Investigation into the circumstances surrounding the death of a prisoner at HMP Swansea, who died in hospital, in June 2007

Report by the Prisons and Probation Ombudsman for England and Wales

October 2008

This is the report of an investigation into the circumstances of the death of a man at hospital in Swansea on 13 June 2007. He was 42 years old. The man had been admitted to the hospital 15 days earlier after collapsing in his cell at HMP Swansea. He had suffered from cirrhosis of the liver and was seriously ill when first received at Swansea in May 2007.

The man died as a result of multi-organ failure. I would like to extend my condolences to his parents, the other members of his family and all those touched by his death.

The investigation was led by one of my investigators. I must thank the management and staff at HMP Swansea for their assistance and co-operation during the course of his enquiries. I am also grateful to the Investigation Manager of Healthcare Inspectorate Wales, who conducted an independent review of the man's medical care in prison.

It is evident that, during his relatively short time at Swansea, the man medical care was efficient and, with one exception, well documented. Once he transferred to hospital, staff maintained regular contact and continued to respond positively and sympathetically to his needs.

Contrary to his wishes, the man's family was unwittingly informed of his whereabouts. Fortunately, this did not cause any acrimony and the family was amicably reunited and able to spend the last few days of the man's life with him.

I am disappointed that the prison did not offer a contribution towards the man's funeral expenses and one of my two recommendations addresses this point. I also identify an instance of good practice.

Stephen Shaw CBE
Prisons and Probation Ombudsman **October 2008**

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SUMMARY

1. The man died in June 2007 in hospital. He had been admitted to the hospital 15 days earlier after collapsing in his cell at Swansea prison.

2. Prior to his imprisonment, the man was already seriously ill with chronic liver disease. During his first health screen, it was recorded that he had cirrhosis of the liver, hepatitis C and B, asthma, chest pains and was very jaundiced. Nursing staff confirmed his medication with his GP practice and the surgery confirmed that he had chronic cirrhosis. The receiving nurse referred the man to see a doctor the following day and gave him diazepam to assist with his alcohol withdrawal. The man had no history of self-harm and was allocated to a shared cell in the Rehabilitation Unit of the induction wing. At his second reception health screen on 26 May he was found to be dependent on morphine sulphate (MST) pain reliever, and was also prescribed medication for withdrawal from alcohol and liver failure.

3. Just after 9.00am on Tuesday 29 May, the man collapsed on the floor of his cell. The attending nurse found him jaundiced, incoherent and in pain. She telephoned the duty doctor who arrived within three or four minutes and diagnosed acute liver failure. The man was then taken to hospital for urgent treatment.

4. Shortly after the man's admission to hospital, his family was inadvertently told of his whereabouts against his wishes. At that point, the man was in a coma so his escort was reduced and no restraints were used. Release on Temporary Licence was considered, but not approved. An accompanied release was therefore authorised and the escorting officers' presence was solely for support purposes.

5. The man remained in the High Dependency Unit until 5 June when he transferred to a ward where he received intravenous medication and continuous oxygen therapy. His general condition remained poor, and on 12 June the prison requested a written prognosis to support an application for his early release from prison. The man died of multi-organ failure at 8.40pm the following day, surrounded by his family. At the request of the man's family and with the agreement of the Coroner, no post mortem was performed.

6. I make two recommendations concerning the loss of a controlled drug prescription and the failure of the establishment to offer a contribution towards the man's funeral expenses. I am pleased that both recommendations have been accepted. In the case of the offer of assistance with funeral expenses belatedly acted upon after a further error was discovered following a letter to my office from the Swansea Coroner. I also identify as good practice the prompt actions of the nurse and Pharmacist who went to great lengths to obtain essential medication for the man. Both staff members have been commended by the Governor at Swansea.

