Investigation into the circumstances surrounding the death of a man at HMP Parc, in December 2008

Report by the Prisons and Probation Ombudsman for England and Wales

September 2009

This is the report of an investigation into the death of a prisoner at HMP Parc. He died at hospital in December 2008, having been taken ill at the prison two days earlier. He was 81 years old. The cause of death was found to be ischaemic heart disease (a lack of oxygen to the heart muscle) due to coronary atheroma (build up of fatty lumps on the arteries) with a secondary condition of chronic bronchitis and emphysema (disease of the lungs). I offer my sincere sympathy and condolences to the man's family and all who have been affected by his loss.

The investigation was carried out by one of my colleagues. An independent review of the man's medical care in prison was carried out by a doctor on behalf of the Healthcare Inspectorate Wales. As ever, I am most grateful to the clinical reviewer for her assistance.

I would also like to thank the Director and staff of Parc for their full and ready co-operation during the course of the investigation. My particular thanks go to the prison liaison officer for his working with my investigator.

The man received appropriate medical care whilst in prison. I am saddened however that, despite his age and frailty, he was cuffed in hospital until just a few hours before his death. I make six recommendations and highlight one example of good practice.

Jane Webb
Deputy Prisons and Probation Ombudsman **September 2009**

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SUMMARY

The man was remanded into custody at HMP Cardiff on 22 December 2006. He had several long standing health problems, including heart disease and kidney disease. He had suffered a heart attack around four years earlier. After being sentenced to seven years imprisonment in January 2007, he transferred to HMP Usk.

Throughout the first half of 2008, the man suffered from cellulitis (an infection of the skin) in his legs. In May, concern was raised about his ability to care for himself after it was reported that he was unable to shower without assistance and was unable to dress himself. When there was no improvement by the end of the month, staff began to look at the possibility of transferring him to a prison with 24 hour healthcare facilities. He was assessed and accepted by the healthcare manager from HMP Cardiff on 1 July, but the prison did not have room for him at the time.

After experiencing some vomiting in mid July, the man was admitted to hospital for tests. He was diagnosed with chicken pox. After his discharge on 25 July, he transferred to HMP Parc. He lived on the inpatients unit at Parc for his first two months at the prison. His health was poor for the first five weeks but he began to improve in early September. On 29 September, he was well enough to move to a ground floor cell on D wing.

His cell mate told the investigator that he asked a nurse to see the man on 15 December, as his chest did not sound well. He said that the nurse just gave him paracetamol. Two days later, the cell mate asked another nurse to see the man. On this occasion, he said that the nurse did not visit him. Neither of the nurses in question recalled these events.

On 18 December, a nurse was called to see the man in his cell after a “rattling” noise was heard from his chest. The nurse took him to the healthcare centre where he was examined by a prison doctor. The doctor admitted the man to an outside hospital later that afternoon.

In hospital, the man was escorted by two officers and cuffed to one of them by means of an escort chain (a long chain with a handcuff at both ends). After a suspected heart attack, the chain was removed at around 9.20pm on 19 December. He did not recover and was pronounced dead a few hours later.

I am pleased to record that the clinical reviewer concludes that the medical care the man received whilst in prison was good. I am disappointed however that he, an older, frail man, was restrained in hospital when his mobility was clearly very limited. Amongst my six recommendations, I ask the Director to consider revising the risk assessment for cuffing older prisoners in hospital.

THE INVESTIGATION PROCESS

1. The investigation was opened on 22 December 2008 when the investigator issued notices announcing the investigation to staff and prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to the investigator. Three prisoners came forward as a result.

2. The investigator was given access to the man's prison files, including the medical record. He visited Parc on 23-24 February 2009 and interviewed five members of staff and one of the prisoners. He had previously interviewed the other two prisoners at HMP Rye Hill, where they had been transferred.

3. An independent clinical review of the man's health care whilst he was in custody was carried out by a doctor on behalf of the Healthcare Inspectorate Wales.

