Circumstances surrounding the death of a prisoner in November 2005 in hospital, whilst a prisoner at HMP Parc

Prisons and Probation Ombudsman for England and Wales

October 2006

This is the report of an investigation into the circumstances of the death of a prisoner in November 2005. At the time of his death, the man was a serving prisoner at HMP Parc.

On 23 September 2005, following a period of illness, the man who died had been diagnosed with tumours in both his lungs and abdomen. He deteriorated quickly and, following admission to the hospital in early November, he died there the next day. He was aged 47.

I would like to extend my condolences to the man's family and friends for their sad loss.

The investigation was led by one of my Investigators. A clinical review into the man's care and treatment was undertaken by a nurse who works for my office, in collaboration with the Healthcare Inspectorate Wales (HIW).

I am grateful to the Director and staff of HMP Parc for their co-operation with this investigation. Although I have made two recommendations about healthcare issues, I am pleased to commend the prison and its nursing staff for the sensitive, multi-disciplinary approach they took to meeting the man's needs. I note that the prison took steps to apply for his early release, although sadly he died before they were completed.

In addition to the normal recipients of my reports, I am also sending a copy of this report to the governors of HMP Swansea and HMP Cardiff for their consideration. The man who died had spent some time in both prisons before being transferred to Parc.

Stephen Shaw CBE
Prisons and Probation Ombudsman **August 2006**

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Summary

The man who is the subject of this report was 47 years old when he died in early November 2005 in hospital, while in custody at HMP Parc. He had been in prison since 14 June 2005. He arrived at Parc on 12 August, after spending brief periods at Swansea and Cardiff prisons.

In August 2005, the man reported swelling to his neck and tightening of his chest. His condition did not improve and he saw a different doctor who found a swelling just above his collar bone. The symptoms continued and the following week his blood test results indicated the possibility of infection.

On 5 September, the man saw a doctor again. The doctor thought that he was generally unwell, and that there were three possible explanations: a malignant lung, tuberculosis and another which is not legible from the notes. The man was admitted to the prison in-patient health unit the next day and also referred to the local hospital for a bronchoscopy the following week.

The man asked to return to his wing when a single cell became available, and the wing and healthcare staff made arrangements for him to receive nursing attention whilst he was there. Two days later, he went for his outpatients appointment, and on 22 September he returned to healthcare to prepare for the bronchoscopy. At that appointment he was diagnosed with lung cancer.

Due to the seriousness of the man's illness, an application for early release on compassionate grounds and Home Detention Curfew (HDC) licence were made. However, these were unsuccessful as the victim, a member of his family, objected and the man had no suitable accommodation. Soon afterwards, the victim became aware that he was seriously ill, withdrew her objections, and further applications were made. The man's release on temporary licence was planned, pending approval of the HDC request. However, his condition deteriorated in the early hours of the day he died and he was admitted to hospital where he died.

In her clinical review, the nurse concluded that the healthcare the man received whilst in prison was commensurate with that he might have received in the local community.

Investigation Process

1. My colleague opened the investigation on 24 September. Notices to staff and prisoners were distributed and displayed around the prison, inviting anyone who wished to see the investigator to make contact. In the event, no-one came forward.

2. My investigator visited HMP Parc on 6 January 2006. She was provided with the man's prison and healthcare records and other records associated with his death. She also met with the Director, a member of the Independent Monitoring Board (IMB) and the family liaison officer. She contacted the Coroner's officer to inform the Coroner of the nature and scope of the investigation and to request a copy of the Post Mortem. A copy of this report will be sent to the Coroner to assist in his enquiries.

3. One of my Family Liaison Officers contacted the man's family to explain the purpose of the Ombudsman's investigation and to discuss any questions that the family might have. The family liaison officer and my investigator subsequently travelled to Wales to meet the family on 12 December 2005.

4. A nurse who works for my office carried out a review of the man's healthcare whilst in custody, in collaboration with the Investigations Manager in the Healthcare Inspectorate Wales (HIW), and the Director of Investigations, HIW.

5. Informal interviews were conducted with those staff involved in the man's care and support whilst in prison.

The Man

1. The man who died was born in July 1958 and raised in Cardiff. He had two older brothers and one older sister, and described his childhood as stable and supportive. He left school after taking his GCSEs and joined the Merchant Navy where he served for 11 years until he was 27, working mainly as a chef. When he returned home he initially had some problems finding work. However, before long he started work in the building trade.

2. Having had no previous contact with the criminal justice system, the man found himself, at the age of 31, before the courts charged with a drugs offence. He served a seven year sentence. On release, he again found it difficult to gain employment, but eventually found work in catering at a local college and later at a hotel.