THE INVESTIGATION PROCESS

7. My investigator visited HMP Swansea on 22 June 2007. He was given a full briefing about the circumstances surrounding the man's death. The liaison governor who was also Head of Security, was subsequently briefed by my investigator on later visits. My investigator also met representatives of the Prison Officers' Association and the Independent Monitoring Board.

8. Invitations were extended to staff and prisoners inviting anyone who might have information relating to the man to make themselves known to the investigator. No prisoners took up the invitation. The investigator met relevant prison staff, including members of the medical department. There was no police involvement in the man's death. One of my Family Liaison Officers wrote to the man's mother and spoke to the man's brother on 20 September.

9. Swansea prison provided copies of the man's prison and medical records. The Investigation Manager at the Healthcare Inspectorate Wales (HIW), conducted a clinical review.

HMP SWANSEA

10. HMP Swansea is a small category B local prison built in the Victorian era. It has an operational capacity of 425, holding adult males, both remanded and sentenced, in cellular accommodation.

11. Healthcare at Swansea is provided by the Swansea NHS Trust. Medical services are provided by a Primary Care Physician who visits daily and sees prisoners who have applied for an appointment. The clinical staff provide a day time service, and are all appropriately qualified. Sudden illnesses and treatments are managed by nursing staff.

EVENTS LEADING UP TO JUNE 2007

12. As noted above, the man was first received into prison at HMP Swansea in May 2007 after he was convicted and sentenced to four months imprisonment by the Magistrates' Court. A pre-sentence report dated May was written by a probation officer. The report said that the man was well known to the Probation Service and that he was frequently in hospital because of his alcohol misuse, although he was alcohol free when the report was written. The report also confirmed that in the recent past the man had suffered from liver failure for which he had received in-patient treatment. His prognosis was poor and a relapse into alcohol use held a real risk of him dying from liver failure. The report proposed that a suspended sentence order with a curfew requirement would be the best way to deal with the offences for which he was before the court.

13. The senior officer (SO) on duty on Friday 25 May, in the reception area at Swansea, was interviewed. He said that the man had arrived at around 4.00pm. He had known the man over several years and had spoken to him. He felt that the man seemed his normal self, but noted that his skin colouring was very yellow. He also noticed that he was more unkempt and thinner than he remembered him. The man told him that he had been living rough prior to his arrest and mentioned that he had a drink problem. The SO's memory was that the man had problems with alcohol in the past.

14. The man went through the normal reception procedures. At his initial reception interview he gave his mother as his next of kin. He also asked that his family not be informed that he was in prison.

15. The duty nurse at reception interviewed the man at about 4.30pm for his first health screen. During the interview the duty staff nurse recorded that the man told him that he was suffering from hepatitis C, which had been diagnosed in 1996, and that he had been a carrier of hepatitis B since 1983. He also recorded that the man had cirrhosis of the liver, asthma, chest pains and was allergic to penicillin. The duty staff nurse noted on the man's Continuous Clinical Record that he had raised concerns about his hepatitis C, that he was very jaundiced and that he had not taken any medication for the previous 24 hours. He also noted that the man was waiting to go into rehabilitation for his drink problems and that he had given the man 10mg of diazepam. The duty staff nurse listed the prescription drugs the man told him he was taking.

16. At 5.40pm, the duty staff nurse telephoned a registered nurse at the Swansea Healthcare Centre (HCC). He asked her to confirm with the man's doctor that the medication listed was correct and that nothing had been omitted. The HCC nurse did so and noted that the receptionist at the GP's surgery emphasised that the man was

extremely poorly with cirrhosis of the liver due to his alcohol abuse. There was no mention of asthma medication.

17. The duty staff nurse continued the health screen to determine whether any other medical condition existed. The man told him that he drank half a bottle of vodka daily and that in the last week he had drunk two bottles. He had not used drugs in the previous month. The man also told the duty staff nurse that he had no mental health problems or history of self-harm. However, his Prisoner Escort Record (PER) said that he had suffered from depression and "s/harm years ago". A urine test was conducted which showed a positive indication for benzodiazepine, a drug prescribed by his GP. As the man used alcohol to excess, the duty staff nurse put him on an immediate alcohol withdrawal regime of 10mg diazepam, the maximum he was allowed to give. He also referred the man to see a doctor the following day for an assessment of his physical health.