4. One of the Ombudsman's family liaison officers contacted the man's son on 15 January, to inform him of the investigation and to give him the opportunity to raise any questions or concerns he had about his father's death. He said that he felt Parc had treated his father very fairly and spoke positively of the support he had received from the prison's family liaison officer.

5. The Ombudsman's family liaison officer also wrote to the man's daughter on 5 February to advise her of the investigation. At the time of writing this report, she had not raised any issues about her father's death.

6. The report was sent out in draft to the Director of Offender Management for Wales, Healthcare Inspectorate Wales and the man's son in July 2009. Comments by each party, including an official response to the recommendations, are incorporated in this final report. An additional section was added to the draft report, in paragraphs 75-81, following concerns raised by the man's son regarding the time it took for him to be notified of his father's hospital admission. A sixth recommendation was added to the report, which was sent to the Director of Parc for her comments. No response was received at the time of writing this report.

7. I hope that this report hopes to clarify any issues that might remain unclear for the man's children and helps them to better understand what happened in the time leading to his death.

HMP & YOI PARC

8. Parc is a category B local prison for men which is situated on the outskirts of Bridgend, Wales. The prison opened in November 1997 and is operated by Group 4 Securicor. It is the only private prison in Wales. Parc holds up to 1,126 adults and young offenders.

9. Healthcare services at Parc are provided by Primecare Forensic Medical Services. There is an inpatient facility with 17 beds and care is provided by a team of three doctors and 25 nurses employed by Primecare. Medical services are also provided by a visiting dentist, optician and psychiatrist.

10. HM Chief Inspector of Prisons last inspected Parc in July 2008. She found that "prisoners had good access to a wide range of clinical services, which were at least comparable with those found in the community". She went on to say that the health needs of older prisoners were well catered for and highlighted as good practice the use of a drop-in clinic on the vulnerable prisoner's unit (where the man lived).

11. In their annual report for 2007/08, the prison's Independent Monitoring Board (IMB, a group who independently monitor and report on a prison) expressed the view that the healthcare unit provided "generally good and wide-ranging services".

12. The man's death was the 11th to occur at Parc since April 2004, when I began investigating all deaths in prison custody in England and Wales. This was the eighth death due to natural causes. There have subsequently been two further deaths at Parc, both due to natural causes. In the case of a gentleman who died around two weeks after the man who is the subject of this report, the clinical reviewer recommended that the NHS ensure that comprehensive discharge summaries are sent to Parc following a prisoner's attendance at hospital. She makes a recommendation in this report regarding the collection of blood test results from hospital.

KEY FINDINGS

13. The man suffered from a number of significant health problems at the time of his imprisonment. His doctor in the community wrote to his solicitor around two months before the man's conviction highlighting ischaemic heart disease (a lack of oxygen to the heart muscle), chronic kidney disease and mascular degeneration (deterioration of the retina). He also reported that the man had suffered a heart attack in June 2002. A list of his medication was provided, including aspirin (to thin the blood and prevent a heart attack), atenolol (for high blood pressure), GTN spray (to relieve chest pain due to angina), ramipril (to treat high blood pressure or heart failure) and simvastatin (to reduce cholesterol and hence the risk of a heart attack).

14. Following his arrival at Cardiff on 22 December 2006, the man saw a nurse for a reception health screen (a routine health screen for all new arrivals into prison). His medical conditions and prescription medication were recorded. The nurse noted that he was frail but had been living in his own flat and caring for himself. He asked for a place on the vulnerable prisoners' unit on account of his offences and was allocated a cell there on the ground floor. The following day, the man said he was worried that he would struggle to collect his own meals, and another prisoner was assigned to help him.

15. On 13 January 2007, the man was visited by a nurse to review his progress. He said that he was managing with the support of staff and had been using a seat to help him shower. He also said that he had been using his GTN spray three times a week on average. Nine days later he was again seen in his cell and, on this occasion, said that just slight exertion made him breathless. A request for a chest x-ray was faxed to a local hospital. (There is no record of such an examination taking place.)

