Investigation into the circumstances surrounding the death of a man at HMP Cardiff in December 2009

Report by the Prisons and Probation Ombudsman for England and Wales

August 2010

The man was 56 when he died in his cell in the healthcare department of Cardiff Prison. He had been in prison since 13 October 1986 and was serving a second life sentence. In September 2009, he was diagnosed as having terminal cancer and was fully aware of the prognosis. For the purpose of this investigation, I have concentrated on events after 1 January 2009, which is when he first began showing signs of illness whilst at HMP Usk. He moved to HMP Cardiff to continue palliative care and died a month later.

My Senior Investigator and Family Liaison Officer join me in offering our sincere condolences to the man's family and friends.

I wish to thank the former Governor for making the necessary facilities available to the investigator. Additionally, I would like to pay particular thanks to the Principal Officer (who has since retired) for his invaluable assistance. He provided considerable support to the Ombudsman's investigator and ensured that the investigation has gone smoothly.

In the course of the investigation, I asked for a clinical review to be carried out into the medical care and treatment the man received in custody. I am grateful to the clinical reviewer from Healthcare Inspectorate Wales for her assistance and report.

I make nine recommendations in my report. They concern procedures in healthcare at both Usk and Cardiff. However, the overriding message from this investigation is a positive one. The man was given a high standard of care at both prisons, and the liaison with his family was also excellent.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Jane Webb
Acting Prisons and Probation Ombudsman **August 2010**

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SUMMARY

The man was sentenced at Crown Court on 13 October 1986 to life imprisonment, after being found guilty of a serious offence. It was the second time that he had received a life sentence.

Due to a recurring chest infection, the man was sent to hospital for a chest x-ray. Initially he was treated with antibiotics, but was later diagnosed as having cancer.

After being told in September 2009 that his illness was terminal, the man asked to remain at Usk. The care he received at Usk was very good, well managed and dignified. However, he later changed his mind and asked to transfer to Cardiff, where he could receive palliative care.

The man made it very clear that he did not wish to be resuscitated and, to ensure that his wishes were followed, a “not for resuscitation” agreement was in place. It is evident that he was given every opportunity to make his final arrangements and that his family were kept fully informed.

Upon arrival at Cardiff, the man was admitted into healthcare where he stayed until he died a month later in December. The level of care given to him at Cardiff was good and appropriately managed. Discussions took place with him about a placement at a local hospice, but he asked to remain at the prison, where he said he felt comfortable.

It was also considered whether the man could be released on compassionate licence. Even though he told prison staff that he did not want to be considered for release, staff completed two assessments in case he changed his mind. After due consideration, it was decided that he did not fit the criteria and no further action was taken.

I make nine recommendations as a result of this investigation. They concern arrangements for healthcare provision at both Usk and Cardiff, including keeping medical records. Separate recommendations include, for Usk, a review of the dispensing of medications and, for Cardiff, development of an end of life care pathway and consideration of the CCTV provision in the healthcare centre.

THE INVESTIGATION PROCESS

1. After receiving notification from the National Offender Management Service of the man's death, I allocated the investigation to senior investigator. He contacted the Governor's secretary and arranged to travel to the prison to open the investigation. A review of his care and treatment was also commissioned from Healthcare Inspectorate Wales.

2. On 14 December, the investigator met the Deputy Governor. Also at that meeting was Head of Healthcare, the Family Liaison Officer for HMP Usk, and the prison liaison officer to the investigator.

3. The following day, the investigator met the Governor and fed back his summary of the opening visit, which he later confirmed in writing. Before leaving the prison, the investigator arranged to return the following month to continue his investigation.

4. On 16 December, the investigator contacted the Coroner's office to update her on progress. The Coroner's officer told him that the inquest would be held on 13 January 2010. He explained that this report would not be completed and was told the Coroner would be content to continue with the inquest without it.

5. Following any death in prison, I publish a notice to staff and prisoners inviting anyone with information and who wishes to contact me, to make themselves known to the investigator. The notices were displayed around the prison for both prisoners and prison staff. At the time of writing this report, no prisoners have asked to speak to the investigator.

6. In the meantime, one of the Ombudsman's Family Liaison Officers (FLO) had been in contact with the man's brother and partner. The FLO explained the purpose of the investigation and provided them with the opportunity to ask any questions or raise any concerns about the care he received for consideration as part of this. The man's brother and partner spoke very highly of the help and support they and he received from prison staff, particularly at Usk, both before and after his death. Neither wished to raise any concerns about the care the man received and felt staff had done all they could to look after him. The family have seen the draft report but have not raised any further issues.