18. A cell sharing risk assessment was completed by the duty SO. This included the information given by the man that he had no history of self-harm. He was then allocated to the Induction Unit (F wing) where he was located in cell R3-02 in the Rehabilitation Unit with another prisoner.

19. The following day (26 May), the man attended a Reception Board which concluded that he should have no problems at Swansea, other than his medical conditions. Later that day, he attended his second reception health screen. He was noted to have a pulse of 112 (the clinical reviewer noted that this is higher than normal) and blood pressure of 133 over 89 (again higher than normal range, but not excessively so). On examination, the man was jaundiced, with a painful abdomen, and he said that he had cirrhosis. The man's mental condition was noted as being fully orientated and normal in appearance, mood and speech. His dependency on morphine sulphate (MST) pain reliever was recorded and the duty medical officer, prescribed the following medication:

    Thiamine 100mg daily - a vitamin B replacement for withdrawal from alcohol
    Vitamin B Compound strong twice a day
    Omeprazole 20mg daily - to treat stomach ulceration
    Spironolactone 100mg four times a day - to treat liver failure
    Frusemide 40mg daily - used to treat fluid retention
    diazepam 15mg twice a day
    MXL 90mg - a slow release morphine sulphate drug for pain relief

20. The medication prescribed was in line with that confirmed with the man's GP surgery by the HCC nurse on the previous evening. All except the MXL 90mg were prescribed for a period of 28 days. At about 10.30 -10.45am, the HCC nurse asked the off duty prison pharmacist, to attend the prison to dispense the drugs for a seriously ill

patient – the man who is the subject of this report. When she arrived at about 11.10am the prison pharmacist went to A wing Treatment Room. The duty medical officer gave her a prescription for the man and told her that all the items must be dispensed. The Prison Pharmacist then went to the prison pharmacy to check her stocks of drugs against the prescription and noted that the spironolactone, vitamin B compound and MXL 90mg were not in stock. She telephoned a local pharmacist with whom she has a support arrangement, but on this occasion he was unable to supply the shortfall. The prison pharmacist then telephoned a local pharmacy supply company, AAH Hospital Service, who delivered the medicines at about 12.15pm.

21. On delivery of the medicines, the prison pharmacist recorded the MXL 90mg, a morphine based "controlled" drug, in the Controlled Drugs Register. She then entered four MXL 90mg capsules onto the Controlled Drug log for use by the man. The other non-controlled drugs were entered by her on the man's Prescription and Administration Record Chart. She dispensed the drugs in accordance with the prescription. The spironolactone and vitamin B Compound were part dispensed on 26 May, the balance being dispensed on 29 May. Four MXL 90mg capsules were dispensed on 26 May to be given at a rate of one daily. At about 1.00pm, the duty staff nurse collected the four MXL 90mg capsules (for which he signed in the pharmacist's Controlled Drugs book) and took them away with him for storage in the D wing treatment room controlled drug cabinet. One MXL 90mg capsule was given to the man at 2.10pm on 26 May by the dispensing nurse, witnessed by the duty staff nurse.

22. The investigator requested and copied documents relating to the acquisition and issue of medication and the destruction of unused controlled drugs relating to the man. However, healthcare staff at Swansea were unable to produce the controlled drug prescription written by the duty medical officer on 26 May covering the man's use of MXL 90mg.

23. On 27 May, the man was given Imodium after reporting sick with a stomach upset. The HCC staff nurse also completed a nursing care plan, with the aim of assisting him to detoxify from alcohol safely and comfortably. At 11.30am, the man was given his prescribed medication which included the administration of MXL 90mg by the dispensing nurse, witnessed by the HCC nurse.

