences in young offender institutions and prison. On **17 May 2013**, he was sentenced to three years and three months for affray and the possession of drugs with intent to supply. He was released on **1 October 2014**. On **14 January 2015**, he was recalled to prison on suspicion of the possession of drugs with intent to supply. He was sent to HMP Cardiff. On **21 May**, Mr Nunes was sentenced to a further year in prison.

3. Mr Nunes occasionally refused to have his blood sugar levels checked and healthcare staff warned him of the dangers of administering insulin without knowing what those risks were. Before June 2015, Mr Nunes' management of his diabetes was variable, and he needed hospital treatment on several occasions.

HMP Parc

June and 2015: five admissions to hospital

4. On **1 June**, Mr Nunes transferred to HMP Parc, where he had previously served a sentence in 2013. At an initial health screen, he told an officer that he had no history of or thoughts of suicide or self-harm. A healthcare assistant noted Mr Nunes' diagnosis of Type 1 diabetes, for which he had been prescribed a NovoMix 30 insulin pen. (NovoMix 30 is a mixture of rapid- and longer-acting insulin that should preferably be taken before meals.) She identified no mental health issues.

5. On **2 June**, Mr Nunes failed to attend an appointment with a prison GP. The appointment was not rescheduled.

6. On **5 June**, Mr Nunes told healthcare staff that he had not been given an insulin pen. A mental health nurse liaised with the prison pharmacy, who said he should receive one. That day, a mental health nurse assessed Mr Nunes' mental health but did not identify any issues.

7. On **15 June**, Mr Nunes told a nurse that he was feeling unwell and had diarrhoea, nausea and vomiting but that his blood sugars were normal, and his ketones were negative. There is no evidence that the nurse took any action to check Mr Nunes' condition. For example, she did not record his blood sugar and ketone levels or note his observations using the National Early Warning Score (NEWS) tool which assesses clinical deterioration. She made an appointment for him to see a prison GP the next day.

8. On the morning of **16 June**, Mr Nunes told a prison GP that he had been vomiting and had had diarrhoea for several days. He said that he "felt terrible" and was worried. The GP gave Mr Nunes cyclizine, an anti-sickness drug, and planned to review him when his blood sugar and urine ketone levels were available. Later that morning, the GP noted that Mr Nunes was deteriorating, that his blood sugar levels had risen and that his ketone levels were high.

9. The prison GP diagnosed Mr Nunes with diabetic ketoacidosis (DKA), and he was admitted to the Princess of Wales (POW) Hospital for treatment. Several hours later, Mr Nunes discharged himself from hospital against medical advice. There is no evidence that prison healthcare staff assessed him, that a GP was contacted or that anyone considered a treatment plan when he returned to Parc. On **17 June**, a mental health nurse tried unsuccessfully to contact the hospital for a discharge summary.

10. On **18 June**, Mr Nunes told a mental health nurse that he had stomach pain, felt dizzy and unwell and that something had to be done. The nurse recorded no observations of Mr Nunes' blood sugars, ketones or vital signs. She sent a task, asking the prison GPs for advice. There is no evidence that GPs responded or took any action. (A task is an internal request on the electronic medical database, SystmOne, that is sent to other healthcare professionals.)

11. On **25 June**, prison staff told a healthcare administrator that Mr Nunes was "still no better and actually appears worse". A nurse reviewed Mr Nunes and noted that he had been vomiting and was unable to eat or hold down fluids. The nurse gave Mr Nunes cyclizine and arranged for him to be reviewed 24 hours later. The nurse made no observations, did not record his vital signs using screening tools and did not review his blood sugar and ketone levels.

12. On **26 June**, a prison officer told the healthcare administrator that Mr Nunes was still very unwell. She told the officer to bring Mr Nunes to the healthcare unit so that a GP could see him. She noted in his medical record that when she had booked him the previous day to see the GP, "he ended up with the nurse instead".

13. A prison GP reviewed Mr Nunes later that day. (This was the first time that Mr Nunes had seen a GP since he had discharged himself from hospital on 16 June with DKA.) The GP noted that Mr Nunes felt tired and sick, looked pale, had visibly lost weight and was unable to keep food and fluids down. He diagnosed gastroenteritis (a common condition that causes diarrhoea and vomiting.) He arranged for blood tests and for the results to be sent urgently that afternoon so that further action could be taken. During the consultation, Mr Nunes told the GP that he "wasn't listening" to him and that "he knows his body and knows something is wrong". Mr Nunes told the GP, "You're not doing fucking anything, I might as well just go back to my cell and ring my mum and keel over" and "No one gives a fuck" and then walked out of the room.

14. Mr Nunes saw a nurse on **28 June**. She noted that he still had stomach pain, nausea, tiredness and that he was crying with frustration. She chased for the results of the blood tests taken on **26 June**. She also noted that Mr Nunes denied using illicit drugs in prison but noted that officers had told her he frequently used PS.

15. On **29 June**, a nurse noted after Mr Nunes attended the medication hatch that he had called out in pain and had told her he had been sick again. She gave Mr Nunes Gaviscon (heartburn and indigestion relief). A prison GP assessed Mr Nunes and noted that his blood sugar and ketone levels were high. The GP suspected DKA and arranged for Mr Nunes to be taken to hospital. While waiting for an ambulance, Mr Nunes' health deteriorated and staff called a medical emergency code blue, indicating a life-threatening situation. This was Mr Nunes' second admission to hospital.

16. On **30 June**, a prison GP made a retrospective entry to 26 June to note that action had been taken about Mr Nunes' blood results which had been taken that day. The GP noted that the results indicated the risk of acute kidney injury and hyponatraemia due to dehydration and vomiting. (Hyponatremia occurs when the concentration of sodium in the blood is abnormally low.)

17. On **2 July**, Mr Nunes discharged himself from hospital and returned to Parc. His medical records did not include a record of when he returned and there is no evidence that he saw the healthcare team. This was the second time that Mr Nunes was not medically assessed when he returned to prison.

18. In the early hours of **3 July**, a nurse assessed Mr Nunes after he was found on the floor of his cell, shouting in pain. He told the nurse that he had been sick and that his blood sugar levels were high. She consulted a GP and Mr Nunes was sent to hospital. This was Mr Nunes' third admission to hospital.

19. On **7 July**, Mr Nunes was discharged from hospital. A mental health nurse saw him in Reception. Escort officers told the nurse that they had left the hospital without Mr Nunes' medication because the hospital pharmacy had been closed. Healthcare staff contacted the hospital who said that Mr Nunes' insulin medication had been changed to a Basal Bolus insulin regime (which involves taking several injections of both Levemir, a longer-acting form of insulin, and Novorapid, a shorter-acting form, which should be taken before or after meals).

20. On **8 July**, a nurse reviewed Mr Nunes' diabetes. (She was not the prison's lead diabetes nurse.) She noted that Mr Nunes was feeling better since the change in his diabetic regime. He told her that he did not want diabetic complications. They discussed his diet and the need for him to take responsibility for checking his blood sugar levels.

21. On **10 July**, a prison GP reviewed Mr Nunes. He told the GP he felt okay but did not have a blood glucose monitoring machine. The GP arranged for him to be given a new one. That day, Parc received a fax from Mr Nunes' solicitor who was concerned that Mr Nunes was having difficulty obtaining his medication. There is no record of the fax in his medical records.

22. On **13 July**, Mr Nunes was diagnosed with bilateral pre-proliferative retinopathy (where the retina of the eye has been damaged by higher than normal sugar levels over several years, a complication of diabetes). Mr Nunes was referred to the hospital ophthalmic department.

23. On **20 July**, Mr Nunes was discussed in the weekly clinically vulnerable and older prisoner (CVOP) meeting. (CVOP meetings provide a multidisciplinary forum to

discuss prisoners with additional clinical needs and develop individual management plans for them.) Healthcare staff attended. Minutes of the meeting noted Mr Nunes' non-compliance with medication regimes, poor engagement with healthcare staff and that he had dismantled his blood sugar testing machine. A task was sent for the diabetic nurse to review Mr Nunes.

24. On **23 July**, a nurse responded to a code blue, which was later deemed inappropriate, as Mr Nunes had reported vomiting and feeling unwell overnight. Mr Nunes' blood sugar was recorded as high. When she told Mr Nunes that he needed insulin, he told her that he needed to eat first. She told him he did not need to eat as his blood sugar was high. She spoke to a prison GP, who noted that Mr Nunes' ketone level should be tested as he would need to be sent to hospital for suspected DKA diagnosis if it was medium or higher. The GP noted that Mr Nunes' non-compliance with his diabetic regime may be intentional to leave "the prison environment for some reason". The GP noted that Mr Nunes seemed to understand the importance of taking insulin but did not monitor his blood sugars or adjust his insulin dosage.

25. Unable to establish Mr Nunes' ketone levels, he was sent to hospital with possible DKA. This was his fourth admission. Mr Nunes refused to be treated in hospital and discharged himself hours later. A mental health nurse assessed him when he returned to Parc. Mr Nunes was tearful and told the nurse that he complied with his diabetic regime but could not maintain a healthy diet in prison. He asked for nutritional supplements. He declined GP intervention and intravenous fluids and said he would drink in his cell. The nurse spoke to a prison GP, who told her that this was Mr Nunes' usual presentation and that he needed to comply with his medication.