7. On 13 January 2010, the Coroner for Cardiff held an inquest into the man's death. After directing the jury, they returned a verdict of natural causes, with the primary cause as lung cancer.

8. Five days later, on 18 January, the man returned to the prison to continue the investigation. During that week he interviewed five members of staff and was assisted on one interview by the clinical reviewer.

9. On 21 January, the man met the Governor and gave feedback on the main issues arising from the investigation. He later confirmed the feedback in writing.

10. After issuing the draft report into the man's death, I received feedback from the National Offender Management Service. I have attached their comments in the recommendations chapter. In their feedback, they accepted all of the recommendations except 2, 5 and 7 (recommendation seven relates to Usk).

HMP USK

11. The prison is located close to the town of Usk, Monmouthshire. It is a closed prison and holds prisoners convicted of sex offences. It forms part of the HMP Usk and HMP Prescoed jointly managed prison.

12. Usk is a closed training prison for category C prisoners. It originally opened in 1844 as a house of correction after which it became the county jail for Monmouthshire before it closed in 1922. It later reopened in 1939 as a borstal and, in 1964, become a detention centre. It had a number of further changes in role before becoming an adult prison in 1990.

Healthcare

13. At Usk there is no inpatient facility. Primary care is provided by a team of nurses and doctors Monday to Friday.

Her Majesty's Chief Inspector of Prisons

14. Her Majesty's Chief Inspector of Prisons reports on all Prison Service establishments. In May 2008, she said in her report the prison had "dipped" in two key areas which were safety and resettlement. She said the prison was fundamentally safe but that the processes to ensure safety were undermanaged and staff were inadequately trained.

15. The Chief Inspector had on a previous inspection made a recommendation that new healthcare facilities should be provided. In her report, she said the recommendation had not been achieved, but did note that work to build a new healthcare centre was due to begin in September 2008. I understand that work is almost complete and the new centre due to open in June 2010.

16. The Chief Inspector concluded her introduction by saying Usk remained a good prison. However, she went on to say the inspection had revealed a degree of complacency and drift, which required a swift remedy for it to regain and retain its high performance status.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) consisting of members of the local community and their role is to monitor the prison and to report any concerns that they have regarding the prison, or how prisoners are treated. In the first instance, the Board report to the Governor, or, if considered necessary, it can report directly to Parliament. Board members are able to visit any area of the prison at any time and have direct access to any prisoner who they wish to see, or who requests to see them. The Board holds regular meetings in the prison, with the Governor attending for part of the meeting. The

Chairperson of the Board produces an annual report to the Secretary of State for Justice.

18. The Board is responsible for reporting on both Usk and Prescoed. In its latest report, which covers the period between April 2008 and April 2009, the Chair of the Board raised concern at the lack of progress in providing healthcare facilities. She said building was due to commence in March 2009, but had not done so and was now rescheduled to begin that summer. She also said the new healthcare unit would not provide any patient accommodation.

HMP CARDIFF

19. The prison is situated close to the city centre of Cardiff. Originally built in the Victorian era, it has undergone extensive refurbishment. The establishment is what is commonly referred to as a local prison which generally means it is used to accommodate remand prisoners, although there are a number of sentenced prisoners.

Healthcare

20. In May 2008, the healthcare unit at Cardiff moved into a purpose built 22 bed, two storey building. It provides 24 hour nursing care and is commissioned by the Local Health Board.

21. Mental health services are provided by an in-reach team commissioned by the local NHS Trust, and two registered mental nurses. In addition there is a part time occupational therapist and a psychiatrist who covers seven sessions each week. Two of the sessions provide tertiary care for those who have been assessed as a high risk.

22. There is one full time doctor and one part time doctor and both are employed by SERCO, who are contracted to provide general practitioner services. The doctors provide 13 sessions each week including Saturday mornings. Out of hours doctor cover is provided by a local surgery.

23. Within Cardiff healthcare there are a number of video cameras which can record images on to a computer system. The images can be played back as necessary and provide a detailed account of movement along most of the ground floor.