24. On 28 May, The HCC nurse's entry in the Daily Record of Nursing Care shows that the man's prescription medication was in place and that he was compliant with his regime. He was eating a little and was encouraged to drink plenty of water and tea. His medication regime appeared to be going well. At 11.45am, the dispensing nurse, again witnessed by the HCC nurse, gave him his prescribed medication which included the MXL 90mg.

25. Soon after 9.00am on the morning of Tuesday 29 May, a Registered mental nurse, was on F wing. The SO who was in charge of the wing, told her that he thought that the man was sitting on the floor of his cell and was unwell. The Registered mental nurse went immediately to cell R3.02. She found the man sitting on the floor and asked his cellmate to step outside. In interview, she said that his face was swollen. He was also jaundiced, mumbling, incoherent and in pain. He looked much worse than when she had seen him a few days before. She realised he was ill, so went to nearest telephone in D wing office and called the HCC. She told the healthcare officer (HCO), who was with the medical officer, that the doctor was needed in the Rehabilitation Unit immediately.

26. The Registered mental nurse went back to cell R3-02 and within three or four minutes the Medical Officer had joined her. She briefed the Doctor, re-iterating that the man looked considerably more jaundiced than when she had seen him two days earlier. The Doctor then took charge. The Medical Officer found the man lying awkwardly on the cell floor between the side of the lower bunk and a cabinet, complaining of pain whenever he was touched. She explained to the man who she was and he agreed to be examined by her in the cell. The registered mental nurse went to the treatment room on D wing to collect a sphygmomanometer (a device to measure blood pressure), a stethoscope and the emergency response bag. There was no stethoscope so she telephoned a staff Nurse and asked him to bring one from the Healthcare Centre. She then went back to the man's cell.

27. When she returned to the cell, the registered mental nurse helped the Medical Officer to lift the man onto the bed to make the examination easier and more thorough, but this caused him much distress. Before the staff nurse who was bringing the stethoscope arrived, the medical officer listened to the man's chest by putting her ear to it. She noted that he was breathless, markedly jaundiced and had bruises to his back and arms. The clinical reviewer comments that this might have indicated that his liver was not working because his blood was not clotting.

28. A short time later, the staff nurse joined the doctor and registered mental nurse in R3-02, bringing the stethoscope and a blood pressure machine. The medical officer found that the man's pulse was weak and his blood pressure could not be measured because of the difficulty in applying the blood pressure cuff. In view of the pain he was suffering, all further examination ceased. It was the medical officer's opinion that the man was suffering from acute liver failure and that required urgent hospital treatment. An emergency ambulance was called at 9.50am.

29. Given the location of the man's cell, the Registered mental nurse was uncertain whether the ambulance crew would be able to get the man on their trolley. She therefore went to the A wing treatment room to

collect a trolley on which to lay him. On returning to the cell, the Registered mental nurse comforted the man. He was barely lucid, but indicated that he was in pain. The charge nurse brought the man's medical record from the Healthcare Centre and the Registered mental nurse made some notes for the ambulance crew. These included that the man was alcohol dependent and hepatitis C positive.

30. The emergency ambulance arrived at 10.01am. According to the Registered mental nurse, very soon after the ambulance arrived the man seemed to pick up and become a little brighter. She allowed the ambulance crew to take the man's medication chart with them. The ambulance left Swansea prison for the local hospital Accident and Emergency Department (A&E) at 10.21am. After examination, the man was admitted to the hospital at 1.30pm.

31. All the necessary internal departments at Swansea were notified. The Prison Service Area Office and the police were also informed. An incident form was completed by the principal officer (PO). Later, the registered mental nurse went back to see the man's cellmate, who had been moved to another cell, to make sure he was alright. He appeared surprised but grateful that she had done so, and told her that the man had been collecting his food but had not eaten any of it.