16. Having been sentenced on 26 January, the man transferred to Usk three days later. It was noted at a reception screen that he could not manage stairs, became short of breath from walking and needed help to collect meals. He was assessed again on 1 February, when it was noted that he was unable to manage his activities of daily living (washing, collecting meals, cleaning cell etc) without assistance.

17. A week later, the man was reviewed by a prison doctor. As well as the medical problems previously listed, the doctor highlighted that he had minor arthritis. On 20 February, an older prisoner assessment was completed. It was now noted that he could walk unaided and care for himself.

18. Over the following months, the man was seen by a chiropodist and attended an outpatient appointment with an opthamologist (eye specialist). The consultant noted that he was "severely sight impaired". The man developed a chest infection in October 2007, and was prescribed a course of amoxicillin (an antibiotic). The chest infection returned three months

later, and he was prescribed a further course of amoxicillin on 16 January 2008.

19. On 22 January, the man was called to attend healthcare after wing staff reported concerns about his health. His legs were very dry and he was losing a lot of skin. It was also reported that he was not showering. He was given moisturiser to use and assured the nurse that he would shower the next day. The nurse advised the man that if he was unable to care for himself he would be transferred to a prison with 24 hour healthcare facilities.

20. The man was diagnosed with cellulitis on 13 February. He was seen regularly by nursing staff over the following weeks regarding dry and broken skin on his legs and feet.

21. On 19 February, the man was told that his son had died over the weekend. He decided not to travel to the funeral, but did attend a service in the prison chapel.

22. Two days later, the man told a nurse that his chest was "bubbly". He was asked to bring a sputum (mucus coughed up from the lungs) sample for analysis, but refused. The following day he also declined an appointment with a prison doctor. Despite this, a request for a chest x-ray was made and he went to an outside hospital on 7 March. The results indicated that "the lungs show evidence of chronic disease and are over inflated".

23. By 14 March, the man again developed cellulitis. He was prescribed a course of flucloxacillin (an antibiotic), with a further course prescribed on 25 March as there was no improvement. He continued to use cream on his legs throughout April, with some improvement noted later in the month.

24. The man had been assessed as suitable to collect his medication on a weekly basis and store it in his cell to use as prescribed. On 21 April, however, it was noted that he was not collecting his medication every week. He was advised of the importance of taking his medication as prescribed.

25. Concerns were raised on 7 and 8 May about the man's ability to look after himself. He said that he was unable to shower without assistance and found it difficult to dress himself. His cell mate, who had helped him considerably, had recently been released. The nurse thought he had lost weight, although he refused to be weighed. She also thought that he was "visibly frailer". It was agreed that the man should start to take Fortisips (a nutritional supplement).

26. Over the following days, the man's blood pressure dropped and a change to his prescription of ramipril was made following a review by a prison doctor on 12 May. Two days later, he reported a lesion on his left ear. He was referred to a dermatologist at the hospital on suspicion of having skin cancer.

27. On 15 May, the man was noted to have developed cellulitis again. He was prescribed a further course of antibiotics. Twelve days later, his cell mate told nursing staff that he had chest pain. He went to the healthcare centre and said that he was just wheezing and had no pain. He declined an ECG (a test to measure the electrical activity of the heart) as he said he was not feeling any pain.

28. At the end of the month, officers on the man's wing raised more concerns with healthcare staff regarding his personal hygiene. They said that he needed assistance with washing and dressing, walking to healthcare and sometimes needed help getting to and from the toilet. This was discussed by senior managers at the prison, who decided to investigate transferring him to an establishment with 24 hour healthcare facilities.

29. In June, it was again noted that the man was not always taking his medication as prescribed. He attended an appointment with a wound care specialist at the outside hospital on 18 June, and was diagnosed with contact dermatitis (a skin rash). He returned to the hospital a week later for a biopsy of the lesion on his ear. The results showed no evidence of cancer.