24. Additionally, although not connected to the man's death, there are two specially designed cells which are adjacent to each other. Both cells have a camera which records images onto a video recording system. Whenever a prisoner is deemed to be at high risk of suicide or self harm, an officer sits outside of the cell and observes the prisoner. If there are two prisoners in the adjacent cells, then two officers sit outside, each watching the prisoner they are responsible for. Unlike the normal cells, the doors are not solid and instead have vertical bars. Covering the bars is a clear Perspex sheet allowing observation into the cell. The officers are seated directly opposite the cell door.

Palliative care policy at Cardiff

25. At Cardiff there is a palliative care policy in place, although it is undated. The policy is in two sections. Section one is titled "Palliative care", section two "Resuscitation policy".

Contingency plan for death in custody at Cardiff (as amended September 2007)

26. Contained within the contingency plan for a death in custody at Cardiff, are a number of instructions, which are divided up between specific job holder tasks. The instructions tell the reader what they should do and are there to ensure nothing is missed.

27. Throughout the contingency plan, in bold letters, it states "Only a doctor or paramedic can certify death. If a prisoner is not breathing, staff must attempt resuscitation unless rigor mortis of the limbs have clearly set in. Once any form of resuscitation has commenced, an ambulance must be summoned".

28. Under the heading "Healthcare responsibility" it instructs the member of staff to write a full, detailed report of the circumstances and the actions taken and witnessed. Again, it reminds the staff member that only a doctor or paramedic can certify death.

29. The orderly officer is a senior member of the uniformed staff. The orderly officer is usually responsible for the day to day management of the prison routine and, in the event of an emergency, will refer to the Duty Governor for advice. During the daytime, the orderly officer at Cardiff is a member of staff from the principal officer grade, whilst at night it is a senior officer.

30. There are detailed instructions for the orderly officer. They should attend the scene, take charge of the incident and ensure staff are aware of who can certify death. Additionally, the officer is told to take advice from the medical staff as to whether an ambulance is required.

Her Majesty's Chief Inspector of Prisons

31. In January 2008, the Chief Inspector carried out an announced inspection of the prison. In the introduction to her report, she said the prison suffered from all the difficulties of an overcrowded and pressurised prison system. She went on to say the prison was essentially safe and that prisoners were more likely to report feeling safe than at other local prisons.

32. The Chief Inspector said that, overall, her report reflected the positive work being done at Cardiff, in spite of the pressures and difficulties within the prison system. She added that the prison's strength was its local links and ethos along with the support it has been able to obtain from the Welsh statutory, private and volunteer organisations.

33. With regards to healthcare the Chief Inspector said primary care was generally good, although a chronic disease management action plan and an electronic patient management system had not been

implemented. She added there was good access to general practitioner services.

Independent Monitoring Board

34. In their latest report covering the period 1 September 2007 - 31 August 2008, the Board Chair said they found Cardiff to be a well run establishment, with good relationships between staff and prisoners. She added that the Board were aware of the financial constraints which had affected both uniformed and administrative staff and hoped the effects would not be detrimental to the positive work being carried out.

35. The Board Chair thanked the Governor and her senior management team for their assistance in keeping the Board informed. She concluded that the staff at Cardiff are friendly, helpful, polite and patient.

Prison officer grades (Usk and Cardiff)

36. There were at the time three levels of uniformed prison officer grades. Prison officers are the front-line supervisory staff and, in the majority of cases, prisoners have first and most contact with them.

37. Senior officers (SOs) are the first grade of managers and act as a reference point for prison officers. SOs are responsible for the day-to-day management of their area, supervising staff and dealing with issues raised by prisoners.

38. Principal officers (POs) were the highest rank of the uniformed staff. They supervised other uniformed staff and had operational responsibility for the prison.

39. In addition to prison officer grades, there are a group of staff known as operational support grades (OSGs). OSGs wear prison uniform and carry keys but do not carry out the same function as prison officers. Their role is to support the areas of the prison that have little or no prisoner contact, for example, the gate.

Personal Officer

40. Each prisoner at Usk and Cardiff is allocated an officer known as a personal officer. The officer is expected to make and to keep in contact with those prisoners for who they are responsible and to contribute towards any reports that may be required. Prisoners are encouraged to interact with their personal officer.

