PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at a hospital in November 2012 while in the custody of HMP Cardiff

Our Vision

'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'

This is the report of an investigation into the death of a prisoner at HMP Cardiff in November 2012. He died of pneumonia in hospital. He was 68 years old. I offer my condolences to his family and friends.

The investigation was carried out by one of my colleagues. Healthcare Inspectorate Wales (HIW) conducted a review of the deceased's clinical care in custody.

The man suffered from both Alzheimer's and Parkinson's diseases. In October 2012, he was admitted to hospital for mental health treatment. He responded badly to his medication, became aggressive and hit nurses. At a care planning meeting on 31 October, it was decided that the man had capacity to be questioned by police about assaulting nurses in hospital. The next day, he was charged with assault and remanded to custody.

The deceased was a frail man who used a wheelchair and found it hard to communicate. When he was remanded to HMP Cardiff on 1 November, he was held in the healthcare centre for observation. He had a lot of support for his mental health and healthcare staff tried to find him a suitable hospital placement. However, insufficient attention was paid to his physical health until his condition had deteriorated so much that he needed admission to hospital.

The clinical review concludes that the clinical care the deceased received at Cardiff fell below that he could have expected to receive in the community. It is of particular concern that, in the weeks that the deceased was at Cardiff, his physical health was not assessed by a doctor. We agree with the clinical reviewer that, had the man been appropriately examined, an earlier diagnosis of pneumonia could have been made and the outcome might have been different.

It is hard not to be shocked that a man in the deceased's condition should end up in prison. I therefore recommend that the Governor of Cardiff prison draws the deceased's case to the attention of the various agencies that dealt with him, including the police, health and social services, to help ensure more suitable arrangements than prison can be found for such men in future.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **November 2013**

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SUMMARY

1. On 6 February 2012, the deceased was charged with assaulting nurses and remanded to HMP Cardiff until 18 February, when he was released after receiving a conditional discharge from court. He then lived in a nursing home for seven months, until he was admitted to hospital for mental health treatment. He became aggressive during his time in hospital and allegedly assaulted nurses. At a care planning meeting on 31 October, the nursing home said that they could not accommodate the man because of his aggressive behaviour. It was agreed that he had the capacity to be questioned by police about assaulting nurses in hospital. He was charged with assault and remanded to HMP Cardiff, charged with assault.

2. At his initial health screen, it was noted that the man suffered from Alzheimer's and Parkinson's disease. He found it hard to communicate and used a wheelchair and Zimmer frame. There is no record of his basic medical observations being taken. He did not have a secondary health screen.

3. The man was accommodated in the healthcare centre so the staff could assess his mental health and help him to wash and dress. Nurses saw him several times a day and his mental health was reviewed. Psychiatrists considered that the man's needs could not be met in prison and agreed that he should be transferred him to a secure hospital or specialist unit. However, he was admitted to hospital, physically ill, before this was arranged.

4. On 9 November, at 6.14pm, two nurses went to help the man get ready for bed and were worried that he looked particularly unwell. His blood pressure was low and his heart rate was going up. He was helped into bed and given a drink. When a nurse checked him at 8.19pm, his breathing was laboured, so the nurse gave him oxygen and referred him to the doctor who examined him 10 minutes later. The doctor thought the man had pneumonia and needed to go to hospital. The doctor requested an emergency ambulance at 8.37pm, but paramedics did not arrive until 9.32pm. He was taken to hospital at about 10.30pm.

5. The man was admitted to hospital, given intravenous antibiotics and fluids to treat pneumonia and blood poisoning (or sepsis). Although he initially seemed to respond to treatment, his condition deteriorated very quickly and he died at 2.06am on 17 November.

6. The clinical review concludes that the care the deceased received at HMP Cardiff was below the standard he could have expected to receive in the community. It is concerning that doctors only reviewed his mental health and the man was not physically examined by a doctor until his condition significantly deteriorated, just before he was admitted to hospital with pneumonia.

THE INVESTIGATION PROCESS

7. The Ombudsman was notified of the deceased's death on 17 November 2012. Notices were issued to staff and prisoners at HMP Cardiff informing them of the investigation process and asking anyone with relevant information to contact the PPO. No responses were received.

8. HM Coroner for Cardiff and Vale of Glamorgan District was informed of the investigation. A copy of the investigation report has been sent to the Coroner to assist her enquiries.

9. The Healthcare Inspectorate Wales (HIW) conducted a review of the deceased's clinical care and was given copies of his medical records. The clinical review was received on 6 March 2013.