32. A senior officer (SO) was the designated Family Liaison Officer (FLO). Soon after the man's departure from Swansea to hospital, he tried to contact the man's family, but was unable to find a telephone number. The Swansea security department then telephoned the police at 12.50pm asking them to notify the man's next of kin, his mother. They eventually contacted her at around 2.00pm. The escorting officer noted on the Hospital Watch Occurrence Log that at 2.00pm he had telephoned Swansea to inform the prison not to contact the man's next of kin.

33. At 2.30pm, the prison officer escort was reduced to one officer. Ten minutes later, at 2.40pm, the charge nurse in Swansea's Healthcare Centre gave the local hospital staff the telephone number for the man's next of kin. At 4.15pm, the man was moved to a ward (Coronary Care Unit) and at 9.20pm he was moved to the High Dependency Unit (HDU). At 1.00am on 30 May, the man's parents, brother and sister visited him, staying until 2.00am.

34. The man's daily progress report for 30 May shows that he was receiving large amounts of oxygen. His hospital risk assessment indicated that he was "currently in a coma" and was very seriously ill. It concludes that, because of his condition, the hospital escort was now an 'escorted absence' and no restraints were necessary. Release on Temporary Licence (ROTL) was considered but not approved. Instead, an accompanied release was authorised and the escorting officers' presence was for support purposes rather than supervision. The risk assessment was authorised by the Head of Security. An unsigned

note indicates that a telephone call was made to the man's mother at 11.40am on 30 May to update her on his condition.

35. On 31 May, it was noted in the man's clinical record that he remained in the HDU and was receiving 100 per cent oxygen. His condition was stable but still critical and he now had a chest infection. A note in the record dated 1 June at 8.35am indicates that he was suffering from pneumonia. At 1.30pm that day, the man's parents, aunt and uncle visited him at the local hospital. At 3.40pm, the man's father received his property from a PO who was at the hospital and the visit finished at 4.00pm.

36. The single remaining MXL 90mg capsule issued for use by the man was returned for destruction to the prison pharmacist, on 31 May by the HCC Nurse . It was destroyed on that day by the prison pharmacist, witnessed by the HCC nurse.

37. The HCC nurse and an accompanying SO visited the man on 3 June. The HCC nurse reported that he was still in the HDU, his level of consciousness had improved and there was a slight improvement in his condition. The man asked for squash or lemonade. The HCC nurse was unable to provide this at the time, but promised to discuss the request with the duty governor on her return to Swansea. She did so and the requested items were supplied from the prison canteen. At the man's request, she also contacted his parents to inform them of his condition.

38. On 5 June, it was noted in the man's daily progress report that he had been transferred to Ward 10, where he was receiving intravenous medication and continuous oxygen therapy. He was visited by the charge nurse and the liaison governor, who gave him £4.35 in cash to buy items while in hospital. The charge nurse recorded that the man was rousable, but very weak and his general condition remained poor.

39. At 12.30pm on 6 June, the man's mother, sister and brother-in-law visited until 1.45pm. The man's hospital risk assessment, authorised by Swansea's deputy governor, indicated that he was "very weak and in a critical condition" and was unable to get out of bed. It was reiterated that the escorting officers' presence was for support only. On 9 June, there was no change in the man's condition. His aunt and cousin visited. His aunt telephoned on 11 June to tell the man that she would visit again during the following weekend.

40. On 12 June, the Head of Healthcare spoke to the Consultant's secretary at the hospital, requesting written confirmation of the man's prognosis with a view to Swansea applying for his early release from prison.

41. On 13 June, the man's family visited at 2.05pm. During this time, an additional SO paid a management visit. He wrote on the management

visit form that the man was in a pitiful condition and that he was being comforted by his mother and aunt. At 8.40pm on the evening of 13 June, the man died with his family around him. A doctor based at the hospital certified his death from multi-organ failure at 8.50pm.