30. A nurse and the healthcare manager from HMP Cardiff visited Usk on 1 July to assess the man. They agreed that he needed to be in a prison with 24 hour healthcare, but had no room for him in Cardiff at the time. They said they would consider him for transfer should space become available.

31. The man remained in bed on 15 July, saying he felt unwell and eating little. The healthcare manager at Cardiff was contacted and again said they had no space for him. Three days later, he complained of feeling nauseous and said he had vomited. Following discussions with the on-call doctor, the man was admitted as an inpatient to the outside hospital for further investigation. He spent a week in hospital, during which time he was diagnosed with a urinary tract infection and chicken pox.

32. Whilst the man was in hospital, arrangements were made for him to transfer to Parc following discharge. He arrived at Parc on 25 July and was allocated a cell in the healthcare inpatients wing. He was assessed by a nurse shortly after his arrival. The nurse noted the man's history of coronary heart disease, kidney disease and mobility problems. A care plan was started the same day, with aims that included providing a safe environment for him, monitoring his food and fluid intake and assessing his mobility. The following morning, he was assessed by a prison doctor. The doctor requested that the man's blood pressure, pulse and temperature should be monitored daily and he should be weighed weekly.

33. Over the following days, the man was noted to have settled in well at Parc. On 31 July, he told staff he had fallen out of bed and bruised his head. A blood sample was taken and the results showed that he had mild

anaemia (a low level of iron in the red blood cells) and mild dehydration. He also told staff he had vomited. He continued to report vomiting over the following days, and his blood pressure fell as low as 70/40 on 3 August. He was therefore admitted as an inpatient to another hospital, on 3 August.

34. The man returned to Parc on 6 August, having been prescribed a course of cyclizine (to treat nausea and vomiting). The hospital discharge note recorded that he had been diagnosed with mild anaemia and low blood sodium (needed to regulate the amount of water in the body). His blood pressure on discharge had improved to 118/72.

35. A revised care plan was produced on 10 August, on account of a general deterioration in the man's health. Over the following week, he began to improve and was seen eating and drinking well. On 17 August, he was visited by his son. The visit took place in healthcare rather than the main visits hall (which meant that he did not have to walk as far).

36. On 24 August, an 'open door' policy was initiated for the man during the night because of his poor health. (This meant that healthcare staff were able to have immediate access to the room overnight.) He continued to experience some episodes of vomiting during the remainder of the month, and was prescribed further doses of either cyclizine or maxolon (also used to treat nausea and vomiting).

37. In early September, the man's health improved and he was noted to be walking round healthcare and eating well. He reported no further episodes of vomiting. For several days he was invited to go to D wing for association, in preparation for a move to a cell on that wing. On some occasions he attended, but on others he said that he felt too unwell. On account of his improving health, the overnight 'open door' policy was stopped on 7 September.

38. A risk assessment to consider the man's needs, were he to move to D wing, was completed on 9 September. This followed a multi-disciplianry meeting attended by healthcare staff and the senior manager in charge of D wing. It was noted that the man was now able to wash himself, take showers and get dressed without assistance. A ground floor cell near the staff office was requested and also a share of a cell in case he was to fall when the cell was locked. The assessment also said that he would require help to collect his meal tray. In a meeting held prior to the completion of the risk assessment it was also mentioned that he needed a wheelchair to travel long distances. Two days later, an entry in the man's nursing notes said that he was now "independent to all of his needs".

39. On 20 September, the man fell over and grazed his right temple. The following day he said that he felt well and had no problems. On 29 September, a space became available on D wing and he moved there later that day.

40. The man had a flu vaccination on 14 October and saw an optician on 4 November. A nurse was called to D wing to see him on 28 November after he said that he had been suffering from diarrhoea for a few days. He told the nurse he felt better and was therefore advised to inform staff if he felt worse again.