26. A hospital discharge letter noted that Mr Nunes did not have DKA but needed to increase his intake of fluids and should return to hospital if necessary. Staff took no observations or recordings of Mr Nunes' vital signs, did not review his blood sugar and ketone levels and did not instruct Mr Nunes on how to manage his insulin.

27. In the early hours of **24 July**, Mr Nunes refused to let a learning disabilities nurse take his observations, as he was unhappy that he had been woken up. Mr Nunes refused to sign a medical disclaimer form.

28. Later that day, an emergency code blue was called after Mr Nunes had been found rolling around on his bed and talking incoherently. A nurse noted that his blood sugar level was high and gave him insulin which he had not had that morning. Mr Nunes did not respond, and he was readmitted to hospital and treated for DKA in intensive care. This was Mr Nunes' fifth admission to hospital.

29. On **25 July**, hospital staff spoke to a nurse as they were concerned that Mr Nunes' health had been allowed to deteriorate to that extent. She told them that Mr Nunes had kept and administered his own medication and had refused treatment.

30. Mr Nunes returned to Parc on **31 July**, without a discharge letter. A mental health nurse reviewed him in reception. She noted that the hospital had advised a gluten-free diet and for Mr Nunes to have a meal replacement drink.

August 2015: two further hospital admissions

31. On **1 August**, a prison GP prescribed nutritional supplements, arranged for Mr Nunes to receive a gluten-free diet and noted that Parc needed further discharge information from the hospital. Mr Nunes told the GP that he had not been monitoring his blood sugar levels but now knew the importance of testing and was adjusting his insulin doses.

32. On **3 August**, Mr Nunes was discussed at a CVOP meeting, although minutes indicate the meeting took place on 4 August. A prison GP and a mental health nurse discussed Mr Nunes and noted that he needed regular weight monitoring, that he should keep a blood sugar level diary and that a diabetic review was needed. The nurse noted that if Mr Nunes failed to attend the clinic, nursing staff should visit him on the wing. A nurse responsible for diabetic clinics at Parc, was asked to arrange a care plan for him.

33. A full hospital discharge summary was faxed to the prison that day. It confirmed that Mr Nunes had been treated for DKA and had an endoscopy which had identified that he had gastro-oesophageal reflux disease. The discharge summary said Mr Nunes' gluten-free diet had helped in settling his vomiting, so he should continue with it. There is no record of the discharge letter in Mr Nunes' medical records.

34. The discharge summary from the hospital dietician (dated 12 August and which Parc received on 18 August) reported that Mr Nunes was identified as at risk of malnutrition and that he had lost significant weight due to hyperglycaemia and oesophagitis (irritation of the tube carrying food to the stomach). The summary advised that Mr Nunes should have food supplements "until his nutritional goals have been reached". Instructions were to stop nutritional supplements if he was maintaining his weight but that his insulin doses may need to be reviewed.

35. On **10 August**, a nurse assessed Mr Nunes and noted that he was feeling very anxious and, that she would ask the mental health team to discuss him at a referral meeting, with a view to assessing him. She noted that Mr Nunes became aggressive and left the room, saying he would report her to his solicitor.

36. A nurse saw Mr Nunes after wing staff reported that he was crying in agony. She noted that when she arrived, Mr Nunes was not distressed and said, "Basically Miss, they wouldn't listen this morning." Mr Nunes felt nauseous, and she told him to keep a food diary, recording when he felt sick and that she would ask for advice about a gluten-free diet. She noted that Mr Nunes became very aggressive and said he would report her to his solicitor.

37. On **11 August**, Mr Nunes complained to a nurse about vomiting. She noted that he refused to listen to her and left the room. She created a care plan for Mr Nunes and noted that he should monitor his blood sugar levels regularly, adjust his insulin, tell staff when his blood sugars were high and that the prison GP should be contacted if he tested positive for ketones. The nurse noted that Mr Nunes should document episodes of vomiting and drink fluids.

38. On **12 August**, Mr Nunes complained to a nurse that he was still vomiting. The nurse told him to make an appointment with healthcare as the previous day he had

refused to listen to her. Mr Nunes became angry, and she had to ask for him to be removed. Mr Nunes told her he would complain to his solicitor. She was asked to see Mr Nunes later that morning. He shouted at her and said she "wasn't doing anything for him". He said he had not recorded his blood sugar levels or kept a food log because he was vomiting. Mr Nunes shouted at her, and officers intervened. Mr Nunes spoke to her again that evening when he collected his medication. He was calmer and told her that he was still vomiting and would keep blood sugar and dietary diaries. No clinical action was taken about his observations, blood sugar or ketone levels.

39. On **15 August**, Mr Nunes told a nurse that he had been vomiting for five days and felt weak and dehydrated. Mr Nunes' blood sugar levels were high and his ketone levels medium. A prison GP advised by telephone that if Mr Nunes' ketones increased, he should be taken to hospital. A drug screen test completed at the time tested positive for cannabis.

40. That evening, a nurse saw Mr Nunes in his cell. He reported no change and said no one was doing anything for him. Mr Nunes shouted at the nurse that he was being forced to eat and drink and that no one was listening to him that he could not do so. Mr Nunes refused to have his blood sugar and ketone levels tested.

41. On **16 August**, a nurse tried to test Mr Nunes' blood sugar levels and take observations. Mr Nunes told the nurse that there was nothing wrong with him and that he was fed up with being disturbed and wanted to be left alone to sleep. No further clinical entries were made for thirty-four hours.

42. On the morning of **17 August**, a nurse noted that Mr Nunes, who was complaining of nausea and vomiting, had high blood sugar and ketone levels. Mr Nunes was admitted to the Royal Glamorgan Hospital with suspected DKA. He was not sent to the POW Hospital as Parc suspected that he may be retrieving illicit drugs there. This was Mr Nunes' sixth hospital admission.

43. Mr Nunes returned to Parc later that day without a discharge letter. A mental health nurse reviewed him when he arrived in reception. Mr Nunes told her he had been put on a drip to treat his dehydration. Later that evening, when a nurse went to check Mr Nunes' blood sugar, he told her that he had not taken his insulin. She told him that he should take it and that she would check on him during the night.

44. In the early hours of **18 August**, prison staff told a nurse that Mr Nunes was vomiting and complaining of stomach pain. She checked his blood sugars and ketone levels, which were both high. An on-call prison GP told staff to send Mr Nunes to hospital. He was admitted to the POW Hospital. It was his seventh hospital admission.

45. On **20 August**, a hospital consultant spoke to the Head of Healthcare. She noted that the consultant suspected that Mr Nunes was not taking his insulin correctly that he should not keep and administer his insulin but be closely supervised in doing so.

46. On **24 August**, Mr Nunes was discharged from hospital. Before he was discharged, a nurse assessed him and liaised with hospital staff. She noted that he had a new insulin regime and that he had told the hospital's diabetes nurse specialist that he would be more compliant, but that he had eaten unsuitable foods

in hospital which had resulted in high blood sugar levels. She noted that Mr Nunes should no longer keep and administer his insulin. A mental health nurse reviewed Mr Nunes in reception when he returned to Parc.

47. In the early hours of **25 August**, Mr Nunes refused to allow a nurse to give him his nightly dose of insulin. She did not report this to a senior clinician. The next morning, Mr Nunes was verbally aggressive towards a learning disability nurse at the medication hatch and was given a written warning.

48. A nurse noted that Mr Nunes had refused to take his insulin at lunchtime after she had asked him to take his blood sugar levels. Mr Nunes said he could not as he had no testing strips. The nurse reminded him that he should order these from the pharmacy. The nurse noted that Mr Nunes was very rude and had walked off.

49. On **28 August**, a nurse told Mr Nunes that she could not give him his insulin unless he had his blood sugar levels taken. Mr Nunes refused and became abusive towards the nurse, telling her if she tried later, he would again refuse. The nurse told a prison GP, who advised that Mr Nunes should be given his insulin, even if he refused to have his blood sugar levels tested. Nursing staff gave him his insulin that evening.

50. That day, an intelligence report noted suspicions that Mr Nunes' admission to hospital over the previous few weeks was to recover packages, thought to contain illicit drugs. The report noted that there was no intelligence that he had received any parcels.

51. On **29 August**, a nurse reported that Mr Nunes had been argumentative about his blood sugar monitoring and insulin regime. That evening, Mr Nunes told the nurse, when he refused to provide a blood sugar reading, that she was refusing to give him his insulin and walked away. Under the instruction of an on-call GP, Mr Nunes was given insulin later that evening despite being his blood sugar level not being tested.

52. On **30 August**, Mr Nunes was verbally abusive to a nurse when she did not give him his insulin as he had not provided a blood sugar reading. Mr Nunes eventually agreed to a reading, and he was given his insulin.

53. Later that morning, a nurse explained to Mr Nunes the importance of managing his diabetes by taking regular blood sugar readings. Mr Nunes told the nurse he would not listen to her, that it was his right to refuse but that he still needed his insulin. Mr Nunes told her he would not check his blood sugar level regularly. The on-call GP said Mr Nunes should sign a disclaimer each time he refused to have his blood sugar levels taken and that his insulin should continue to be given, as prescribed.

September to October 2015: two further hospital admissions

54. In the early hours of **2 September**, a nurse gave Mr Nunes paracetamol as pain relief for toothache. Mr Nunes refused to attend a diabetic clinic appointment at the POW Hospital that day. He later told the nurse that this was because she had upset him by asking him to fetch his identification card when he had attended the medication hatch earlier in the day.