ACTIONS AFTER THE MAN'S DEATH

42. The accompanying officer informed the orderly officer of the man's death. He also extended condolences to the man's family and ensured that they had the appropriate contact details for the prison, including those of the chaplain. The family then left the hospital and returned to Northampton. The accompanying officer thanked the hospital staff for their help and left at 9.45pm. The orderly officer initiated the prison's contingency plan for responding to a death in custody. All necessary Prison Service staff were informed and the man's prison and medical records were secured.

43. At 2.20pm on 14 June, the Family Liaison Officer, telephoned the man's mother. He spoke to her son and gave his condolences. He also inquired about disposal of the man's remaining property at Swansea and was asked to return it by post, which he did. The Family Liaison Officer gave the son of the man's mother his details but the family chose to make no further contact. At the request of his family and with the agreement of the Coroner, no post mortem examination was carried out on the man.

44. The Acting Governor sent a letter of condolence to the man's parents on 18 June, in which he invited contact with the Family Liaison Officer should they wish to do so. No offer of assistance with funeral expenses was made either in that letter or at any other time.

ISSUES CONSIDERED DURING THE INVESTIGATION

Medical care

45. The man was seriously ill with chronic liver disease when he arrived at HMP Swansea in May 2007. The probation officer who prepared his pre-sentence report for the court was aware of this and had included it in what he wrote.

46. The clinical review carried out by a doctor from the Healthcare Inspectorate was based on the man's prison medical record, hospital bed watch logs and statements from prison staff. It included an assessment of the care provided for the man by staff at Swansea after his reception, as well as their subsequent contacts with him and the local hospital until his death on 13 June.

47. The clinical reviewer reported that the Swansea healthcare nursing staff correctly contacted the man's GP surgery on 25 May to find out what medication he had been prescribed so that they could administer the correct dosages.

48. The man was seen by the duty medical officer on 26 May. The medical officer prescribed appropriate medication for the conditions with which the man presented and in line with medication given by his GP prior to his detention at Swansea. The nurse on duty was so concerned about the seriousness of the man's condition, coupled with the fact that it was a Bank Holiday weekend, that she called in the Swansea pharmacist from home to dispense the prescriptions. These included a Controlled Drug Prescription for MXL 90mg, a morphine based drug. The pharmacist made strenuous efforts to acquire sufficient drugs to enable the man's medication to proceed without hindrance until after the extended weekend. All the documentation supporting the acquisition and administration of the drugs is correct as is the recording of the destruction of prescribed but unused drugs. However, the Controlled Drug Prescription written by the doctor on 26 May could not be found at Swansea.

    The Governor and Swansea Local Health Board should review the arrangements at Swansea for the safe retention of healthcare documents.

49. A nursing care plan was completed on 27 May to assist the man to detoxify from alcohol. This regime appeared to be going well until his collapse on 29 May. He was seen immediately by the prison doctor who made a working diagnosis of acute liver failure and sent him to hospital. In her report the clinical reviewer said that medical staff had acted promptly in sending the man to hospital following the collapse. Prison nursing staff then maintained contact with the hospital to monitor his progress. She described this as good practice.

50. The clinical reviewer judged that the quality of the entries in the medical and nursing notes was very high. They had been timed, dated and signed legibly, as recommended in the professional standards for record keeping. Prescriptions had been clearly written. Hospital bedwatch logs were completed correctly by the accompanying officers and, from the information within those logs, the clinical reviewer identified no problems with secondary healthcare.

Escort and early release arrangements

51. On 29 May, the man had been assessed and confirmed as a category D prisoner (the lowest security category). He had been provisionally allocated to HMP Prescoed, an open prison.

52. When the man was transferred to hospital, his condition was serious and his prognosis poor. He was escorted at the local hospital by the normal complement of two prison officers who took with them the standard security equipment, including handcuffs. In light of the man's poor prognosis and his security category, the escort was subsequently reduced to one officer.