3. The man then met his partner and they had a daughter and enjoyed family life together for ten years. However, his partner suffered from post natal depression and later made a suicide attempt, sustaining severe injuries and thereafter requiring full-time care. She and their daughter went to live with her mother, initially as a temporary arrangement, but when her health did not improve, it became a permanent situation. He saw his daughter regularly and maintained a close relationship with her up until his death.

4. After the break up of the family home in 1999, the man stayed with various friends and family members, including his mother and sister. This was an unstable time and, having struggled with alcohol in the past, he developed a serious addiction to alcohol. He was taking various prescribed medications at this time, suffered from depression and was prescribed diazepam before his arrest. His family said that he was particularly affected by the death of his two brothers in the previous four years.

5. The man and his sister enjoyed a very close relationship and she had supported him considerably over the previous few years. She worried about his alcohol abuse and urged him to get help on several occasions. Unfortunately, in March 2005 they had an argument and he became violent. He was arrested and bailed to a probation hostel, but after breaching his bail conditions he was remanded into custody at Swansea prison.

6. He was described as a man full of warmth and generosity. He will be greatly missed by those he has left behind.

HMP Parc

7. Parc is a private prison that opened in November 1997. The operating company is Group4Securicor Justice Services. Health Care Services are provided by Primecare Forensic Medical Services. The population is usually around 1000.

8. Parc holds unsentenced juveniles, remand and sentenced young offenders and sentenced adult males. The main accommodation for adult males is A wing which comprises four 90 bed units. All cells have in-cell sanitation, ventilation, electricity and television.

9. The prison was last inspected by Her Majesty's Chief Inspector of Prisons (HMCIP) in September 2002. She reported that in broad terms it was a safe and respectful environment. However, there was room for improvement in terms of staff engagement with prisoners and constructive time out of cell.

10. The healthcare department has 17 in-patient beds and provides two doctors sessions each day between Monday and Friday, and one session on both Saturdays and Sundays. Out of hours cover on the evening and weekend is provided by Primecare's own doctors.

11. Under section 36 of the Criminal Justice Act 1991 (for those prisoners sentenced under the provisions of the Criminal Justice Act 1991) and section 248 of the Criminal Justice Act 2003 (for those prisoners sentenced under the Criminal Justice Act 2003), the Secretary of State may release a prisoner on licence at any point in the sentence if he is satisfied that this is justified by "exceptional circumstances". Early release on compassionate grounds may be considered on the basis of a prisoner's medical condition or as a result of tragic family circumstances. It is granted in only the most exceptional cases. It is described in detail in Prison Service Order 6000.

12. This office has investigated two other deaths at Parc in 2005, both from natural causes. I have found no similarities with this case.

Events leading up to his death

13. The man who died was remanded to Swansea prison on 14 June 2005. A First Reception Health Screening examination was completed by a Health Care Worker. The man was described as having no chronic disease, but he told the healthcare worker he had lost two stones in weight in 12 weeks 'due to anxiety'. A note was made to check his weight in two weeks time. He was also seen by the prison doctor at Swansea, who described him as stout and strong and in good health. His personal record shows he completed his induction programme the next day.

14. On 20 June, the man was transferred to Cardiff prison. As part of the reception process at Cardiff, he was again seen by a member of the healthcare team who noted that he was fit and well. It was also recorded that he had declined a medical interview. On 5 July, he appeared at Cardiff Crown Court where he was convicted, but not sentenced. On his return to the prison, he again told healthcare staff in reception that he did not wish to see the doctor.

15. There are several other entries in the man's personal record indicating that he settled well into life at Cardiff. It was noted that he was not a problem for staff, was working as a wing cleaner, and liked his peace and quiet.

16. He was transferred to Parc on 12 August. The reception health care assessment recorded that he had chest problems and queried whether he had a chest infection. He was noted to be a smoker, but nothing else of any significance was recorded. On 13 August, he was seen by the prison doctor at HMP Parc, who noted his cough but found nothing abnormal in his chest. However, the man was prescribed an antibiotic, Amoxicillin 250mg three times a day, which was dispensed on 15 August.

17. The man presented at the medicines hatch on 16 August, complaining of a painful neck with a swollen area on the rear right side. He mentioned he had been given antibiotics but the pain was increasing. A nurse gave him paracetamol and ibuprofen for pain and referred him to the doctor. The same day, he was seen by the reception board and it was noted in his personal record that he did not raise any concerns.