55. At 2.02am on **4 September**, Mr Nunes asked Nurse A, a mental health nurse, for his evening dose of long-lasting insulin. The nurse noted that Mr Nunes' blood sugar levels were high and sought the on-call GP's advice. Given Mr Nunes' history, she told the nurse that no action should be taken as it was the middle of the night. Mr Nunes was not given insulin.

56. At a CVOP meeting on **7 September**, which nurses attended, it was noted that Mr Nunes' behaviour had improved since his insulin administration had been supervised, nurses were monitoring him closely, he was compliant with his medication regimes and his blood sugar levels were stable.

57. On **11 September**, a nurse created a prevention of hypoglycaemia and diabetic care plan for Mr Nunes. This included regular monitoring or blood sugar levels and the issuing of insulin at the medication hatch. The care plan noted that both Mr Nunes' long-acting and short-acting insulin could be given at the same time. She also noted that staff should ask Mr Nunes to sign a disclaimer if he refused either his insulin or blood sugar testing and that the consequences of his non-compliance should be explained to him.

58. On **14 September**, a letter was received from a consultant physician at the POW Hospital to say that Mr Nunes had missed a diabetic clinic appointment on 2 September. The letter reviewed his earlier admission to hospital for treatment of DKA and weight loss. The physician asked Parc to supervise Mr Nunes' insulin administration as his poor insulin compliance for several years had resulted in gastroparesis (a condition in which the stomach cannot empty itself of food, causing nausea, vomiting and weight loss). The physician advised treatment with maxalon (metoclopramide), that the hospital diabetic specialist should be contacted about insulin advice and that a further diabetic hospital review appointment would be arranged. Mr Nunes was discussed at the CVOP meeting that day.

59. On **15 September**, a letter dated **3 September** was received from a consultant gastroenterologist at the POW Hospital to say that they needed to undertake further tests of Mr Nunes' gastroparesis. An appointment was made for 2 October.

60. During **September**, Mr Nunes continued not to comply with blood sugar testing and signed 14 medical disclaimers that month.

61. At a CVOP meeting on **21 September**, which medical staff attended, they discussed Mr Nunes' refusal to have his blood sugar levels tested and that he was signing medical disclaimers. A prison GP arranged to meet Mr Nunes, with a nurse, on **29 October**.

62. On **23 September**, a nurse noted that Mr Nunes continued to feel "fed up". Mr Nunes failed to attend GP appointments on 24, 29 and 30 September.

63. On **2 October**, Mr Nunes refused to attend his gastroparesis appointment at the POW Hospital. He told a healthcare administrator that there was nothing wrong with him. Mr Nunes refused to sign a medical disclaimer to confirm his refusal to attend. She noted that Mr Nunes was aggressive and that she was shocked by his attitude towards those trying to help him.

64. On **9, 10, 12 and 19 October**, Mr Nunes failed to attend nurse-led clinic appointments. On 14 October, he refused to take his insulin and did not explain why. A nurse noted that wing staff had said he had been angry all day.

65. On **21 October**, a mental health nurse reviewed Mr Nunes after he told staff he felt nauseous and kept collapsing. He noted that both Mr Nunes' blood sugar level and temperature were high and that he was clearly unwell. Mr Nunes was sent to the POW Hospital for assessment. This was Mr Nunes' eighth admission to hospital.

66. Mr Nunes discharged himself later that day and had no discharge letter. Mr Nunes told a nurse when she reviewed him on his return to Parc that he had been told he needed a liver scan and was happy to return to his wing. Mr Nunes had no discussion with a GP, there were no care plans created or investigations about his blood sugar or ketone levels.

67. That day, Mr Nunes was placed on closed domestic visits as intelligence suggested he may be passed illicit drugs. The closed visits were scheduled to end on 13 January 2016.

68. On **22 October**, an emergency code blue was called as Mr Nunes was vomiting in his cell. A nurse attended and later reported that Mr Nunes' behaviour had been exaggerated, saying he could not breathe and felt hot and that he was forcing himself to be sick. A prison GP saw Mr Nunes and noted that his ketone levels were dangerously high and that he was at risk of DKA. Mr Nunes was taken to the Morriston Hospital for treatment. (Mr Nunes was not taken to the POW Hospital as intelligence suggested he was manipulating hospital admission.) This was his ninth admission to hospital.

69. On **24 October**, Mr Nunes discharged himself from hospital because the prison would not allow his mother to visit him (because he was on closed visits). When he arrived at Parc without a discharge summary, he told an HCA that he felt fine and wanted to go to his cell. Mr Nunes did not see a GP, no one assessed his blood sugar or ketone levels, and no treatment plan was created.

November 2015: two further admissions to hospital

70. On **3 November**, Mr Nunes refused to attend an ultrasound scan of his abdomen at the POW Hospital and signed a disclaimer. The following day, Mr Nunes refused to attend a flu vaccination appointment.

71. On **17 November**, a nurse did not give Mr Nunes his insulin as his Novorapid prescription chart had ended. Mr Nunes became verbally aggressive. The prison GP was told that Mr Nunes had not been given his insulin. Later that day, Mr Nunes refused again to test his blood sugar levels.

72. During the day, a HCA confirmed a new appointment for Mr Nunes to attend the hospital diabetic clinic. It could not be cancelled as it had been rearranged twice before and if it was, Mr Nunes would be removed from the clinic's waiting list.

73. On **18 November**, Mr Nunes told a nurse that he had a toothache. The nurse gave him pain relief and advised him to book an appointment with the dentist. He received more pain relief over the following days.

74. On **19 November**, it was assessed that Mr Nunes should remain on closed domestic visits.

75. On the morning of **21 November**, Mr Nunes complained to a nurse of vomiting and toothache. He did not take his blood sugar levels himself as he was too weak but let his cellmate help him take them. His blood sugar and ketone levels were high. The nurse told Mr Nunes to collect his insulin from the medication hatch and made an appointment for him to see the GP. The GP later diagnosed DKA and Mr Nunes was admitted to hospital. The GP noted that he thought Mr Nunes had an alternative agenda to manipulate the system and was concerned that he was making himself sick to go to hospital to pick up illicit drugs. This was Mr Nunes' tenth admission.

76. On **22 November**, Mr Nunes discharged himself from hospital. On his return to Parc, he refused to see a nurse in Reception or to have his blood sugar or ketone levels taken. The nurse spoke to the hospital, who told her that Mr Nunes had not been compliant with his treatment and did not have DKA when discharged. The hospital consultant said Mr Nunes had the mental capacity to discharge himself. There is no record that Mr Nunes' return to Parc was discussed with a GP or senior nurse or that a treatment plan was formulated.

77. Early that evening, a nurse noted that Mr Nunes continued to vomit and that both his blood sugar and ketone levels were very high. There was no observation or recording of his vital signs, including use of NEWS and the sepsis screening tools. She noted that Mr Nunes was very tearful and said it was her fault for not giving him insulin that morning. She told him that this was because she had tried to contact the hospital to establish his treatment. A code blue was called that evening and Mr Nunes was readmitted to the POW Hospital. It was his eleventh admission to hospital and second within 24 hours.

78. On **23 November** 2015, a prison chaplain contacted Mr Nunes' mother to tell her that her son had been admitted to hospital but that she would not be able to visit him because he was subject to closed domestic visits.

79. On **25 November**, Mr Nunes discharged himself from hospital against medical advice. He had no discharge letter. A nurse assessed Mr Nunes in Reception. The nurse noted that an officer had told her that Mr Nunes had said he would increase his insulin dose when he next attended the medication hatch. Mr Nunes told the nurse he had said this as he felt frustrated as he wanted to administer his medication himself. The nurse did not discuss Mr Nunes' return to prison with a GP or make investigations into his blood sugar or ketone levels, but she referred him to a prison GP.

26 November to 2 December: management under ACCT procedures and two further hospital admissions

80. At around 6.22am on **26 November**, a nurse saw Mr Nunes in his cell after he had refused to attend hospital after vomiting and complaining of pain through the night. Although his blood sugar levels were normal, his ketones were recorded as medium and hospital staff advised that Mr Nunes should be admitted to hospital for assessment. The nurse said Mr Nunes, who was lying on his mattress on the floor,

was verbally abusive to her when she advised him that he should go to hospital for further investigations. He said, "I'm not fucking going" because he had been threatened with ACCT monitoring. The nurse told Mr Nunes that she was not advising that ACCT procedures start but that he should be checked hourly as he had refused to go to hospital. The nurse asked Mr Nunes to sign a medical disclaimer, but he refused. A prison GP reviewed Mr Nunes and prescribed metoclopramide (anti-sickness medication), which Mr Nunes had found helpful in the past.

81. At 11.30am, a complex case manager chaired a multidisciplinary case conference due to Mr Nunes' poor management of his diabetes, his refusal to receive medical treatment and advice that he should go to hospital for further assessment. An operational manager and a security manager attended. (Parc's multidisciplinary case conferences are a forum to address the issues and concerns of prisoners who have self-harmed, are at risk of self-harm or have other complex needs. The complex case manager usually chairs case conference meetings and attends ACCT reviews with the aim of providing extra support and guidance about a prisoner's needs. The case conference is not an ACCT enhanced case review.)