53. The man remained very seriously ill. The prison therefore reduced the hospital escort to an escorted absence without restraints. Release on Temporary Licence (ROTL) was considered, but not approved. Instead, an accompanied release was authorised by the Head of Security. The accompanying officers' presence was for support purposes only. This position was reiterated on 6 June by the deputy governor.

    I commend the Head of Security for authorising the accompanied release which afforded the man a greater degree of dignity at the end of his life.

54. On 12 June the Head of Healthcare, asked the secretary of the man's Consultant for written confirmation of the man's prognosis, with a view to submitting an application for his early release from prison under the provisions of section 10(1) of the Crime (Sentences) Act 1997:

    > "10(1) The Secretary of State may at any time release a prisoner if he is satisfied that exceptional circumstances exist which justify the prisoner's release on compassionate grounds."

55. It is evident that Swansea took into account all the circumstances surrounding the man's situation. They took appropriate steps to ensure that he was properly escorted, as well as initiating the procedure for early release. Unfortunately, the man died before the application could be made.

Next of kin issues

56. The man had asked, on reception, that his whereabouts be kept from his family. This request was noted. The Family Liaison Officer at Swansea, knew of the man's poor prognosis but had been unaware that he had asked for his next of kin not to be told of his whereabouts. He made attempts to contact the man's mother without success, before passing the matter to the prison security department. An SO telephoned the Police and sent a fax asking them to contact the family. The man's mother was informed by police at 2.00pm. Coincidentally, at the same time a message was passed from the man's escorting officer to the prison telling them not to contact his next of kin. Very early on the morning of 30 May, the man's mother, father, brother and sister visited him in hospital.

57. Under most circumstances, the wishes of the prisoner in respect of his family must take precedence and be respected. However, in this case, an unwitting mistake by the FLO set in motion the process that led to the man's family being informed and attending the hospital. Following that first visit, it is evident that the man and his family were in regular contact until his death two weeks later, something that appeared to benefit them all.

58. Given that this information was divulged as a result of a genuine mistake rather than a deliberate contravention of policy, and that the contact clearly benefited both the man and his family, I have made no recommendation on this point. The staff at Swansea appear to be aware that it is mandatory to respect the wishes of prisoners with regard to their next of kin.

59. Paragraph 4.2 of PSO 2710 advises that, following a death in custody, prisons must send a letter of condolence to the family containing an invitation to them to visit the establishment. It also requires that an offer to help with reasonable funeral expenses be made. Although a letter of condolence was sent, some elements required by PSO 2710 were not included. The investigator found no evidence that an offer to assist with funeral expenses was made.

The Governor should ensure that the requirements of PSO 2710 are fully met and that assistance with funeral expenses is offered. A retrospective offer should also be made to the man's family.

Family issues

60. On 20 September 2007, my Family Liaison Officer had a telephone conversation with the man's brother in which he expressed some concerns about a conversation between his mother and a doctor at the local hospital.

61. The doctor had told his mother that the man already had morphine in his system and that they could not give him any more. The family was confused because they thought that morphine could not have been

prescribed in prison. The man's brother said that the family was aware that toxicological tests could reveal whether this was the case or not. However, no post mortem examination took place and as a result no toxicological samples were taken from the man. The clinical reviewer has confirmed that morphine and other 'controlled' drugs can be prescribed if a prisoner needs them. The investigation found that morphine was prescribed to the man on 26 May by the duty medical officer. The prescription itself has since been lost but supporting documentation indicates that it had been properly administered.

62. The mans' brother also said that the hospital had wanted to establish the trigger for the man's rapid deterioration. The clinical reviewer commented:

> "The hospital staff would try to establish a trigger for the man's relapse, by performing various tests - on his blood, for example. Reasons for a relapse are many and could be an infection, sedation or a bleed from the stomach. For this reason, since the man had had morphine in HMP Swansea, the hospital would be unable to give the man morphine-based pain relief, until they were aware of the cause of his relapse."