18. The prison doctor saw the man again on 17 August, and suspected an infected lymph node. He prescribed a stronger painkiller, co-dydramol, and a different antibiotic. He also ordered blood tests and a chest X-ray. He indicated he was considering sending the man for an ultrasound scan, but no referral form or letter was found in the file. In the event, a referral was made later in the month by a different doctor.

19. Later that day, he moved on to the Voluntary Testing Unit (VTU), which is a part of the prison that is committed to being drug free. The prisoners have to sign a compact to show their agreement. Again it was recorded that he settled down well on the wing, was polite to staff and there were no problems to report.

20. On 21 August, he reported that his chest was increasingly tight. He was advised to stop smoking and once more referred to the doctor. The doctor saw him the next day, and found a swelling in the area above the collar bone. He noted the blood tests were not back, prescribed a different codeine based analgesic, and would see him again in a week.

21. The man saw the same doctor on 25 August who observed that his blood test results indicated the possibility of infection (raised Erythrocyte Sedimentation Rate (ESR)) and a raised white blood cell count. The doctor noted that he would need a further appointment and that the ultrasound needed to be chased up. This doctor made a referral for the scan. In the event, the appointment for the scan came through for 21 October, by which time the man had had a computerised tomography (CT) scan, making the ultrasound scan unnecessary.

22. A different doctor saw the man the next day and described him as bronchitic and chesty, but not breathless. This doctor described the swelling on his collar bone as hardly to be seen, and advised him to stop smoking.

23. He was weighed on 30 August, and his weight was recorded as 71kg. The next day, he did not attend for a blood test, though there is no record of any tests being ordered. His failure to attend was followed up and the blood tests, which were a repeat of those found to indicate infection on 25 August, were done the next day. On 3 September, he presented at the daily surgery with constipation, and was prescribed senna. The next day, he complained again and was advised to stop the co-dydramol and use paracetamol for pain instead.

24. He saw a doctor again the following day, 5 September, and was described as generally unwell. This doctor's description of the swelling on his collar bone was that it was a hard lump. From the blood tests, he noted that the ESR was still raised and he also had raised blood platelets. His liver function tests were showing signs of raised alkaline phosphatase, which can be indicative of liver or bone disease. The doctor arranged for the chest X-ray result to be faxed to him at the prison. The X-ray had been carried out on 31 August, two weeks after the initial request had been made. The doctor noted that there were three possible diagnoses: malignant lung cancer, tuberculosis (TB) and a third which was not legible in the medical record. He also noted that the man had been exposed to asbestos in the Merchant Navy, and should be reviewed as a priority the next day.

25. The prison doctor saw him on 6 September, and his record repeated many of the previous day's findings. He noted there was no family history of TB. He contacted the chest physician at the hospital to discuss the findings and also referred him formally by letter. They agreed that the man should have a bronchoscopy (a visual examination of the airways) the following

week. Meanwhile, he was admitted to the prison in-patient unit where sputum samples were collected to test for TB.

26. On 7 September, a doctor wrote in the continuous record that the X-ray report showed a pneumonic diagnosis. In fact the X-ray report said:

    a. *"there was patchy consolidation in the right upper lobe. This may represent a pneumonia however I cannot exclude TB on this examination."*

27. The doctor ordered sputum to be sent for microscopy, culture and sensitivities and mentioned covering with a broad spectrum antibiotic. The prescription chart showed that Erythromycin 250mg was prescribed, but the prescription was ambiguous. No recommendation was made as to how many times per day it was to be given, or how long it should be taken for. The prescription was marked (ii), which usually means two tablets or capsules of the prescribed dose, but it might have been taken to mean twice a day. The more usual prescription is four times a day. According to the administration record, it was actually given twice a day, for eight days.

28. On 9 September, a nurse recorded that all three sputum specimens were negative at the preliminary laboratory test, but the full result would not be known for ten weeks. She also indicated that advice about the possible diagnosis of TB had been obtained from the local public health department. The public health nurse had advised that a notification was only necessary if a firm diagnosis of TB was made.

29. On 11 September, the man saw another doctor in the prison who found him fit for normal location[1]. He had expressed the wish to return to the wing and go to the healthcare centre as required. He was discharged to House Block C on 12 September.

30. His medical record shows that he had been to hospital for the bronchoscopy on 13 September, but in fact the entry was erroneous (see entries about 18/19 September below). He had probably been for a preliminary outpatient appointment with the chest physician at which the plan for a bronchoscopy had been confirmed. On the recommendation of the hospital, his ibuprofen had been discontinued and he was prescribed Co-codamol two tablets four times a day for pain relief, Lactulose for constipation and Gaviscon for gastro-intestinal symptoms.