41. His cell mate told the investigator that the man's chest sounded like a "bucket of bolts" on 15 December. The cellmate said he went to the treatment hatch on the wing and asked the nurse to see the man. He went on to say that the nurse gave the man some paracetamol. The nurse told the investigator that he did not recall seeing him on this occasion. He explained that he is experienced in dealing with chest problems. If the man's chest had sounded as described he would have noted it in the medical record and arranged for him to see a prison doctor. The nurse said that the most likely scenario was that the man had just said that he was feeling under the weather and wanted some paracetamol.

42. The cellmate told the investigator that he again went to the treatment hatch on the morning of 17 December to ask a nurse to see the man. He said the nurse told him that she would come when she had finished distributing the medication, but did not do so. The treatments nurse said she did not recall the cellmate speaking to her about the man. She added that if he had done she would have gone to see him, assessed and dealt with his complaint, and made an appropriate entry in his medical record.

43. At around 1.00pm on 18 December, a prison custody officer (PCO) was outside the man's cell and could hear him wheezing. The PCO went in and found him sitting on his bed. The PCO said that he could hear that the man's "chest was rattling". He called for nursing staff to attend.

44. Two nurses went to D wing to see the man. He said that he had been feeling unwell for around a week and one of the nurses observed that his chest sounded "bubbly". The nurses therefore took him to healthcare for further checks. His pulse, blood pressure, temperature and oxygen saturation levels (a measure of the oxygen level in the blood) were taken. He had low saturation levels and was therefore given oxygen through a mask.

45. Shortly afterwards, the man was assessed by a prison doctor. The doctor observed that he was extremely short of breath and unable to walk. He thought that he might have fluid on his lungs and may have experienced some degree of heart failure. The doctor therefore arranged for the man to be admitted to an outside hospital for further investigation. He arrived at the hospital at around 3.30pm.

46. A risk assessment was completed later that day, which concluded that the man was unlikely to try to escape and was of a low to medium risk to the public or hospital staff. He was also noted to be mobile but physically frail. The form was approved by the Head of Security at Parc. He concluded

that the man should be accompanied by two officers at hospital and cuffed to one of them by means of an escort chain.

47. Shortly after the man's arrival at hospital, blood samples were taken and he had a chest x-ray. That evening he was given oxygen through a mask and, later, through a tube in his nose. He had earlier been moved to a private room. In the early hours of the morning on 19 December, he complained of feeling unwell. One of the bedwatch (a prison term referring to the escort of hospital inpatients by prison officers) officers called a nurse in to see him. The nurse took his blood pressure (the results of which are not recorded in his prison records) and encouraged him to get some sleep. That afternoon, it was reported that fluid was taken from his chest (to help his lungs expand).

48. A revised risk assessment was completed on 19 December, again signed off by the Head of Security. The revised form was completed because the man's status had changed from a hospital outpatient to an inpatient. The medical assessment section of the form is blank and it contains no additional information to that provided in the previous day's risk assessment. The Head of Security again concluded that an escort chain should be used.

49. At around 8.00pm, the man was given oxygen by nursing staff following fears that he might have had a heart attack. Shortly afterwards he was able to breathe by himself again. At around 9.20pm, the escort chain was removed, although the officers remained. Permission to remove the escort chain was given by the orderly officer (the person in charge of the prison overnight) following a request from the escorting staff. An hour later the man's son arrived at the hospital to visit, having been informed of his condition earlier that evening by hospital staff.

50. The man died at 1.55am the following morning. The prison family liaison officer telephoned his son to break the news of the death. (This had been agreed with the man's son during his visit a few hours earlier.)

51. A post mortem revealed the cause of death as ischaemic heart disease (a lack of oxygen to the heart muscle) due to coronary atheroma (build up of fatty lumps on the arteries) with a secondary condition of chronic bronchitis and emphysema (disease of the lungs). The man's funeral was held on 19 January 2009. The investigator found that the prison's contribution to the funeral costs was in accordance with PSO 2710 (the Prison Service Order that sets out the actions to be taken following a death in custody).