82. Healthcare staff did not attend the meeting but contributed to it. It was noted that Mr Nunes' diabetes was unstable and that he had been verbally abusive to nurses the previous night and had refused to be admitted to hospital against medical advice. The security manager said that Mr Nunes was "massively" involved in the prison's drug culture, and he was suspected of receiving packages while in hospital. However, there was no intelligence to suggest that this was the case. The complex case manager advised that Mr Nunes had not attended hospital so they should consider putting him in a camera cell as the Head of Healthcare had told her that his diabetes was dangerously unstable.

83. Mr Nunes told the conference he had refused to go to hospital because staff had wanted to monitor him under ACCT procedures, and he did not understand why as he had not harmed himself or threatened to do so. Mr Nunes was told that by refusing his medication, he was harming himself and so would be subject to ACCT monitoring. Mr Nunes became agitated, shouted that Parc had stopped his medication and would not give him his insulin pen and walked out.

84. Staff started ACCT procedures for Mr Nunes. In a statement to the Coroner, an operational manager said ACCT procedures were started as "Mr Nunes was intentionally or recklessly failing to take responsibility for his health to the extent he was causing harm to himself". (Parc has since lost the ACCT document and the investigator was unable to review it. Details about this ACCT have been evidenced from other written sources, including Mr Nunes' medical records.)

85. In the afternoon, the complex case manager and members of the case conference spoke to Mr Nunes again about their concerns that he had discharged himself from hospital. Mr Nunes said he would do it again as he became agitated and could not rest there. Mr Nunes said he had never threatened to "crank up" his insulin levels but wanted to keep and administer his insulin himself in case he needed it at night. Mr Nunes was concerned that his insulin pen had not been re-prescribed the previous week and he had missed three injections as a result. She told Mr Nunes that she would investigate what had happened.

86. The complex case manager asked Mr Nunes if he wanted to speak to his mother. Mr Nunes said he had already spoken to her and did not want her to take part in the case conference. Mr Nunes said that when he was checked, he would block his observation panel as he did not want to be monitored under ACCT procedures or be put in a camera cell, as had been suggested at the case conference. Mr Nunes was told an initial review would take place the following day and he would be monitored until at least the following week. Mr Nunes accepted that he sometimes came across as threatening to people not used to his behaviour and that he should be mindful of this. It was noted at the case conference that as Mr Nunes was being managed under ACCT procedures, there was no need for a supported living plan (SLP) or management plan. (An SLP identifies medical issues and consequent risks that can be shared with prison officers to inform them about a prisoner's healthcare needs.)

87. In the early hours of **27 November**, a nurse saw Mr Nunes after it was reported he was vomiting and crying in pain. He told her that although his blood sugar levels were normal, his ketones were raised, and he felt nauseous despite taking his anti-sickness medication. She told him that she would try to get him reviewed later that day.

88. That morning, a nurse visited Mr Nunes as he had not collected his medication. He refused to tell her his blood sugar readings but said he was not eating and questioned the point of taking his medication. He became abusive and walked off. Mr Nunes' cellmate told the nurse that Mr Nunes' blood sugar was low. She took no immediate action to address this low reading which potentially indicated a hypoglycaemic episode, but she visited Mr Nunes to check his blood sugar at lunchtime. Mr Nunes was abusive and aggressive and told her to "fuck off from my cell" and said he would not allow his blood sugar level to be taken. Healthcare staff did not give Mr Nunes his insulin and took no further action.

89. That afternoon, the complex case manager chaired Mr Nunes' first ACCT case review. A prison manager and a nurse attended. The nurse noted that Mr Nunes was abusive and did not want to be monitored under ACCT procedures, did not want his blood sugar levels taken or his cellmate involved in his care. Mr Nunes refused to listen to staff's concerns about his welfare and he left the room. The review concluded that Mr Nunes would remain on two checks an hour and that he would be reviewed again on **29 November**.

90. The complex case manager emailed the Head of Healthcare to say she had contacted Mr Nunes' mother to update her about her son's welfare and that she had given her contact details.

91. In the early hours of **28 November**, Nurse A saw Mr Nunes after he complained of vomiting. He noted that Mr Nunes' blood sugar levels were high but that he was unable to measure his ketone levels as there were no testing strips available. He noted that Mr Nunes became agitated and uncooperative, shouting that he was very ill. The nurse referred him to the GP.

92. A prison GP assessed Mr Nunes later that morning. He noted that Mr Nunes had been vomiting, that his blood sugar levels were high and that he could smell ketones on Mr Nunes' breath. He noted that Mr Nunes had not been reliably testing or taking his insulin and that it was suspected he did this on purpose to get to

hospital. He also noted that Mr Nunes knew the risks he was taking by not complying to his diabetic regime and that there was a very real risk of death from DKA, or an event related to it. Plans were made to admit Mr Nunes to hospital for suspected DKA. Mr Nunes told a nurse that he would remain in hospital until he was discharged. She noted that she had discussed with a prison manager the possibility of Mr Nunes being put in a camera cell when he returned from hospital so he could be monitored more closely. This was Mr Nunes' twelfth hospital admission.

93. On **30 November**, a CVOP meeting discussed Mr Nunes' non-compliance with his diabetic regime. Prison and healthcare staff attended. A nurse asked for Mr Nunes to be put in a camera cell as there was a belief that he was deliberately putting his health at risk to go to hospital. The meeting discussed that Mr Nunes had told his mother that he was not being given his insulin and that the complex case manager, as the point of contact, would visit Mr Nunes and his mother in hospital the following day.

94. However, Mr Nunes was discharged from hospital that afternoon. An HCA saw him when he returned to Parc and noted he had been treated in hospital for DKA. Mr Nunes told her he still felt unwell and weak, and she told him to eat, drink plenty and to rest. She did not discuss Mr Nunes' return with a prison GP or take his blood sugar and ketone levels but referred him for a GP appointment.

95. A diabetes specialist nurse (DSN) from the POW Hospital wrote a handwritten discharge letter, addressed to prison GPs. The DSN said Mr Nunes needed his rapid-acting insulin to be injected 10-15 minutes before each meal of the day. The nurse reported that Mr Nunes had said that as the medication hatch is closed at lunchtime, he often got his lunchtime insulin after lunch and sometimes significantly later. The DSN asked the healthcare team to consider how Mr Nunes could get his mealtime insulin with or just before meals. The DSN reminded Parc about the importance of regular blood glucose monitoring, attendance at the hospital diabetes clinic and that DSNs at the hospital could be contacted for advice about adjusting his insulin levels.

96. On **1 December**, a prison GP reviewed Mr Nunes at an emergency appointment as he had complained of abdominal pains and said he should be back in hospital. The GP noted that prison staff were not withholding Mr Nunes' insulin, as he had told hospital staff. Mr Nunes told the GP that he could not be bothered to check his blood sugar levels if he felt fine and acknowledged he could be difficult and aggressive towards staff. Mr Nunes said he felt that his diabetes was worse than when he was a child. The GP noted that in the past, Mr Nunes' mother had checked his blood sugar levels. Mr Nunes said he never thought about his diabetic regime as it was something his mother just did for him. Mr Nunes told the GP that he was aware of the risks of death from DKA and denied manipulating admissions to hospital to retrieve illicit drugs. Mr Nunes said he feared taking responsibility for controlling his diabetes. The GP concluded that Mr Nunes had the mental capacity to make decisions about his health and medication and knew about the severity of his diabetes.

97. The GP concluded that healthcare staff needed to find a way to engage with Mr Nunes if he administered his insulin himself. He encouraged Mr Nunes to complete a blood sugar level diary, made plans for weekly reviews with GPs, for nurses to

check on him two or three times a week, for an appointment to be made with the hospital diabetic clinic and for metoclopramide to be prescribed for his nausea and sickness.

98. The GP noted that Mr Nunes might also benefit from mental health support as his anxiety was sometimes disabling. The GP noted that it was hard to know how much of his anxiety might be a symptom of his poor blood sugar level control and episodes of DKA. The GP noted that Mr Nunes might benefit from mental health support and prescribed duloxetine, anxiety medication. Mr Nunes told the GP that he had no thoughts of suicide or self-harm.

99. On the morning of **2 December**, a nurse asked Mr Nunes if he had taken his insulin. He was crying and told the nurse, "Of course I haven't had my fucking insulin, I haven't been able to eat anything."

100. At 8.30am, a nurse noted that Mr Nunes had complained to wing staff that he was not feeling well and noted that she had already spoken to a colleague about it and had told her to speak to the prison GP. The GP told the nurse to give Mr Nunes cyclizine (anti-sickness medication) and that his ketone levels should be taken as he might need hospitalisation. Mr Nunes' ketone levels were not taken until later that afternoon.

101. At 10.31am, a prison manager chaired Mr Nunes' second ACCT review. A nurse also attended. As Parc lost the ACCT document, it is not clear who else attended although there were some notes on the internal electronic case management system (CMS). Mr Nunes said he had no thoughts of suicide or self-harm and that he wanted ACCT monitoring to stop as it was affecting his sleep. The manager noted that after a period in hospital, Mr Nunes now kept and administered his insulin himself, and his condition had stabilised. Mr Nunes said he was happy as he had control of his insulin levels.