31. On 14 September, the man refused to attend the healthcare centre (for blood tests), but they were done the next day. The tests were repeats of the previous full blood count (FBC) and erythrocyte sedimentation rate (ESR).

[1] This presented little if any risk to others. Although TB spreads by breathing in air from someone with infectious/active TB, it generally takes many hours of exposure (and often days) for a previously non-infected person to become infected. Thus, most people who breathe in TB germs do not get TB disease.

32. On 17 September, the prison doctor found that the man weighed 68kg, three kilos less than on 30 August. He diagnosed an upper respiratory tract infection and prescribed an antibiotic, Erythromycin 250 mg four times a day. A prescription was issued using the out of hours procedure.

33. The man was admitted to the healthcare centre on 18 September in preparation for the bronchoscopy and CT scan the following day at the local hospital. The prison doctor saw him before he went for the examination. On his return to the prison, he went back to the wing.

34. On 22 September, the man reported coughing up blood. He was referred to the doctor and given a sickness certificate stating he was unfit for work or the gym. The next day, a nurse's entry said he had pneumonia and the co-codamol that he was taking might be making him short of breath. It was recommended he take paracetamol and return for review later.

35. Also that day, he went back to the hospital for a chest clinic appointment with the chest specialist , after which a nurse recorded that she had received a telephone call from the clinic to say that the man was aware that he was diagnosed with lung cancer. The hospital wanted him to begin taking dexamethasone[2] 2mg, three times a day and pain relief. The nurse making the entry added that he was to have night sedation for three nights, for which she had obtained a verbal instruction from the prison doctor. The prescription chart shows that the nurse wrote:

    a. *'Dexamethasone 2mg tds Verbal order from the prison doctor'*

36. The '2' has been changed to 4 and the entry was not endorsed with a doctor's signature.

37. A nurse at the prison saw the man when he returned to the prison and spent some time with him discussing his diagnosis and his reaction to it. He understood he had tumours in both lungs and secondaries in his abdomen, and she said he was positive and keen to fight the illness. The nurse concluded that, despite receiving such upsetting news, he was not at risk of suicide and noted that the chaplains at the prison were helping him break the news to his family.

38. The hospital had made an appointment for the man to see the consultant again in a week and were arranging for him to have chemotherapy at Velindre NHS Trust in Cardiff. She recorded the names of the consultant and the lung nurse specialist.

39. On 26 September, the nurse at the prison noted that the man's medication dose was doubled 'after discussion with the senior nurse', which may explain why 2mg was altered to 4mg as described above. The man also

[2] Among its various uses, dexamethasone is given to treat the nausea and vomiting which is a side effect of radiotherapy.

reported that, despite taking senna, the constipation was worse. He was prescribed movicol, but none was available in the pharmacy. He refused his evening medication, because he was concerned about the constipation. The nurse at the prison also noted that the dexamethasone he had been prescribed was unavailable.

40. On 27 September, the man was signed off as unfit for work until further notice. A nurse contacted the chest specialist's secretary at the hospital about the man's continuing care plans. The secretary confirmed that she would fax a plan of care from the chest specialist to the prison.

41. A letter from the chest specialist, addressed to the Medical Officer, written on 27 September and received at Parc on 4 October, confirmed that the man had advanced lung cancer with secondary malignant changes in the adrenal glands. The chest specialist had referred him to the oncologist for chemotherapy and radiotherapy. He advised that early release from prison custody on compassionate grounds would be in the man's best interests, and gave a prognosis of approximately 12 weeks to live.

42. On 29 September, the man returned from an appointment at the hospital with news that he was to have radiotherapy on ten consecutive days. The prison doctor revised the man's medications on the recommendations of the hospital. He was due to have a visit from the Macmillan nurses later in the week.

43. The man had started receiving radiotherapy treatment, but on 5 October he felt too ill to attend. The doctor who saw him at the prison arranged alternative times for him to attend, and prescribed nystatin for a fungal infection of the mouth. The doctor noted that he was very thin and weak due to losing weight and wrote that he should be offered Ensure, which is a high energy liquid protein drink. The doctor also noted that he had completed the medical section of a compassionate release form for the man who died. A prescription for Ensure was written on 5 October, but it was not available for two days.

44. On 6 October, a nurse noted that the man's medication had been rewritten and he was prescribed Dexamethasone 4mg three times a day, Fluconazole 50 mg in the morning, Nystan oral suspension three times a day, Co-danthramer strong 2 at night, Salbutamol inhaler two puffs four times a day as required for breathlessness, Lactulose solution 10mls twice daily and Diclofenac 75mg twice daily. Four of the drugs were written up on one prescription chart which was not signed by a doctor, nor dispensed or issued. All the drugs were written up on another chart, which was signed by a doctor, and they were dispensed and issued that day.