10. The deceased's prison records were received by the PPO and interviews with healthcare staff carried out in January and February 2013. Some of the interviews were conducted jointly with the clinical reviewer. Written feedback to the Governor about the initial findings was provided.

11. One of the Ombudsman's family liaison officers (FLO) contacted the man's brother and explained the purpose and scope of the investigation. His brother had the following questions:

    - Where was his brother just before he was taken into custody in November?
    - When did his brother contract pneumonia, when was it diagnosed and how was it treated?

    The deceased's brother saw this investigation report in draft and had the opportunity to comment on its factual accuracy.

HMP CARDIFF

12. HMP Cardiff is a local prison, predominantly serving the Welsh courts and the South West of England. It holds around 800 adult convicted and remand prisoners.

13. The local health board commissions health services, but all nurses and other healthcare staff are employed by the Prison Service. The general practitioner (GP) service is delivered by the local health board, which also employs a consultant psychiatrist for seven sessions a week. A 22-bed inpatient facility in the healthcare centre provides 24-hour nursing and medical cover. A mental health in-reach team provides both primary and secondary mental health services.

Her Majesty's Inspectorate of Prisons

14. The Inspectorate carried out an unannounced short follow-up inspection of Cardiff in June 2010. About healthcare, the report noted that inpatients with acute needs had no access to day care or activity. Primary mental health provision was fragile with no designated staffing, but the mental health in-reach team provided a good service to the small number of prisoners on their caseload. The inspectors noted that a recommendation from a previous inspection in 2008, that secondary health screening should be mandatory unless specifically refused, had not been achieved. Although they were told it was offered, there were no designated clinics for secondary screening and the section in the reception screening template had not been completed in the records they reviewed.

Independent Monitoring Board (IMB)

15. Each prison in England and Wales has an Independent Monitoring Board of unpaid volunteers from the local community who monitor standards to help ensure prisoners are treated fairly and decently. In its most recent annual report, the IMB reported that healthcare had improved significantly as a result of a management restructure. Primary care services had benefited from more staff and an adjusted GP rota, although mental health services were still under strain. The IMB noted that it consistently reported on the stresses placed on the Prison Service by the use of custody for offenders with mental health problems and questioned whether any alternatives were being explored.

Previous deaths at Cardiff

16. In the two years before the man's death, there were three other deaths from natural causes at Cardiff. In this report we have commented on the need for all prisoners to be examined appropriately in the reception health screen and to ensure that secondary health screens take place. It is concerning that this is a recurring issue, which has been identified in previous investigation reports and by the Inspectorate.

KEY EVENTS

February 2012

17. On 6 February 2012, the deceased was charged with assaulting nurses at a psychiatric hospital and remanded to HMP Cardiff. It was his first time in prison. In reception, the nurse noted in the man's clinical record that he suffered from Alzheimer's and Parkinson's disease and found it hard to communicate. He struggled to walk and used a wheelchair. He had been an inpatient at a psychiatric hospital since April 2011. The nurse referred the man to the doctor for a review of his physical health and his medications. He was accommodated in the healthcare centre.

18. The man had a secondary health screen on 7 February with another nurse. His weight was recorded as 75 kilograms (kg) and his blood pressure was within the normal range[1], at 109/75. He knew he was in prison, but could not remember the day or the month. He was referred to the doctor for a full physical assessment.

19. On 8 February, the doctor assessed the man and noted that he was in poor health. The doctor did not think that prison was an appropriate place for him and discussed this with the mental health in-reach team. The doctor advised contacting the hospital to discuss transferring the man back into their care. There is no evidence of such a discussion in the deceased's clinical record. On 18 February, the man went to court. He was given a conditional discharge[2] and released from custody. He went to live in a nursing home.

Remand to custody

20. In October 2012, the man was admitted to hospital for mental health treatment, but responded badly to his medication and allegedly assaulted nurses several times. At a care planning meeting on 31 October, the nursing home said that they could no longer meet his needs if he was discharged from hospital because of his aggression. At that meeting, it was agreed that the man had capacity to be interviewed by the police about the alleged assaults. He was charged with assault and, on 1 November, he was remanded into custody.