102. However, a nurse noted in Mr Nunes' medical record that he continued to struggle with eating. In her statement to the Coroner, the nurse said that although the ACCT had been started due to concerns about Mr Nunes' diabetes, he had demonstrated at the ACCT review that he knew how to properly manage it. In her statement, she said all those who attended the ACCT review agreed that monitoring should stop as they were satisfied that Mr Nunes now had control over his insulin levels. She said it was agreed that as his risk had reduced, there was no requirement to continue ACCT monitoring. The prison manager told the inquest that a post-closure review was scheduled for 9 December.

103. At 7.26pm, a nurse noted that Mr Nunes had high blood sugar and ketone levels. The nurse noted that Mr Nunes should not be taken to the POW Hospital, as officers had told her that he was taking drugs and was making himself ill to collect drugs from hospital. That evening, Mr Nunes was admitted to the POW hospital with suspected DKA. This was his thirteenth admission.

3 to 10 December 2015: a further hospital admission

104. On **3 December**, Mr Nunes discharged himself from hospital against medical advice and refused to wait for a gastroscopy. Nurse B saw Mr Nunes when he returned to Parc that afternoon, but she did not discuss Mr Nunes' discharge from

hospital with a prison GP and did not check his observations, blood sugar or ketone levels. Another nurse noted however that the hospital had reported that they were stable. She noted that on Mr Nunes' return, they discussed the possibility of moving him to another wing.

105. That evening, a nurse asked Mr Nunes to move to a camera cell for observation. He refused but agreed to move in with a new cellmate. He then told the nurse that she did not know what she was doing, sending him to hospital when he did not need to go. She reminded him of the importance of complying with his diabetic regime.

106. On **4 December**, a nurse asked Mr Nunes to sign an SLP. Mr Nunes refused to speak to the nurse or to discuss the SLP and told her she was deliberately winding him up.

107. On **6 December**, wing staff asked a nurse to see Mr Nunes. He told her he was managing his blood sugar levels but was concerned about his stomach "whirling", which resulted in him vomiting. Mr Nunes said his anti-sickness medication was not working and wanted it changed to cyclizine. The nurse noted that Mr Nunes looked tired, and an on-call GP gave him a cyclizine injection. The nurse made no record of Mr Nunes' observations and did not review his blood sugar and ketone levels.

108. On **7 December**, wing staff asked a nurse to see Mr Nunes as he was complaining of vomiting and that his stomach was "whooshing". The nurse noted that his breath smelt sweet, indicating the presence of ketones, but did not know what level they were as Mr Nunes had run out of testing strips. However, a later ketone test showed that Mr Nunes had possible DKA, and he was referred to the prison GP.

109. Later that morning, a prison GP reviewed Mr Nunes. He noted that he smelt ketonic and was ill again. When the GP discussed that he would have to be treated in hospital, Mr Nunes became angry and said he was not going to hospital for "the fucking staff to talk down to him like they always do and give him fucking nickings". Mr Nunes told the GP he wanted dioralyte (a treatment for diarrhoea) instead. The GP explained that the point for relying on dioralyte to correct his ketosis had passed. Mr Nunes still refused to go to hospital and said that he would rather "die puking all over himself". The GP agreed to give dioralyte but noted that he felt this would not work and if it did not, Mr Nunes had agreed to go to hospital.

110. A nurse checked on Mr Nunes several times that evening. Overnight, Nurse A checked Mr Nunes' blood sugar levels. Mr Nunes was abusive and argumentative shouting at the nurse that it was his ketones he should be checking and complained of vomiting. He took readings of Mr Nunes' blood sugar and ketone levels, which were both high, but made no other recording of vital signs and did not use the NEWS or sepsis screening tools. The nurse spoke to the on-call GP, who said Mr Nunes should be reviewed by a GP the following morning if there was no significant change in his presentation.

111. On **8 December**, Mr Nunes refused to attend his GP appointment, and a nurse visited him in his cell. Mr Nunes refused to let her test his blood sugar levels and, despite encouragement from his cellmate, Mr Nunes continued to refuse assistance. She told Mr Nunes about the seriousness of his illness, and that he could die from it. Mr Nunes told the nurse he knew what could happen.

112. At around lunchtime, the complex case manager emailed the Head of Healthcare to say that she had spoken with Mr Nunes' mother, who had agreed she would join a conference call that afternoon to discuss her son.

113. A prison GP saw Mr Nunes that afternoon. Mr Nunes said he could not do with the fuss of people coming to see him all the time. Although Mr Nunes said he felt better, the GP told him he should be sent to hospital. Mr Nunes again refused to attend and acknowledged he was at risk of death.

114. That evening, a nurse saw Mr Nunes after staff had reported that he was upset, tearful and feeling unwell. She noted both his blood sugar and ketone levels were high and arranged for him to be admitted to hospital urgently. It was his fourteenth admission to hospital.

115. On the morning of **9 December**, the complex case manager chaired a second multidisciplinary case conference to discuss Mr Nunes' poor diabetes management and refusal to receive hospital treatment. A prison manager, a nurse and Mr Nunes' mother attended.

116. The case conference noted that Mr Nunes' ACCT monitoring had ended, and he had refused to sign an SLP. They also noted that Mr Nunes had been difficult to manage due to fluctuating moods and on occasion, he did not accept advice about his best interests and wellbeing. The nurse said healthcare staff had wanted to open an SLP, but Mr Nunes had refused to sign one. This would have allowed his condition to have been discussed with prison staff. However, many already knew about his diabetes and knew to call healthcare staff immediately if he was unwell. The nurse told the conference that that Mr Nunes administered his insulin himself, he was monitoring his condition and nurses were checking on him twice a day.

117. During the meeting, Mr Nunes' mother expressed concern about her son's situation and said she was waiting for staff to "turn up on her doorstep informing her that her son had died". The complex case manager said that Mr Nunes' mother had said she accepted that the prison was doing all they could for her son and that he was aware of how to look after himself. Mr Nunes' mother thought that her son's cellmate may be supplying him with PS as she had had a phone call with her son in which he sounded under the influence of drugs. Mr Nunes' mother said she felt her son was depressed and his use of PS was hiding his true feelings and thoughts. An intelligence report was submitted about Mr Nunes' possible use of drugs.

118. The case conference identified that Mr Nunes was at risk of suicide or self-harm and should be monitored under ACCT procedures. It noted that as Mr Nunes would be monitored under ACCT procedures, there would be no need for an SLP or management plan. However, despite agreement that Mr Nunes should be monitored under ACCT procedures, staff did not initiate them.

119. A prison manager said that the ACCT post-closure review did not take place as it should have on 9 December because Mr Nunes was in hospital. However, a case conference generic management plan was created. It noted that Mr Nunes would remain on B1 wing in a double cell, that his current cellmate would be moved, and that he would share with another prisoner who could alert staff if Mr Nunes felt unwell, and that Mr Nunes would be monitored by an SLP. The action plan was

poorly completed and there was no further indication that the actions had been completed.

120. Although it is not noted in the case conference notes, the prison manager said that it was agreed that Mr Nunes' mother would be told if her son was taken to hospital so that she could try to persuade him to stay and receive treatment. Mr Nunes' mother and the complex case manager visited Mr Nunes in hospital. He was surprised to see his mother and during the visit, he asked if he could share a cell with another prisoner as he said his current cellmate was not a good influence on him.

121. That afternoon, a nurse opened an SLP. Mr Nunes refused to sign the plan to consent to relevant medical information being shared with officers on his wing. Despite this, she raised five objectives in the immediate action plan: that he was to have immediate access to healthcare if he asked or was unwell, that officers were to tell healthcare staff if his behaviour became erratic, that he was to have access to all meals and be given a diabetic pack. A review of the SLP was scheduled for 16 December but there is no evidence that it took place on that date.

122. On **10 December**, Mr Nunes was discharged from hospital. A nurse assessed him in reception, gave him medication and referred him to the prison GP.

11 December to 31 December: management under ACCT procedures

123. On the morning of **11 December**, Mr Nunes refused to go back to his cell. He told a nurse that his cellmate was smoking PS and he was inhaling the fumes. She did not discuss Mr Nunes' diabetes with him as she felt he was hostile. As Mr Nunes' former cellmate had been taken to another wing, Mr Nunes was moved to another cell, but he was told he had to share a cell because of his health. Mr Nunes was not happy with the decision and told staff that he would assault anyone he was asked to share a cell with.

124. In the afternoon, a Supervising Officer (SO), the wing manager, chaired a third case conference with Mr Nunes. A nurse and a representative from the violence reduction team attended. The case conference was held to discuss Mr Nunes' diabetes and his refusal to share a cell. Mr Nunes was told that he had been asked to share a cell for his wellbeing. It was noted that Mr Nunes, who was aggressive and threatening, said he would hurt anyone he was asked to share a cell with or any member of staff checking him under ACCT procedures. Mr Nunes again refused to move to a camera cell. Plans were made for him to remain on the wing, that he was to receive regular support from healthcare staff and that his behaviour would be observed.

125. At 3.30pm, staff started ACCT procedures because of Mr Nunes' ongoing health concerns and his refusal to share a cell. Mr Nunes expressed his unhappiness about the decision. Because he was being monitored under ACCT procedures, Mr Nunes was told he would be unable to keep and administer his medication. He later refused to check his blood sugar levels. At an ACCT assessment, Mr Nunes denied thoughts of suicide or self-harm.

126. On **12 December**, Mr Nunes again refused to have his blood sugar and ketone levels taken. He also refused to take his antidepressants as he said that he did not need them.