ISSUES

Findings from the clinical review

52. The clinical review was carried out by a doctor on behalf of the Healthcare Inspectorate Wales. The clinical reviewer makes the following comment regarding the standard of care that the man received whilst in prison:

> "The health care given by staff at HMP Parc and HMP Usk appeared to be good. Staff were conscientious about obtaining primary care records, secondary care opinions and for dressing his legs as prescribed. Efforts were made to transfer [the man] to a prison with 24 hour healthcare when the seriousness of his physical condition was recognised. The progressive deterioration in his health and mobility was likely due to his old age."

53. The clinical reviewer goes on to say that the man's medical records were illegible in places and his blood test results were not always filed in the record. She makes the following recommendation:

Healthcare staff should ensure that blood results are obtained from hospital pathology departments, reviewed and filed correctly, and that medical records are legible.

Care received by the man on D wing

54. Prior to his move from healthcare to D wing, a multi-disciplinary meeting was held on 9 September to highlight any specific needs that the man would have were he to live on the wing. The group concluded that he should have a ground floor shared cell near to the staff office. It was noted that he was able to wash, shower and dress himself without assistance but that he would require help collecting his meal tray.

55. One other measure to help the man prepare for life on D wing was to allow him to attend evening association on several occasions. This gave him the opportunity to get to know wing staff and his fellow prisoners prior to his move. It also allowed staff to develop an understanding of his requirements. I consider this to be an example of good practice.

The man was given the opportunity to attend association on D wing prior to moving from healthcare to the wing.

56. On the day of his move to D wing, an entry was made in the man's medical record saying that he was to attend healthcare weekly for a bath. It is not clear whether this took place. His cell mate told my investigator that arrangements were made for their cell to be unlocked at 7.00am on Monday, Wednesday and Friday mornings so that he could help the man to shower. The cellmate said, however, that this did not happen on a regular basis and the man therefore went without a shower. Two other

prisoners said that he never came out of his cell and was given no help by the staff on the wing.

57. The manager of D wing, told my investigator that she thought staff on the wing had very good support from healthcare staff. She was sure that any arrangements with healthcare regarding the care of individuals would be adhered to, although it may have been forgotten some days because of operational issues.

58. The manager of D wing went on to say that there are some older prisoners who do not come out of their cells very often. She tried to encourage them to come out for association at least once a day. In addition, she said that she expected staff to check on anyone who was staying in their cell to see that they are alright.

59. At interview, the PCO said that the man preferred to shower in the adapted showers on the wing rather than go to healthcare for a bath. The PCO said there was a note on a board in the office to remind staff to unlock the man but they relied on someone remembering to do this. He also said that he did not come out of his cell much because he was concerned about being knocked over due to his lack of mobility. The PCO said that staff tried to encourage the man to come out of his cell more. He began to come out of his cell more often in October and November 2008, but would usually return after an hour.

60. Regular baths and showers were especially important to the man, who had a recurrent skin complaint. It should be easy to monitor whether prisoners who need assistance to bath or shower receive the help that they require. For example, staff could have been asked to sign his wing record or the wing observation book to confirm that he had been unlocked for a shower. Alternatively, a reminder could have been written on the office white board, for staff to initial on Monday, Wednesday and Friday mornings. In lieu of such arrangements, I have to conclude that it is unlikely that the man was able to shower three times a week, as arranged.

    The Director should implement means of monitoring the personal care arrangements for those prisoners who require assistance.

61. The man's medical record reveals little contact with healthcare staff during the three months that he lived on D wing. At interview, the prison doctor suggested that it would be appropriate to hold a monthly review of older prisoners who had been in healthcare as an inpatient. I agree. A regular review would give the patient the opportunity to raise any concerns about their care or their daily living arrangements.

    The head of healthcare should ensure that older prisoners living on wings who have previously spent time as inpatients in healthcare are reviewed by a doctor on a regular basis.