45. At the same time, the man was assessed to determine whether there were any risks arising from him keeping the medications in his own possession. (The assessment is standard practice and considers whether a prisoner is likely to take the drugs as prescribed, is likely to overdose, or is likely to

sell the drugs to other prisoners.) There were three assessments on the man's record on 13, 22 and 26 September, all of which found him suitable for in possession medication.

46. Also on 6 October, a nurse at the prison recorded another conversation with the man. They discussed his reluctance to be admitted as an in-patient in the healthcare centre, and his preference to remain on the wing. The nurse assured him that he could have all the care he needed on the wing.

47. The first steps to initiate compassionate release were made via a letter to the probation service. As well, an application for a Home Detention Curfew (HDC) licence was made (this is normal procedure for prisoners serving short sentences). The application for HDC includes consultation with the victim of the offence and a check that the proposed home address is suitable. The man gave his mother's address as the place where he would live, but when it was checked the probation officer, found that it was unsuitable as there was only one bedroom. Also there was no telephone line, which meant that the HDC monitoring equipment could not be installed.

48. When the victim of the man's offence was asked her opinion, she said that she wanted him to get help for his problems and, as this had not been possible when he was in the community, she felt that being in prison would enable him to gain access to the help he needed. It should be noted that, at the man's request, she had not been informed of his diagnosis.

49. At the same time, the application for Early Release on Compassionate Grounds was being processed. There are many sections on the form which were completed by different people involved with his care. The final section was completed on 5 October by a doctor in the community who agreed to care for the man on his release.

50. On 7 October, the prison doctor noted he had reviewed the man's health on the wing and found him to be losing weight rapidly. Later that day he saw two Macmillan nurses who made a long entry in his medical record and noted that they were considering admitting him to the local hospice when it was appropriate. They recommended further changes to his medication. The new drugs they recommended were MST 20mgs twice daily[3], Oramorph 5mgs as needed, Lansoprazole 15mg and senna with magnesium twice daily. The nurses also recommended stopping the treatment for oral thrush and the other laxatives recently prescribed.

51. The prescription cards show that the prison doctor prescribed the MST and Oramorph that day but there was a delay in the availability of the Oramorph until 10 October. There was also a prescription for

[3] This is a controlled drug, ie its prescription and administration must comply with the Misuse of Drugs Act 1971

Dexamethasone 6mg twice daily, seemingly in place of but equivalent to 4mg three times a day.

52. The same day (7 October), the prison nurse wrote a very comprehensive entry about the man's plan of care as agreed with the Macmillan nurses. Had he been admitted to the healthcare centre, various standard forms would have been used to document this care plan. However, since he was very keen to remain on the third floor of C wing among friends, the nurse used her initiative and substituted an alternative form and used it to plan his care on the wing.

53. The nursing care plan aimed to assess and control the man's current symptoms and enhance his quality of life. It also dealt with the management of the two controlled drugs and ensured he could have Oramorph whenever his pain was such that he needed it. The nurse recorded that the Oramorph was unavailable before 10 October.

54. The nurse noted that there was a risk that he might suffer asphyxia because of the pressure of the tumour on his airway, and also there was a risk of a haemorrhage if the tumour eroded a major blood vessel. She and another nurse explained the risks to the wing staff to help them understand what might happen and what they should do in the circumstances.

55. The prison nurses planned to visit the man on the wing three times daily or more if needed, and the doctor would see him every other day or more if required. If he could not go to the medicines hatch to collect his medicines, they would be taken to his cell, and a bed in the healthcare centre would continue to be offered every day in the hope of his agreement as it would provide closer nursing supervision.

56. An entry in his personal record on 7 October explains that wing staff offered him a ground floor cell, believing that it would be easier for him to move around, but he refused, saying it was too noisy.

57. The nursing care plan was followed that night, after which he told the nurses that he was disturbed by the night staff when they switched the light on to check on him every half an hour. As a result of the nurses' intervention, the checks were reduced to twice nightly, once by wing staff and then by the nursing staff, and the change was recorded in his personal record. On 8 October the man refused pain medication at 2pm because he thought it was making him feel ill. He refused it again the next day. The nurse noticed his chest sounded full of secretions.

58. The next morning, 9 October, another prison nurse recorded that the man had refused his Dexamethazone 6mg and later that day another doctor reduced the prescription to 4mg twice a day because the man had unspecified side effects on the higher dose.