127. That afternoon, Mr Nunes had his first ACCT case review. A mental health nurse attended. Although Mr Nunes refused to engage in the review, he told a prison manager that his medication was always being "messed up", that he would not share a cell and that he had no thoughts of suicide or self-harm. The review concluded that Mr Nunes should be checked twice an hour. Mr Nunes' refusal to share a cell was noted in the caremap as an ongoing issue. (This was indicated as completed on 22 December, the day ACCT monitoring stopped.)

128. On **13 December**, Mr Nunes was sick, and as his blood sugar and ketone levels were high, he was told he would need to be admitted to hospital. An hour later, while waiting to be taken to hospital, Mr Nunes said he felt fine. Despite healthcare staff explaining the importance of going to hospital, Mr Nunes signed a medical disclaimer and was taken back to his wing. He was told that if he felt unwell, he should contact healthcare staff. No observations or recording of his vital signs, including sugar and ketone levels, were made overnight.

129. On **14 December**, a prison manager chaired Mr Nunes' second ACCT case review. The complex case manager, a nurse and Mr Nunes attended. Mr Nunes said he would share a cell but only with someone he knew and could deal with his diabetes. He said he had lost weight and asked for nutritional drinks as carbohydrates were too heavy for his stomach. The nurse said she would speak to the kitchens and doctor to arrange suitable meals and told him that nurses would continue to give him his insulin. Mr Nunes denied any thoughts of suicide or self-harm and as he was not sharing a cell, he remained on two checks an hour. The prison manager noted on the caremap that Mr Nunes and an operational manager would sort out a cell share and that some healthcare staff would address his food issues. At inquest, the complex case manager said she told Mr Nunes that by refusing his medication, he was self-harming, but she said he did not really understand this.

130. During the afternoon, Mr Nunes was discussed at a CVOP meeting and seen by a locum GP. Mr Nunes asked for nutritional supplement drinks, but the GP did not prescribe them, noting that there was no need for them as eating food was "clearly a better option". The GP noted that Mr Nunes was very unhappy and left the room angry. This was the last time that Mr Nunes saw a prison GP.

131. On **15 December**, Mr Nunes moved to share a cell with another prisoner.

132. On **16 December**, Mr Nunes refused to attend for an endocrinology appointment at the POW Hospital. (Endocrinologists specialise in treating diseases related to problems with hormones, such as diabetes.) Mr Nunes told a nurse he would not go as staff at the hospital "take the piss out of him" and he said he felt "fine now anyway" and adding, "Will you lot just leave me the fuck alone?"

133. On **16 December**, the complex case manager emailed the Head of Healthcare to say that Mr Nunes' mother had called to say that Mr Nunes had spoken to her by telephone and she was worried because he had not been given his insulin or had medication for his stomach since returning to Parc.

134. On **17 December**, Mr Nunes complained to a nurse about the level of care he was receiving from the healthcare team and that the previous day, he had not been given his insulin until 2.00pm. She told him that the prison was providing good care. Mr Nunes then swore at her and asked her to leave. Later that day, Mr Nunes told her he felt sick, became tearful and said he was crying all the time. She noted that when she left him, she saw him talking to other prisoners and he was no longer tearful. She took no observations or recorded Mr Nunes' vital signs.

135. The Head of Healthcare referred Mr Nunes to the prison's mental health team as the complex case manager had told her that his mother had called the prison to say she felt he was depressed and needed antidepressants.

136. On **22 December**, a prison manager chaired Mr Nunes' third ACCT review with a nurse. Mr Nunes said he had never self-harmed in the community or in custody and had no thoughts of doing so. The manager noted that Mr Nunes fully understood the consequences of not monitoring his blood sugar levels and said that his actions in not doing so were not actions of self-harm. Mr Nunes said his blood sugar levels had stabilised and that he had started to eat normally again so there was no need for ACCT monitoring. She noted that Mr Nunes was on an SLP and that she had agreed with the nurse that ACCT procedures should stop. She noted that all the caremap issues had been addressed. She made an entry about the closure of ACCT procedures in the SLP and scheduled a post-closure ACCT review for 29 December.

137. On **23 December**, a nurse asked Mr Nunes if he wanted to keep and administer his insulin himself. He told her he would prefer to receive it at the medication hatch.

138. On **24 December**, a nurse noted that Mr Nunes had again refused to test his blood sugar level, keep a diary or show her his blood sugar testing machine. Mr Nunes told her he knew when" he is out of control". Mr Nunes asked about his special diet, and he was told the hospital had not recommended one. She told him that it was her responsibility to ensure that he understood his diabetes but that it was his responsibility to control it. Mr Nunes told her not to treat him like a child.

139. On **26 December**, a nurse gave Mr Nunes paracetamol after he complained of toothache.

140. On **27 December**, a nurse noted that Mr Nunes had complained of swelling and pain to the left side of his face and that it had been getting worse for the last two days. She identified a suspected dental abscess. She assessed Mr Nunes' risk for keeping and administering antibiotics due to his increased risk of DKA from infection. That evening, a nurse sent a Task to Time for Teeth (TfT) to make an appointment for Mr Nunes to see the dentist about an abscess. (The Task indicated that Mr Nunes was on an antibiotic regime but there is no record in his medical record to indicate that antibiotics had been prescribed or dispensed at that time.)

141. According to evidence provided during the inquest and by the Head of Healthcare in her statement to the Coroner, the Task sent by the nurse to the dentist was actioned and an appointment was made for 18 January.

142. On **28 December**, a nurse noted that Mr Nunes was verbally aggressive after he was refused an additional dose of insulin because he would not let the nurses see his blood sugar levels. He was given the insulin later that day after showing his blood sugar levels to staff. A HCA said that when Mr Nunes was low on insulin, he did not comply and could be verbally aggressive, that he knew he needed his insulin and that she had never seen a diary recording his sugar levels.

143. At lunchtime on **29 December**, a prison manager completed an ACCT post-closure review. This was not recorded on the official ACCT post-closure form but on Parc's own post-closure form. She noted that his cell location issues had been resolved, he had no thoughts of self-harm and was happy for ACCT monitoring to end.

144. A mental health nurse assessed Mr Nunes that afternoon after his mother raised concerns about him. Mr Nunes told her he was feeling low because he was tired of being in prison. He denied thoughts of suicide or self-harm but said that he had had a difficult day. The nurse reminded him that he could speak to any member of healthcare staff for support.

145. Mr Nunes failed to attend GP appointments with a prison GP on **29 December** and again on **5** and **12 January 2016**. No further follow-up appointments were arranged with a GP.

146. On **30 December**, Mr Nunes complained to a nurse that he had not received his lunchtime medication and that it was disgraceful. She explained that officers on the wing were unable to bring him down and that nurses were unable to take it to him. Mr Nunes became abusive and said his medication should be brought to him and that he would contact his lawyer. She gave Mr Nunes his medication.

147. On **31 December 2015**, Mr Nunes told a nurse that his fingers were sore and that he only needed to take his blood sugar levels twice a day but walked away when the nurse told him he needed to take them more regularly.

January 2016

148. On **1 January 2016**, a nurse noted that Mr Nunes still refused to check his blood sugar levels regularly or show staff his blood sugar diary. She suggested to Mr Nunes that he may want to administer his insulin himself again. On **3 January**, Mr Nunes verbally abused a nurse and said he would not test his blood sugar.

149. On **4 January**, a nurse noted that Mr Nunes did not receive his medication because he had not been brought to the medication hatch as requested and her attempts to contact the wing by telephone went unanswered. The following day, Mr Nunes told a nurse that he was unhappy that his blood sugar levels were being checked daily by healthcare staff.

150. On **4 January**, Mr Nunes was discussed at a CVOP meeting. It was agreed that they would ask Mr Nunes if he wanted to administer his insulin himself. Mr Nunes agreed to do so and the next day, he was given his medication in possession. A nurse reminded him of the importance of checking his blood sugar levels and reassured him that healthcare staff would visit him regularly.

151. On **8 January**, a nurse noted that Mr Nunes had not checked his blood sugar levels but had taken his insulin.

152. Between **8 January** and **12 February,** healthcare staff saw Mr Nunes regularly for diabetes reviews and made over twenty entries in his medical record about their contacts. They regularly found that he had failed to measure or record his blood sugar and ketone levels and when this happened, healthcare staff reminded him of the importance of him controlling his diabetes and of the need to keep a diary recording them. However, Mr Nunes continued to refuse to check his blood sugars and to keep a diary and was frequently abusive to staff when they checked on his welfare. During this time, healthcare staff made no changes to his healthcare management.

153. On **18 January**, an administrative co-ordinator for TfT, who worked remotely, noted that Mr Nunes had not attended his dental appointment. The reason was not recorded and there is no record that a follow-up appointment was made. Mr Nunes refused to attend an appointment at the Ophthalmic Clinic, University Hospital of Wales.

154. In a telephone call to a friend on **27 January,** Mr Nunes said he had the flu. In telephone calls on **29 January,** he complained to his mother and girlfriend that he had flu, was sick and told his mother he felt "rough". On **30 January,** he told his mother that although his blood sugars had been high, he had taken his insulin and was feeling better.

155. On **1 February**, Mr Nunes refused to attend his re-booked ophthalmology appointment. He told a nurse to "fuck off", that staff did not care about his health and that his eyesight was good.