Events in the week leading up to the man's death

62. The cellmate told my investigator that he asked a nurse to see the man on 15 December because his chest sounded like a "bucket of bolts". He added that the nurse gave him some paracetamol. The treatment nurse said he did not remember seeing the man on this occasion but that if his chest had sounded as described he would have arranged for him to see a prison doctor. He thought it likely that the man had said he was feeling under the weather and had asked for paracetamol.

63. The cellmate said that he again asked a nurse to see the man on 17 December. On this occasion, he said that the nurse did not come to the cell, despite saying that she would. The treatment nurse on duty on that occasion said she did not recall the cellmate speaking to her about the man. She added that if he had done she would have gone to see him, assessed and dealt with his complaint, and made an appropriate entry in the medical record.

64. It is unfortunate that neither of the two treatment nurses recall the events that the cellmate describes. Had they seen the man and observed the symptoms described by his cell mate, I would expect them to carry out a medical assessment and make a record of the findings. As it is, I cannot say for certain what did happen on these occasions. The Director may wish to satisfy herself that healthcare staff do attend prisoners when healthcare needs are reported.

65. After reading the draft report, the man's son told the Ombudsmans family liaison officer he was concerned that healthcare staff did not take his father's cell mate more seriously when he approached them on 15 and 17 December. He felt healthcare staff could have done more to examine and treat his father and that it was not enough to have simply given paracetamol to a man of that age and history of ill health.

Use of restraints

66. The man was admitted to hospital on 18 December 2008. He was accompanied by two PCOs and cuffed to one of them by an escort chain. The decision regarding whether or not to cuff a prisoner in hospital is made by means of a risk assessment, with the final decision being signed by the Director, Deputy Director or the head of security or operations. The risk assessment considers factors such as the prisoner's escape risk and the risk to the public if they did escape. An assessment of the prisoner's physical capacity to escape unaided is also considered.

67. The risk assessment completed on 18 December concluded that the man was unlikely to try to escape and was of a low to medium risk to the public or hospital staff. A prison nurse completed the medical assessment section of the form. She noted that he was "mobile but physically frail". The head of security at Parc made the final decision on the cuffing level and instructed that restraints should be in place.

68. This decision was reviewed on 19 December, once it became clear that the man would stay in hospital as an inpatient. On this occasion the medical assessment section of the form was blank. The head of security decided that there should be no change to his cuffing status.

69. The escort chain was removed at around 9.20pm on 19 December. Permission was given by the orderly officer following a request from the escorting staff. Just over an hour earlier, the man had been given oxygen by nursing staff after he had a suspected heart attack. He had also been given oxygen therapy the previous day, firstly through a mask and then through a tube in his nose.

70. The man was a frail 81 year old man with an extensive medical history. His mobility was poor and, prior to his hospitalisation on 18 December, he had to be taken from his cell to healthcare in a wheelchair. The prison doctor, who assessed the man on 18 December, told my investigator that "he couldn't walk, [his mobility] was bad". The doctor also said that the man was "extremely short of breath". There is no evidence to suggest that he was an escape risk.

71. The decision about whether to cuff a prisoner at hospital is a difficult one and the balance between decency and security can be hard to find. Nevertheless, in these circumstances I do not think that it would have been unreasonable to escort the man in hospital without the use of restraints. Given his condition, I judge that the presence of the two prison officers would have been an adequate security arrangement. This conclusion could have been more easily reached at Parc had the medical assessment section of the risk assessment been completed prior to its review on 19 December.

    The Director should remind staff that the medical assessment section must be completed whenever the risk assessment is reviewed.

    The Director should encourage senior managers to take less risk averse decisions when determining the cuffing levels required for seriously ill, older prisoners with very limited mobility.

Contacting the next of kin when the man was admitted to hospital

72. The man was admitted to hospital in the afternoon of 18 December 2008, after complaining of shortness of breath. The prison doctor, thought he might have fluid on his lungs and may have experienced some degree of heart failure. He therefore arranged for his admission so he could undergo tests and further investigation.