November 2012

21. In reception at HMP Cardiff, a nurse listed the man's current medications; testogel[3], clozapine[4] and co-careldopa[5]. She noted in his clinical record that he had poor communication and eye contact. He needed assistance with his personal care, such as washing and dressing, and was accommodated in the healthcare centre. The nurse referred the man to the doctor for both his physical and mental health to be reviewed. There is no record of his weight or blood pressure being taken or that he saw a doctor for a further health screen. A

[1] An "ideal" blood pressure reading is between 90/60 and 120/80.
[2] The offender is released and the offence registered on their criminal record. No further action is taken unless they commit a further offence within a time decided by the court.
[3] A gel that contains the male hormone testosterone. It is used as testosterone replacement for men with low levels of the hormone which can cause impotence, infertility, decreased mental and physical activity, fatigue and weakening of bones.
[4] Anti-psychotic medication.
[5] Medication used to treat Parkinson's disease.

healthcare assistant noted that the man remembered some of the staff in healthcare and could remember being in prison earlier in the year.

22. On 2 November a psychiatrist discussed the man's medication with the pharmacist. The psychiatrist noted that the man was taking clozapine, but advised for it to be stopped as it had caused his blood pressure to drop while he had been in hospital. The psychiatrist did not see the deceased but noted that he would review him in a week's time.

23. On 4 November, the nurse recorded that she had looked after the man when she was a nurse at hospital. She suggested contacting a doctor at the hospital for a report, if staff needed more information. The deceased had been known to the mental health services for over 30 years and, when he had last been at this hospital, he had apparently been diagnosed with a personality disorder caused by Parkinson's disease.

24. Later that day, the man wet himself. As healthcare staff tried to wash and dress him, he tried to hit them. He was given an adapted hospital bed because staff were worried about him falling out of a standard bed.

25. On 5 November, another nurse saw the man in his cell and helped him with his care needs. This nurse recorded his blood pressure as 143/98. He recorded no other observations. The nurse said that this was slightly high, but he was not concerned as the man had no symptoms and, if he had had concerns, he would have spoken to a senior nurse or doctor. He said that he did not know his "normal" blood pressure reading to be able to compare, because it had not been taken until that point.

26. A doctor from a local community mental health unit saw the man on the same day and described him as non-communicative, but she did not think he had any form of psychosis. This doctor discussed the deceased with the psychiatrist and explained that she had not been able to assess his needs properly. The doctors agreed that the man should stay in the healthcare centre for further observation and assessment.

27. The man needed encouragement to eat and drink. Staff kept diet and fluid charts to monitor what he was eating and drinking every day. On 6 November, a nurse weighed the man, who was 65kg. He had lost 10kg (nearly one and a half stone) in about eight months. The nurse noted that the doctor had prescribed supplement drinks[6] and nurses should continue to monitor his dietary intake. There is no record that he was examined, referred to the doctor, or that his weight loss was investigated.

28. On 7 November, a senior healthcare officer noted that the man had been lethargic throughout the day and had been unable to feed himself. The senior healthcare officer thought the man's care needed urgent review. He did not think prison was an appropriate environment for him, because of his mental health and social care needs. The senior healthcare officer explained that the man would have "good and bad days" and on some days needed more help than others.

[6] High calorie drinks used to help increase a patient's weight

29. On 9 November, a consultant psychiatrist from another community mental health facility assessed the man. The consultant psychiatrist said that the man sat in his wheelchair with his head bowed and no facial expression. He did not reply to any questions, except to nod his head. He was able to communicate that he was hearing voices, did not feel safe and could not eat. The consultant psychiatrist prescribed quetiapine (an antipsychotic drug) and referred the man for a specialist neurological review. The consultant psychiatrist suggested that the man needed admission to a psychiatric intensive care unit.

30. After the consultant psychiatrist's visit, the psychiatrist went to the hospital that day to discuss the deceased's possible admission, but it was agreed that he would need a more specialist unit. The psychiatrist said that funding was an issue so further discussions were needed before a transfer could be arranged.

31. At 6.14pm, a nurse and the senior healthcare officer went to help the man get ready for bed. The nurse said that he was noticeably more frail. His blood pressure was quite low, at 103/75, and his heart rate was increasing. The nurses helped him into bed and gave him a drink to help keep him hydrated.

32. At 8.19pm that evening, the nurse went to check on the man. The nurse gave him oxygen, which helped his laboured breathing and took his blood pressure (105/77). The nurse said that he was concerned about the deceased, so telephoned the on-call doctor. It took the on-call doctor ten minutes to get to the prison from her home. She examined the man at 8.30pm. The on-call doctor listened to his chest, took his blood pressure (150/70) and checked his temperature. She was told that his health had deteriorated over the past day or two, he was less responsive and had rapid, shallow breathing. She thought he had pneumonia and he needed to go to hospital.