156. On the morning of **2 February**, Mr Nunes was aggressive towards a nurse. He refused to show her his blood sugar diary and said that healthcare staff did not care about him. He asked why he should do what they say when they did not come to see him when he needed them.

157. A prison manager and a nurse held a SLP review later that morning. It was noted that Mr Nunes had said he was much better, was monitoring his blood sugars and that healthcare staff were monitoring him daily. A further review was scheduled for 4 April. That afternoon, the nurse discussed with Mr Nunes his lack of blood sugar recordings and noted he was aware of the danger to his life in not controlling his diabetes.

4 to 19 February 2016: dental issues

158. In a telephone call to Mr Nunes' mother on **4 February**, he told her he had toothache and that it was "killing" him.

159. On **5 February**, a nurse gave Mr Nunes painkillers after he complained of toothache. She noted that an urgent dental appointment had been booked for 8 February, although a dentist was working in the prison that day. Two other nurses gave Mr Nunes pain relief that day. He told his mother his toothache was "bad".

160. On **6 February,** Mr Nunes complained to his mother again about his toothache. A friend and fellow prisoner also spoke with Mr Nunes' mother that afternoon telling her that Mr Nunes' jaw was "bad" because of his toothache, that he was in pain, could not talk and that he was trying to get a dental appointment.

161. On **8 February**, a nurse reviewed Mr Nunes. The nurse noted that he was not keeping a blood sugar diary and his breath smelt of ketones but that he had said his blood sugar levels were fine. Mr Nunes complained of toothache, and she arranged for him to see the dentist as the side of his mouth looked swollen.

162. That morning, a prison dentist assessed the swelling to Mr Nunes' jaw. He noted in Mr Nunes' electronic medical record that due to the swelling Mr Nunes was unable to open his mouth wide enough to examine the affected area clearly or for an x-ray to be taken. He prescribed a seven-day course of amoxicillin, an antibiotic, to be taken every eight hours. He also gave him painkillers. He noted that Mr Nunes was taking insulin and made plans to see him again during a follow-up appointment the following week, 15 February, when the swelling and infection had cleared.

163. On **9 February,** Mr Nunes spoke to his mother about his toothache, told her he was in pain, that his face was swollen, he could not swallow properly or open his mouth. He told his mother the dentist had given him antibiotics, saying his tooth could not be taken out until his abscess and infection had cleared.

164. At around 2.00pm on **10 February**, a pharmacy technician noted that Mr Nunes had collected his antibiotic medication, two days after the dentist had prescribed the medication, and that he would hold them in his own possession. That afternoon, Mr Nunes told his mother by telephone that his toothache and his blood sugars were "alright".

165. On **12 February**, the pharmacy technician noted that Mr Nunes had been rude and aggressive when he collected his medication and refused to engage with her when she went to check on him.

166. On **15 February**, the administrative co-ordinator, working remotely, noted that Mr Nunes had not attended his dental appointment. Reasons were not recorded, his dental health was not followed up, and no further dental appointment was made.

167. In the early hours of **17 February**, Nurse A saw Mr Nunes after he complained of toothache and feeling sick. The nurse noted his ketone levels were medium and his blood sugar level was high. An on-call GP decided that no further action was required. The reasons for the decision were not recorded in the medical record.

168. At 8.35am, when Mr Nunes went to collect his medication, he complained to a mental health nurse of toothache and about the effectiveness of his antibiotics. Mr Nunes asked for further pain relief, but he walked off during the discussion with the nurse. Neither the prison GP or dental team were told about Mr Nunes' complaints and the nurse made no observations or recordings of Mr Nunes' vital signs and did not test his blood sugar or ketones levels.

169. On the evening of **18 February**, Mr Nunes told a nurse he was still struggling with his mouth and the nurse noted that his face was "clearly swollen". She gave Mr Nunes pain relief and said that she would hand over to the nursing night staff telling

them to get metronidazole (an antibiotic) from the patient group directions (PGD) cupboard and arrange for the dental team to review Mr Nunes. (PGDs allow specified healthcare professionals to supply and/or administer a medicine to a patient with an identified clinical condition without the need for a prescription or an instruction from a prescriber. The healthcare professional is responsible for assessing that the patient fits the criteria set out in the PGD.) Despite her handover, staff were unable to obtain the antibiotics as access to the medication cupboard was restricted to registered general nurses who were on the PGD list.

170. In the early hours of **Friday 19 February**, wing staff told a nurse that Mr Nunes was still waiting for his antibiotics. The nurse noted that the night nursing staff had not been told Mr Nunes needed to be given the antibiotics. The nurse consulted Nurse A, and they concluded that he could not give Mr Nunes his antibiotics as he was not qualified to prescribe it under the PGD. He went to see Mr Nunes and noted that his face was swollen and that he appeared in a lot of pain. He gave Mr Nunes pain relief and Nurse A booked a dental appointment for him later that day.

171. At 11.02am, a dental therapist assessed Mr Nunes. She noted in his SystmOne medical record that he was unable to open his mouth for examination due to swelling on the left-hand side of his face and that he was in pain. She noted that Mr Nunes had not been given the antibiotics he had been prescribed and that she needed to discuss the issue with the prison GP. (She was not qualified to prescribe the antibiotic.) She noted that the GP should possibly prescribe pain relief and antimicrobials to target the infection in Mr Nunes' mouth. She told Mr Nunes to tell wing staff if his mouth swelling worsened and she booked an appointment for him to see the dentist on Monday 22 February. She later noted in the medical record that a healthcare nurse should monitor the swelling on Mr Nunes' face. She made no further comments.

172. A dental nurse told a nurse that Mr Nunes had been prescribed antibiotics for his mouth abscess and that if there was no improvement the following day, he was to be sent to hospital. Mr Nunes was given pain relief. At 11.24am, a nurse dispensed metronidazole (an antibiotic) to Mr Nunes, 15 hours after it had been prescribed.

173. A prison manager said that during the day Mr Nunes' cellmate asked to move out of the cell as Mr Nunes had kept him up all night and he needed a good night's sleep

20 February: Mr Nunes' penultimate admission to hospital

174. At around 00.20am on **20 February**, Officer B told a nurse that Mr Nunes felt unwell. The nurse noted that his blood sugar and ketone levels were high, and he was at a considerable risk of DKA. She told a Custodial Manager (CM), the night manager, that Mr Nunes needed to be admitted to hospital. At around 1.50am, Officer B and Officer C escorted Mr Nunes to the POW Hospital in a taxi. Officer C said in a statement to the Coroner that because Mr Nunes' jaw was quite inflamed, he was more irritable than he had been during previous escorts to hospital. Officer B said the abscess was causing Mr Nunes pain. Mr Nunes arrived at hospital at around 1.55am and he was admitted at 2.10am. This was his fifteenth and penultimate admission to hospital.

175. At around 2.30am, an emergency department doctor assessed Mr Nunes. At inquest, he said that Mr Nunes, who was handcuffed to prison guards, was alert and orientated. He said there was no evidence that Mr Nunes had not been taking his diabetic medication, that he had checked his blood sugar levels, that there were no mental health issues and that all Mr Nunes' vital signs were within limits. He said Mr Nunes complained of toothache. The doctor said there was no obvious swelling or redness to Mr Nunes' face, but Mr Nunes had an abscess. Mr Nunes could open his mouth and did not object to him inspecting it. He noted that Mr Nunes had a very high sugar level and diagnosed him with borderline DKA and a localised infection in the mouth. He said there was no indication of sepsis or that Mr Nunes life was threatened.

176. Mr Nunes was moved to the hospital's resuscitation unit at 3.05am. He also received his previously prescribed antibiotic, which he had not taken earlier that evening.

177. Officer B said that at around 3.55am, Mr Nunes said he wanted to return to prison as the hospital was too noisy but that a nurse advised against this.

178. At around 4.00am, Mr Nunes was given co-codamol after he complained of toothache. At 4.20am, Officer B said Mr Nunes began to settle. The doctor said that at around 5.00am, he was asked to see Mr Nunes, who was still complaining of toothache. Mr Nunes was given a stronger painkiller. He said he told Mr Nunes that he should remain in hospital, and Mr Nunes agreed.

179. At around 5.40am, Mr Nunes again told staff that he wanted to leave the hospital and return to Parc. Officer B said that at around 6.15am, Mr Nunes became very agitated, shouting and swearing and saying he wanted to leave the hospital as he was tired. Officer B told Mr Nunes that a hospital doctor would first need to see him.

180. In his statement to the Coroner, the doctor said that at around 6.35am, he spoke to Mr Nunes, in front of officers, for around ten minutes. The doctor talked about the risks of Mr Nunes discharging himself, including that it might lead to being admitted to the hospital's intensive care unit, the possibility of long-term damage to his organs and that Mr Nunes might die.

181. Officer C said in a statement to the Coroner that he told Mr Nunes he was not well enough to discharge himself and that he should listen to the doctor. He said although he was not medically trained, he felt it was obvious that Mr Nunes should stay in hospital for treatment.

182. Officer B said in her statement to the Coroner that the doctor told Mr Nunes, "You are very ill, do you realise this illness can kill you?". The doctor noted in hospital records that Mr Nunes' condition was "life threatening". She said the doctor could not have been any plainer and she recalled him writing that Mr Nunes was aware his medical issues were life-threatening and that he was refusing treatment which may lead to death or a serious consequence, but that Mr Nunes would not listen. She told the inquest that Mr Nunes listened to the doctor with his arms crossed but was not really listening. She said none of them could make him stay in hospital. Officer C also said he heard the doctor tell Mr Nunes his condition was life-threatening.