63. No cause for the man's deterioration has been established.

CONCLUSION

64. Since 1990, the man had served a number of short prison sentences, several of which had been at Swansea. All his offences were related directly to his misuse of alcohol. Eventually, this led to serious health problems of which the court was aware when he was sentenced to imprisonment on 25 May.

65. On the man's arrival at Swansea, his medical conditions were noted and confirmation of his medication was obtained from his GP. He was assessed by a prison doctor on the following day. Appropriate medication was prescribed and an off duty prison pharmacist was brought in to dispense the medicines.

I commend the HCC Nurse and the prison pharmacist who acted promptly to obtain sufficient medication for the man.

66. The man's medical regime progressed smoothly. The clinical reviewer pointed out a number of instances of good practice at Swansea. These include confirming medication with the patient's GP, the prison maintaining regular contact with the hospital and supplying the hospital with the telephone contact details for the man's next of kin (albeit that in this instance next of kin contact had been invoked in error). The clinical reviewer also noted that the quality of the entries in the medical and nursing notes was very high. Entries were timed, dated and signed legibly, and prescriptions were clearly written, as recommended in guidelines. I agree with her assessment. However, the Controlled Drug Prescription written by the prison's medical officer is not now available having been mislaid. All other relevant healthcare documentation supports the actions taken by healthcare staff in the administration of the man's medication.

67. For the brief period that the man was at HMP Swansea, his treatment for his pre existing condition was appropriate and timely. When he became so ill as to require transfer to hospital, this was undertaken quickly. After he was sent to hospital, the contact between the local hospital and healthcare staff at Swansea was such that the man's condition and needs were monitored by Swansea and acted upon, sympathetically and promptly.

68. The arrangements for escorting the man were appropriate and proportionate when he was first admitted to hospital. Thereafter, the escort was reviewed and reduced in line with the prevailing situation. It was commendable that the accompanying officer was eventually present solely for support purposes. It is clear that the officers who accompanied the man at the hospital acted in a discreet and humane manner with him and his family.

69. The man's request that his family was not to be informed of his whereabouts were not adhered to. As he was unaware of the man's

wish, the FLO began a process that led to his family being informed and attending the hospital. Following that first visit, the man's family visited several times and they were in regular contact with him throughout his time in hospital. They were also with him at his death. Although a mistake had been made in informing the man's next of kin of his illness, the outcome was a positive one for him and his family.

70. Some oversights were made in the letter of condolence sent on 18 June as it seems that the prison made no offer of a contribution towards funeral expenses. This should be remedied retrospectively.

RECOMMENDATIONS

The Governor and Local Health Board should review the arrangements for the safe retention of healthcare documents.

This recommendation has been accepted by HMP Swansea who responded in an Action Plan dated 13 June 2008 that:

> "All medical documents to be retained in a safe environment – these documents must be available for future access."

The Action Plan target date identifies that this action has been completed.

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The Governor should ensure that the requirements of PSO 2710 are fully met and that assistance with funeral expenses is offered. A retrospective offer should also be made to the man's family.

This recommendation has been accepted by HMP Swansea who responded in an Action Plan dated 13 June 2008 that:

> "Death in custody contingency plan to be followed in any future event."

The Action Plan target date identifies that this action is an ongoing item

> "Head of finance to ensure retrospective offer is made to the family of the man"

The Action Plan target date identifies that this action has been completed. Following the receipt of a letter from HM Coroner in Swansea dated 18 August my investigator made enquiries at Swansea prison revealing that no retrospective offer had been made. The Deputy Governor at Swansea investigated and established that an error had been made. On 27 August an offer of assistance with funeral expenses was made to the man's family by the Swansea Family Liaison Senior Officer.

GOOD PRACTICE

I commend the Head of Security for authorising the accompanied release which afforded the man a greater degree of dignity at the end of his life.

I commend the HCC Nurse and the prison pharmacist who acted promptly to obtain sufficient medication for the man.

The Governor at Swansea also commended these members of his staff.