33. The on-call doctor telephoned the urgent admissions unit at the local hospital to let them know that a patient was being sent in and asked for an emergency ambulance, which was requested at 8.37pm. The on-call doctor stayed with the man while they waited for the paramedics and telephoned the ambulance service a couple of times to see where they were. The first paramedics arrived in a response vehicle an hour later at 9.32pm. They did clinical observations while they waited for the ambulance to arrive. An ambulance arrived at 10.20pm and took the man to hospital ten minutes later.

34. As part of the duty to protect the public, prisons make judgements about the level of security needed when prisoners are taken out of the prison for any reason. An individual risk assessment should be completed on each occasion. Although the escort risk assessment initially recommended the use of an escort, the duty governor authorised that the man should be taken to hospital without handcuffs and he remained unrestrained at hospital.

35. When the man arrived at hospital, he was given intravenous antibiotics and fluids. On 10 November, his condition seemed to improve, but he needed to stay in hospital for a day or two. A family liaison officer was appointed and rang the man's brother to tell him that he was in hospital.

36. On 11 November, the man's condition deteriorated. He was being treated for pneumonia and blood poisoning (sepsis). The hospital called his brother to

suggest a visit. Hospital staff decided that resuscitation would not be appropriate should his condition deteriorate further. The man remained critical but stable.

37. On 16 November, he was still critically ill, but blood test results showed an improvement, and his prognosis was apparently good. However, his condition then deteriorated quickly and he died at 2.06am on 17 November.

Support for prisoners

38. The Governor issued a notice announcing his death, and expressing his condolences. The notice told prisoners of the support available from officers, the chaplaincy and Listeners (prisoners trained by the Samaritans to provide confidential support for other prisoners).

Support for staff

39. The Head of Reducing Offending held a hot debrief to support the officers who had been with the deceased when he died. The officers were offered the support of the staff care team.

Family liaison

40. The hospital tried to telephone the deceased's brother that night, but there was no answer. The prison called the family liaison officer at 2.45am, and told her that the man had died and the hospital had not been able to reach his brother by telephone. The family liaison officer decided that she would wait until the morning to make contact. The deceased's brother called the family liaison officer at 8.00am the next morning because he had been called by the hospital to inform him that his brother had died. The family liaison officer explained the inquest process and what would happen next. The prison offered reasonable funeral expenses, in line with national guidance.

ISSUES

Clinical care

Health screening

41. Prison Service Instruction (PSI) 74/2011[7], early days in custody, instructs that *"all incoming prisoners must be medically examined by a qualified member of the healthcare team"*. When the man arrived at Cardiff on 1 November, he was seen by a nurse for an initial health screen. The nurse listed his medications and that he would need assistance with his care needs, but there is no record that his blood pressure was taken or that he was weighed. Because of his physical and mental health needs the nurse referred him to the doctor. This was in line with Prison Service Order 3050 on continuity of healthcare, which indicates that the purpose of the initial assessment is to "identify any existing problems and to plan any subsequent care'. The PSO also requires that, in the week following reception, "every prisoner must be offered a general health assessment."

42. There is no evidence that the man had a secondary health screen or was examined by a doctor for his physical health problems until the day he was sent to hospital on 9 November. It is of concern that this is an issue which has been commented on in previous investigation reports and is also an issue which HMIP were concerned about in their latest inspection report.

    The Head of Healthcare should ensure that all prisoners are appropriately examined during their health screen and that secondary health screens are completed in a timely manner.

Care management

43. The deceased suffered from Parkinson's disease and Alzheimer's. Healthcare staff helped him to wash, dress and eat. On 5 November, the nurse recorded man's blood pressure as low, but there was no follow up. He had lost 10kg in eight months, and although his diet was monitored and he was prescribed supplement drinks, he was not examined and possible reasons for his weight loss were not investigated. On 9 November, his health deteriorated and he was admitted to hospital with pneumonia and sepsis.

44. HIW concludes that the deceased's clinical care at Cardiff fell below the care he could have expected to receive in the community. Although his mental health was being taken care of, there was no assessment of his physical health. HIW considers that regular observations could have led to an earlier diagnosis of pneumonia. HIW considers that the deceased's physical healthcare was unacceptable and his "death may have been preventable and foreseeable". In light of the clinical review, we make the following recommendation:

    The Head of Healthcare should ensure that the physical health of prisoners in the healthcare inpatient unit should be checked regularly, by observations and assessments.

[7] Prison guidelines containing mandatory instructions, which are written in italics.