59. The man attended an appointment at hospital for radiotherapy on 10 October. Later that day, he refused the codeine based analgesic because

it made him constipated and took paracetamol instead. The prison nurse noted that she had spoken to the Macmillan nurses who were planning to admit him to the hospice for a 24 to 48 hour period in order to assess the level of pain. The man was agreeable, but no beds were available at that time. He refused to take the lunchtime dose of Dexamethasone because he could not swallow after his radiotherapy session.

60. On 11 October, he went straight from hospital to the hospice for his pain to be assessed. He remained there until 18 October. Whilst he was there, a probation officer at Parc prison, contacted Cardiff Probation to ask them to check a new address for the man's HDC release.

61. Also whilst he was in the hospice, a multi disciplinary meeting took place on 17 October which discussed the management of his short and long term care at the prison. He was to be offered a bed in healthcare, but it was expected that he would prefer to stay on the wing. The Macmillan nurses supported his wish, and said that he should be in as normal an environment as was possible in the circumstances. Plans were made to contact a doctor in preparation for compassionate release, although this had already been done and a doctor had supported the application in the early release document. It was noted that security risk assessments would need to be completed to pass to the other agencies, and the man was to be asked to consent to disclosure of his details. The nursing care plan was revised and written up in detail, similar to the previous version of 7 October.

62. He returned to Parc on 18 October and, as expected, went to the wing. By the next day, the probation officer had had no response to her request for his proposed address to be checked, and so she visited the property herself and confirmed that it was appropriate.

63. On 21 October, the man was booked for an ultrasound scan but was too ill to attend. In fact, when healthcare staff informed the hospital that he was unable to attend, it was confirmed that the scan was no longer necessary because a CT scan had been carried out two days previously.

64. Later that night at 11.30pm, the prison nurse was on duty and recorded that she had been unable to administer hiss night-time medicines because she was attending a medical emergency elsewhere in the prison. The medication for pain relief was to be administered at regular 12 hour intervals, at 8.00am and 8.00pm, which was essential for his pain to be relieved as effectively as possible. She also noted that he was concerned about his constipation, inadequate pain control, blistering gums, and dry skin, and was finding it hard to swallow and so was not eating. She arranged for him to be reviewed by the doctor the next day and also for the Macmillan nurses to be contacted.

65. A doctor reviewed he man the next day and she found the same problems that he had reported to the nurse. She suggested increasing his morphine (MST) to 60mg twice daily, continuing the Oramorph and adding Adcortyl

for mouth ulcers and suppositories for constipation. Also that day, the prison nurse wrote a new care plan for the man using the healthcare centre documentation. From then on, the prison nurses recorded his care on the wing in the same way that they would have done if he had been an in-patient.

66. The prison nurses arranged for the Macmillan specialist nurses to visit on 25 October. They recommended increasing his fortified drinks as he was eating so little. They also emphasised to the man that he must ask for additional painkillers when he required them, and noted that the MST might need to be increased further. All his medication was reviewed and they recommended reducing the Dexamethasone on a sliding scale as recommended by a consultant in palliative medicine. The prescriptions were written on 25 October but were rewritten by another doctor on 28 October because the first version was unclear.

67. On 1 November, the Macmillan nurses advised that the man was to have a blood test for haemoglobin and calcium. He was to be seen in outpatients on 9 November. In the meantime his prescription for Voltarol (another non-steroid anti-inflammatory drug) was to cease, and he was to continue on the current dose of Dexamethasone.

68. A second HDC application was started about this time, the first section completed by the man's personal officer who recommended that he was suitable. The probation officer, also interviewed the man as part of this process and he told her that he would not contact the victim of his offence should he be released.

69. On 7 November, the chaplaincy at Parc received a call from the victim who had learnt of the man's illness and wanted to do all she could to help him get released. She also contacted the South Wales Probation Area where she spoke to the Victim Liaison Officer to explain that she hoped that he could be released as soon as possible, and that she no longer requested any licence conditions.

70. One of the prison doctors saw the man on 8 November, found him mildly dehydrated and recommended that the nurses encourage him to take more fluids. He planned to review him further as required. Later that night, at 11.15pm, he was given additional Oramorph at his own request. At midnight, the night nurse found him in great distress, finding it hard to breathe, with copious secretions from his chest and signs of severe abdominal pain. The nurse consulted the prison doctor who gave a verbal order for Hyoscine Bromide. (According to the British National Formulary, antimuscarinic drugs are used less frequently these days as premedicants to dry bronchial and salivary secretions.)