73. Over the following 24 hours, the man was given oxygen and had some fluid drained from his lungs. On the evening of 19 December, he had a

suspected heart attack. His son was then contacted by hospital staff and was able to visit later that night.

74. After reading the draft report, the man's son told the Ombudsman's family liaison officer that his father was being kept alive by a life support machine when he arrived at the hospital to visit on the night of 19 December. He felt he could have been contacted sooner so that he might have had a chance to say goodbye to his father.

75. It is a policy at Parc to contact the next of kin 24 hours after a prisoner is admitted to hospital. This is done by chaplaincy staff, who are given a list on a daily basis by the orderly officer (a senior member of uniformed staff who responds to situations arising in the prison during the day).

76. A chaplain at Parc tried to contact the man's next of kin on the afternoon of 19 December. It does not appear as though he had any next of kin recorded at Parc. The chaplain therefore got a telephone number for one of his sons from his prison telephone account. He left a message on an answerphone that afternoon.

77. Unfortunately, it later emerged that the son who the chaplain tried to contact had recently died. The man's other son had by then been contacted by hospital staff. It would appear that the man himself gave his son's contact details to staff at the hospital.

78. The policy at Parc to contact the next of kin 24 hours after a prisoner is admitted to hospital is a commendable one. It is unfortunate that, on this occasion, up to date contact details were not held. The Director will wish to ensure that contact details are held for all prisoners who are willing to provide them. This is particularly relevant for older prisoners with long standing health problems who, like the man, might be at greater risk of hospital admission.

    The Director should ensure that up to date next of kin details are held for all prisoners and that these are accessible to chaplaincy staff.

CONCLUSION

79. The man was an older prisoner with several long standing health problems. On account of his declining health he transferred to Parc in July 2008, in order that he might benefit from their 24 hour healthcare facilities. His physical health improved greatly during his two months as an inpatient in Parc's healthcare centre. I am pleased to see that he was given the opportunity to spend time on his future wing whilst waiting for a cell to become free, giving him the chance to get to know staff and his fellow prisoners.

80. My investigation found that the man received good and appropriate medical care whilst in prison. However, I believe that it was inappropriate, given his age and frailty, that he was handcuffed in hospital until around four and a half hours before his death. As the Ombudsman has expressed in a number of previous reports, escort risk assessments should pay more attention to the physical capabilities of the patient and less to the type of offences they have committed.

RECOMMENDATIONS

1. Healthcare staff should ensure that blood results are obtained from hospital pathology departments, reviewed and filed correctly, and that medical records are legible.

   Accepted – the healthcare manager will ensure that protocols are in place for dealing with blood results and that all medical records are legible.

2. The Director should implement means of monitoring the personal care arrangements for those prisoners who require assistance.

   Accepted – a review will be conducted and procedures implemented to ensure that prisoners who require assistance with personal care are monitored and cared for appropriately.

3. The head of healthcare should ensure that older prisoners living on wings who have previously spent time as inpatients in healthcare are reviewed by a doctor on a regular basis.

   Accepted – a review will be carried out by the healthcare manager to implement systems that ensure all prisoners over the age of 65 are to be reviewed regularly to access their healthcare needs.

4. The Director should remind staff that the medical assessment section must be completed whenever the risk assessment is reviewed.

   Accepted – staff will be reminded of the need to ensure this requirement is met.

5. The Director should encourage senior managers to take less risk averse decisions when determining the cuffing levels required for seriously ill older prisoners with very limited mobility.

   Accepted – all necessary information will be taken into consideration when assessing the level of security required on hospital escorts. However, senior managers will be advised of the need to pay particular attention to mobility and health status of older, seriously ill prisoners.

6. The Director should ensure that up to date next of kin details are held for all prisoners and that these are accessible to chaplaincy staff.

   No response received.

GOOD PRACTICE

1. The man was given the opportunity to attend association on D wing prior to moving from healthcare to the wing.