Family liaison

45. Prison Service Instruction (PSI) 64/2011 instructs that "wherever possible, the FLO and another member of staff must visit in person the next of kin or nominated person to break the news of the death".

46. As the man was in custody when he died, it was the prison's responsibility to break the news of his death. We do not believe it was satisfactory to wait until the morning to break the news of his death. The family liaison officer had already established contact with his brother. She should have had his address and discussed how he wanted to be contacted in an emergency. In the absence of information to the contrary, prison staff should have gone to the deceased's brother's home which was not far away. We make the following recommendation:

    The Governor should ensure that, wherever possible, the family liaison officer and another member of staff visit a deceased prisoner's next of kin in person to break the news of the death.

The deceased's location

47. The deceased was remanded into custody after he was charged with assaulting nurses at the hospital where he was being treated. Prisons must accept whoever the courts deem it necessary to send to them, but it was quickly apparent that Cardiff prison was not equipped to manage and care for this man appropriately. He had longstanding health problems and suffered from both Alzheimer's and Parkinson's diseases. His mobility was very poor and he relied on a walking frame and wheelchair to get about. His apparent aggressive behaviour in hospital appears to have been as a result of his illness or a side effect of his drug treatment.

48. Healthcare staff at Cardiff recognised that the prison was not a suitable place for the deceased and made efforts to have him transferred to an appropriate mental health facility. Unfortunately, his physical health deteriorated very quickly and it was not possible to arrange a transfer before he was admitted to hospital with pneumonia and he died shortly afterwards.

49. In their last annual report, the Independent Monitoring Board (IMB) for Cardiff indicated that alternatives to prison were needed for people with mental health problems. It would seem that this man ended up in prison because of the sort of gaps in the system identified by the IMB. We consider that better awareness of the limitations of the care available in prison for someone in the deceased's condition among the various agencies which dealt with him, including the police, health and social services, might help avoid such a situation in future.

    The Governor should draw the circumstances of the deceased's case to the attention of relevant agencies, including the police, health and social services in order to help avoid a similar situation in future.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that all prisoners are appropriately examined during their health screen and that secondary health screens are completed in a timely manner.

2. The Head of Healthcare should ensure that the physical health of prisoners in the healthcare inpatient unit should be checked regularly, by observations and assessments. .

3. The Governor of Cardiff should ensure that, wherever possible, the family liaison officer and another member of staff visit a deceased prisoner's next of kin in person to break the news of the death.

4. The Governor should draw the circumstances of the deceased's case to the attention of relevant agencies, including the police, health and social services in order to help avoid a similar situation in future.

ACTION PLAN: The deceased – HMP Cardiff

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that all prisoners are appropriately examined during their health screen and that secondary health screens are completed in a timely manner.	Accepted	This is a performance area that is under constant review, we do complete more than 75% of our secondary health screens within 24 hours. We are looking at improving the secondary health screening process and making it clinically more effective via a 1000 lives workshop, part of this is auditing time taken to deliver care to patient via secondary health screening.	August 2013	
2	The Head of Healthcare should ensure that the physical health of prisoners in the healthcare inpatient unit should be checked regularly, by observations and assessments.	Accepted	On admission to the Healthcare centre all prisoners have their observation's taken which gives a baseline. During their stay in Healthcare their observation's are then taken weekly (every Tuesday) and documented onto their Clinical System	Completed	
3	The Governor of Cardiff should ensure that, wherever possible, the family liaison officer and another member of staff visit a deceased prisoner's next of kin in person to break the news of the death.	Accepted	Due to retirement, resignation etc HMP Cardiff now has only one FLO. The Governor recognises that this is not an ideal situation and an advertisement has gone out asking for staff that has an interest in the post. The one remaining FLO is fully aware of the need to visit and liaise with the next of kin of the deceased prisoner. This will form part of the training/awareness for all staff who volunteers to be FLO at HMP Cardiff.	Completed	

			Memo has been sent to all Senior Managers that a FLO must be informed of any death in custody and the next of kin must be informed by staff from the establishment including a FLO, whatever the time day or night.		
4	The Governor should draw the circumstances of the deceased's case to the attention of relevant agencies, including the police, health and social services in order to help avoid a similar situation in future.	Not Accepted	The HMPS cannot influence the courts sentencing procedures for offenders regarding the alternative custody for them. The conditions of the warrant have to be adhered to by HMPS. However, HMP Cardiff has procedures in place when the offender arrives in reception to conduct a full medical assessment to highlight medical conditions. The offender would have the opportunity to contact his legal representative to help him to challenge his alternatives to custody due to his medical condition and any other issues.		