71. The doctor and nurse agreed that admission to the healthcare centre was the best option, and the nurse persuaded the man to move. This was accomplished with some difficulty, as he was taken in a carry-chair which had to be manoeuvred down the stairs from the third floor, where he was

transferred to a wheelchair. The nurse placed him in a cell with the door open and two officers present on the landing. She then went to the pharmacy to collect the additional medication, but could not find any.

72. The nurse kept meticulous notes of her care of the man over the next hour. He vomited twice at 1.30am. She administered oxygen and contacted the prison doctor again at 1.45am. The doctor advised that the man now needed to go to hospital and he went by ambulance at 2.20am. He was admitted as a patient of a general surgeon because a bowel obstruction was suspected, and this was confirmed the following afternoon when the prison nurse visited him in the Medical Admissions Unit. His mother also visited him after he was admitted.

73. At 3.30pm the following day, a second multi-disciplinary meeting was held at the prison. The Home Office Controller at the prison considered granting temporary release on compassionate grounds. A Release on Temporary Licence (ROTL) form was completed and agreed by the Director of Parc. ROTL was agreed as a temporary measure, whilst the man was in hospital, until he was discharged when release on compassionate licence would be requested. Plans were made for the Home Office Controller to receive the necessary medical information and to contact the palliative care team about the longer term situation. However, before this could happen, news was received the next day, that the man had died.

The prison's response to the man's death

74. The man died at 10:30pm in early November, and the information was passed to the prison in a telephone call from the hospital at 11:38pm. The Death in Custody (DIC) log shows that the chaplain was informed at 11:45pm and the Controller at 11:55pm, together with the Independent Monitoring Board. At 11:56pm, the communications manager was contacted, and at 11:57pm the National Operations Unit at Prison Service headquarters was notified. The log goes on to say that the Director, arrived at the prison within half an hour of being contacted, at 12:08am, together with the chaplain.

75. The prison's local policy for responding to deaths in custody was followed. So was Prison Service Order 2710 which provides detailed instructions on the actions required following a death in custody. All these actions were followed appropriately and in a timely manner.

76. His mother had spent most of the day at the hospital with her son and, having been advised by nursing staff, she went home to get some sleep. She said she had just arrived home, when she received a telephone call from the hospital to inform her that he had just died.

77. His funeral took place on 17 September 2006 and was attended by several members of staff from Parc included the chaplain. A memorial service was also arranged and held at the prison, but his family could not attend because of illness.

Issues Considered

The man's Clinical Care

78. The man spent just a few days at Swansea, but it is disappointing that neither the health care worker nor the doctor who saw him on reception found anything untoward about his sudden weight loss. He was not weighed and, although it was decided that he should be followed up two weeks later, no arrangements were made for this to happen. The man attributed the loss of weight to anxiety, which was not questioned. The clinical reviewer makes a recommendation about his care and I endorse her sentiments.

    I recommend that when a prisoner volunteers potentially significant information about his health, his past medical history should be obtained from his general practitioner.

79. He was at Cardiff for just over seven weeks but there was no note of any medical or nursing intervention whilst he was there. He declined to see the doctor when he arrived, and again on 5 July when he was returned after appearing at court .

80. I am pleased to find that the clinical care at Parc was overall of a very good standard. The nursing records confirm that the nurses demonstrated high levels of concern, and delivered excellent care in a flexible way. I was particularly impressed that they continued to look after him on the wing, even though their preference was for him to transfer to healthcare. The medical care was also thorough, although there was a lack of continuity at the beginning. (He saw a different doctor on four consecutive consultations, and they differed in their view of at least one of his symptoms.) I am also impressed by the way the man was consulted about his own care and that his wishes were respected, for example, to remain on the wing instead of in healthcare. I am also pleased to note that that bed watches at the hospital were conducted in a sensitive and appropriate manner. Parc made the right decision and agreed he did not need to be handcuffed during his last few days at the hospital.

81. The prison's prescribing and pharmacy arrangements were not of the same high standard and on four occasions the pharmacy did not stock a medicine prescribed. The most serious example was the absence of Hyoscine Bromide on the night of 8 November. The prescription cards in the file were also of a poor standard. There were none from Swansea or Cardiff, and those from Parc were not held chronologically and changes were not properly annotated. For example, changes were unsigned and undated and were not fully explained in the clinical record. Some forms or entries were written by the nurses and were not signed by a doctor. The clinical reviewer suggests Primecare Forensic Medical Service should consider a review of its medicine management. This is an important recommendation which should be implemented as soon as possible.