183. In his statement to the Coroner, the doctor said he told the officers that if Mr Nunes had breathing difficulties, vomited, was unable to keep down fluids, became confused or drowsy or if he changed his mind, he should be sent back to the hospital immediately. He said he told Mr Nunes, in front of the officers, that if he was unable to control his sugar levels, he should report this to staff and return to hospital. He said he reiterated to the officers and Mr Nunes that, as his treatment was not completed, he may become unwell and would likely need to return to the emergency department.

184. At inquest, the doctor said that Mr Nunes presented with no evidence of someone with cognitive impairment or any mental health issues which could have compromised his decision to discharge himself and showed no signs of being under the influence of illicit substances.

185. At around 6.40am, Officer B said she contacted the control room to tell them that Mr Nunes was returning to Parc. She said she spoke to the CM A, the duty night manager, who she said was surprised to hear that Mr Nunes was returning. At 6.44am, Nurse A noted that the CM had told him that Mr Nunes was discharging himself from hospital.

186. Mr Nunes and the officers arrived back at Parc at 7.05am. Officer B said the hospital did not provide any discharge information.

187. Officer B told the inquest that when they arrived at Parc, Mr Nunes was taken to reception at 7.14am and was put in a holding cell. She said there had been a delay at the prison gate as there was no one in reception at the time to book Mr Nunes into the prison. She said that she spoke by telephone to CM A, the day operational manager, who was relieving another CM. (CM A no longer works at the prison.) Officer B said she asked him for someone to come to reception to book Mr Nunes back into the prison as she and Officer C did not know the process. She said Mr Nunes was “quite chirpy” and was walking around but his face was visibly swollen. Officer C said Mr Nunes was in pain and feeling ill but was talking and chatting.

188. CM A told the inquest that when he arrived at work that morning, he went to the gate to receive his handover from CM B. He said that CM B briefed him that Mr Nunes had discharged himself from hospital and was returning to prison. CM A did not see Mr Nunes but said that when Mr Nunes returned from hospital, he should have been booked in, seen by a nurse and taken to his wing if there were no issues.

189. Officer C told the inquest that he gave CM A a handover and told him that the hospital doctor had told Mr Nunes he should not discharge himself, that his condition was serious and life-threatening, and that Mr Nunes was not listening to what people were saying to him. He said Mr Nunes talked more about the abscess in his mouth, which he said you could see was swollen, than his diabetes.

190. Officer B told the inquest that she completed the escort paperwork while Mr Nunes was in hospital. She said that she wrote in the paperwork that Mr Nunes had discharged himself against medical advice and that the doctor had wanted him to stay as his condition was life-threatening. She said the paperwork was returned to the prison which she said she left in reception. She said the prison’s duty manager would have dealt with this.

191. Officer B told the inquest that she left reception to relieve the officer in safer custody who would be able to book Mr Nunes into Parc. She then left the prison at around 7.30am as her shift had ended at 7.00am.

192. Officer D, a reception and safer custody officer, said he was in safer custody when he was asked to go to reception to book Mr Nunes in. Officer C told the inquest he waited in reception until Officer D arrived.

193. At 7.37am, two officers took Mr Nunes to his cell. CM A said that at 7.45am, he made an entry in the prison ledger that Mr Nunes had been booked in and taken to his cell.

194. CCTV footage shows that an unidentified prisoner passed something under Mr Nunes' cell door at 8.16am. At 8.40am, Mr Nunes was unlocked for breakfast but did not leave his cell and, five minutes later, he appeared to have pushed the door closed. At 9.05am, after breakfast, an officer locked Mr Nunes in his cell.

195. At 10.33am, an unidentified officer spoke briefly to Mr Nunes before his cell was unlocked again at 10.50am. An unidentified prisoner went into the cell before leaving a minute later. At 11.30am and again at 12.20pm, CCTV footage shows unidentified officers briefly going into Mr Nunes' cell.

196. Nurse B told investigators that Mr Nunes did not collect his medication from the medication hatch that morning. She said she contacted the wing and was told that he was refusing to get out of bed. She said she spoke to healthcare colleagues, and they agreed that, as Mr Nunes already had a GP appointment arranged, his morning medication could be given to him then. At 4.37pm, she made a retrospective note in Mr Nunes' medical record that she had spoken to a female officer who told her that Mr Nunes' face was swollen and that he felt unwell. She told the officer that Mr Nunes had failed to attend a GP appointment that morning and she noted that the officer told her that Mr Nunes was unwilling to get out of bed. She said she had no further dealings with Mr Nunes as she had handed over the issue to her supervisor, Nurse C, the lead nurse in charge of healthcare that day.

197. Nurse C said that since starting her shift at 7.15am, no one had told her that Mr Nunes had been in hospital and that neither the reception nor escort officers had told her that Mr Nunes had returned to prison. She said she was aware that Mr Nunes needed to be seen about his dental issues at the weekend but was not aware of his emergency admission to hospital. As Mr Nunes had failed to attend his GP appointment that morning, she arranged for him to see a nurse at the nursing clinic that afternoon.

198. At 12.21pm, Mr Nunes left his cell for a shower and returned to his cell at around 12.30pm. Several unidentified prisoners visited Mr Nunes in his cell before it was locked at 12.52pm. Mr Nunes cell was unlocked again at 2.23pm and between then and 4.52pm, when he briefly left his cell to stand on the wing landing, two officers between them checked on Mr Nunes four times.

199. In a call to his mother at 4.30pm, Mr Nunes told her that his abscess was "killing him" and "fucking him up" and was "going to take him out." His cellmate later called Mr Nunes' mother and told her that Mr Nunes was "alright".

200. At 4.53pm, an unidentified prisoner took a tray of food to Mr Nunes. Five minutes later Mr Nunes put the food tray outside his cell before visiting the cells of two other prisoners on the wing. Mr Nunes returned to his own cell at 5.00pm, where another prisoner visited him. At 5.22pm, an officer completed a roll check before a further check was carried out at 7.50pm.

201. At 7.14pm, Nurse C noted in a retrospective entry in Mr Nunes' medical record that he had failed to turn up to his GP appointment and that she had been told that he did not attend his appointment with the nurse in the afternoon as he "could not be bothered again to come over". She said she telephoned Mr Nunes' wing and was told that he did not attend because he could not be bothered to get out of bed. She had re-booked for Mr Nunes to attend the nursing clinic the following afternoon, 21 February. She told the inquest that she did not go to the wing to follow up Mr Nunes' non-attendance and had not assessed or seen him during the day.

202. At 8.52pm, Officer B, the night patrol officer, carried out the evening roll check. She said that Mr Nunes did not ring his cell bell that evening or into the early hours of the following day.

Events of 21 February

203. At 2.54am on **21 February,** an unidentified officer passed something under Mr Nunes' cell door. (This is likely to have been an appointment slip for the nurse's clinic later that morning.)

204. At 5.32am, Officer B carried out the early morning roll count. She told the inquest she looked into the cell and saw Mr Nunes asleep in his bed. She said his cell light was on, but she was not concerned. At 7.09am, Officer E carried out the morning roll check but raised no concern about Mr Nunes.

205. At 8.40am, Officer F unlocked Mr Nunes' cell door, but did not look or go into the cell to complete a welfare check in line with local policy.

206. At 9.04am, Officer E was passing Mr Nunes' cell and checked on him because he knew of his recent ill health. In his statement, he said Mr Nunes was lying on his bed, that he had no clothes on and one of his legs was hanging out of the bed, touching the floor. He said that when he tried to talk to Mr Nunes, he made a groaning noise. The officer asked Mr Nunes if he was okay and saw that he had been incontinent of urine which he noticed was on both the bed and floor. He could not recall seeing any vomit on the cell floor. He radioed a medical emergency code blue, and an ambulance was called at 9.14am.

207. At 9.09am, an HCA arrived at the cell and found that Mr Nunes had vomited. She said vomit could be seen in his bin and on the cell floor, which she said was dark in colour and had started to dry up. She noticed that Mr Nunes was very lethargic and had also been incontinent of urine. She said that although he was unable to open his eyes, he responded, "I'm not well" and that he had been ill throughout the night. She told the investigator that she thought Mr Nunes had been that way for some time.

208. The HCA took Mr Nunes' basic observations and calculated his Glasgow Coma Score (GCS) as six. (The GCS records the conscious state of a person. A score of

eight or less indicates a serious injury.) Between 9.20am and 9.30am, the HCA measured Mr Nunes' GCS twice more and found that it had dropped to five. A nurse arrived and assisted her. The nurse checked Mr Nunes' blood sugar levels, which she said were too high to register, and gave him oxygen as his oxygen levels were low.

209. At 9.34am, paramedics arrived at Mr Nunes' cell and having stabilised him, they took him to the POW Hospital at 9.44am. Before leaving the prison, the paramedics asked for Mr Nunes not to be restrained and a prison manager authorised the decision. This was Mr Nunes' sixteenth and final admission to hospital.

210. Mr Nunes was diagnosed in hospital with severe DKA and aspiration pneumonia. He was moved to the hospital's intensive care unit and placed in an induced coma. Mr Nunes' condition deteriorated further, and he died later that evening at 10.45pm. His family were present when he died.

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