I recommend that Primecare Forensic Medical Services should consider a comprehensive review of medicines management by the local Drugs and Therapeutics Committee (or appropriate equivalent body). This should include prescription writing, organisation of prescription cards especially where multiple cards are in use, stock-keeping in the pharmacy and contingency arrangements for obtaining prescribed medication, particularly out of hours.

82. Access to medication was also delayed on one occasion because of staffing issues. On 21 October, the night nurse was unable to administer his night-time medication because she was attending a medical emergency. I agree with the clinical reviewer that it was unacceptable for a patient like the man who died, who was terminally ill and in pain, to receive his medicine over three hours late.

I recommend that Primecare Forensic Medical Services revise their night-time staffing arrangements to ensure that a situation cannot arise where the care of a seriously ill patient is compromised by the only registered nurse on duty being called to attend another patient in an emergency.

Release Arrangements

83. The man's first HDC application, dated 5 October 2005, was completed by one probation officer. The comments in section J indicate that the home address given by the man was unsuitable as there was no bedroom for him. The probation officer believed that alternative accommodation should be sought and referred the application for an enhanced assessment. Later that month, another probation officer visited the new address and confirmed it was appropriate.

84. The man's compassionate release document contains a Compassionate Medical Condition Report. It shows that he was examined on 5 October 2005 and his prognosis was then understood to be life expectancy of 12 weeks or less. The form was signed by a doctor in the community and also contains details of the man's consultant and his GP. Page 12 of this form is for completion by the probation officer, and he also confirmed that the prognosis was poor and liaison between Parc, the GP and hospital was needed for release is to be organised.

85. When my investigator visited Parc, the then deputy director, explained that the first HDC application was turned down because the address was unsuitable and the victim objected to his release. I understand from her that when the first application was turned down, and although the probation officer approved the second more suitable address, the application was unfortunately not pursued in a timely way. The records are sparse and there is nothing in the paperwork to indicate what happened between the address being approved and three weeks later when the man died. The deputy director explained that the prison believed

that, as the man had been found unsuitable for release on a HDC licence, he would also be considered unsuitable for a compassionate release.

86. Having spoken to Prison Service headquarters regarding the relevant Prison Service Order (PSO 6000 Early Release on Compassionate Grounds), it is clear that the Home Office Controller can apply to the Prison Service if he or she supports the release. If the Prison Service agrees with the application, it is submitted to the Prisons Minister for a decision. Regardless of the failure of the HDC application, this option should have been pursued. It is unfortunate that a release on compassionate grounds could not have been arranged for the man who died.

Family Contact

87. I understand that he gave the prison details of two people as his next of kin on admission to Parc - his mother and a friend. However, after he was diagnosed he told the chaplain that he wished his friend to be treated as his next of kin rather than his mother. Our family liaison officer did contact the friend at the start of this investigation, but she did not respond to the correspondence. I understand the prison has had contact with her, after which she attended the memorial service at the prison and was also able to take possession of his belongings.

88. This has been difficult for the family as communication between them and the friend has been scant. Additionally, according to the family, at the friend's request, the man was not buried in the family plot near his home, as previously planned, but at a cemetery of her choice. I am also aware that, when his personal belongings were handed over to the friend, his mother and sister did not have access to items that they might have appreciated as a reminder of him. This is a sad situation but I appreciate the difficulties faced by any prison in dealing with several members of a family, particularly when there is little communication between the parties. However, I know that both the man's sister and mother were on balance happy with how they were treated and his mother managed to visit him many times while he was at the local hospital.

89. Regrettably, there has been a long delay in getting funeral expenses to the family which I know has caused further unnecessary upset. Despite the best efforts of the prison, the funeral expenses have only recently been met, after a nine month wait. This is unacceptable and I draw this matter to the Director's attention for the avoidance of any such delay in the future.

Recommendations

1. When a prisoner volunteers potentially significant information about his health, his past medical history should be obtained from his general practitioner.

2. Primecare Forensic Medical Services should give consideration to a comprehensive review of medicines management by the local Drugs and Therapeutics Committee (or appropriate equivalent body), to include: prescription writing, organisation of prescription cards especially where multiple cards are in use, stock-keeping in the pharmacy, contingency arrangements for procurement of prescribed medication, particularly out of hours.

3. Primecare Forensic Medical Services should consider revising their night staffing arrangements to ensure that a situation cannot arise where the care of a seriously ill patient is compromised by the only registered nurse on duty being called to attend another patient in an emergency.

Good Practice

1. The Director and Primecare should commend the staff on C wing and healthcare, especially the prison nurse, for the quality of care they provided for the man which enabled his wish to remain with his friends to be granted.