Compassionate release on licence

41. Under section 30 of the Crime (Sentences) Act 1997, the Secretary of State may, at any time, release a prisoner on licence if he or she is satisfied that exceptional circumstances exist which justify early release on compassionate grounds. Before exercising this power, the Secretary of State is required to consult the Parole Board, unless the circumstances make such a consultation impracticable.

42. The criteria for compassionate release on medical grounds for those serving life sentences are:

- The prisoner is suffering from a terminal illness and death is likely to occur very shortly. Although there are no set time limits, three months may be considered to be an appropriate period for an application to be made to the Lifer Review and Recall Section, which forms part of the National Offender Management Service.

- The risk of re-offending (particularly sexual or violent nature) is minimal.

- Further imprisonment would reduce the prisoner's life expectancy.

- There are adequate arrangements for the prisoner's care and treatment outside prison.

- Early release will bring some significant benefit to the prisoner or his or her family.

43. In the man's case, he was considered for release on two occasions. I am told that he had asked not to be released, as he preferred to remain in an environment that he was familiar with, and with his peers. Despite his request, the assessments were carried out as a precautionary measure, just in case he should change his mind, and to ensure that there would not be any delay in releasing him.

44. The first assessment was carried out in October 2009, whilst the man was at Usk. The second was completed the following month at Cardiff. On both occasions he was deemed not to meet the criteria due to the risk of re-offending. An additional factor was that his doctors had assessed his life expectancy at less than six months.

Care team

45. Each prison has its own care team. Care team staff are drawn from all areas of the prison and are trained specifically to help and support prison staff. Following any serious incident, they provide an invaluable role to any member of staff who requires support.

Police investigations of deaths in custody

46. With all deaths in prison custody, the police are notified by the prison as soon as the death has been discovered. In the first instance, the police treat the area where the person is found as a potential crime scene and, as part of their investigation, note the names of everyone involved and those who have been in contact with the body. Additionally, they note the identity of all those entering and leaving the cordoned area. It is only when the police are satisfied that the death is not suspicious that the Ombudsman's investigators are allowed to begin their own investigations.

Previous investigations of deaths in custody.

47. Since 2004, the Ombudsman has investigated five deaths at Usk. In four of these investigations, a recommendation has been made concerning record keeping. There have been 13 previous deaths at Cardiff. While none of the circumstances of those investigations are similar to this, previous recommendations have also referred to record keeping.

KEY FINDINGS

48. Although I concentrate on events after 1 January 2009, it is worth mentioning that the man had a number of identified health problems before that date. In 2002 he had a quadruple heart bypass operation following two heart attacks. He is also recorded as suffering from emphysema (a progressive disease of the lung causing shortness of breath) and asthma. A health screening completed in 2005 recorded that he was taking several different medications, including aspirin (a pain killer), diuretics (used to lower blood pressure) and statins (a treatment for angina).

49. A further health screening, conducted at Usk in June 2008, confirmed that the man was also taking Lansoprazole (to treat gastric ulcers), simvastatin (to control cholesterol) and ramipril (a drug used after heart attacks). He was also taking several drugs to relieve asthma.

Events in 2009

50. On 12 January 2009, a prison doctor at Usk requested a chest x-ray because the man had a recurring chest infection. Eighteen days later, he was taken to hospital where the x-ray was carried out. From the clinical review report it would appear that the prison contacted the hospital twice, on 18 February and 2 March, asking for the results.

51. A few days later, on 5 March, the man went to healthcare complaining of shortness of breath and coughing. The doctor who saw him prescribed antibiotics after diagnosing a chest infection. From what has been gleaned from the clinical review, this would appear to be the first occasion he was given antibiotics. The doctor noted in the man's medical record that the x-ray results had arrived and showed consolidation in the right middle lobe (where part of the lung is filled with liquid rather than gas) and that a further x-ray was required. When this was discussed with him, he refused to go to hospital. There is no explanation as to why he refused to go.

52. On 30 March, the prison doctor spoke to the man again and on this occasion he agreed to a further x-ray. The doctor also sent a sputum sample to hospital. The man was diagnosed with a chest infection and antibiotics were prescribed.

53. The record of events log, which forms part of the prison record, shows that the man was interacting well with prison staff and other prisoners. In March 2009, it was noted that he was helping prisoners who were having problems with reading and writing. Additionally, he was employed in the prison laundry and assisting with the design of computer spreadsheets, used for allocating work.

54. On 24 April, the man returned to the hospital for a further x-ray. His medical record shows that the result of that x-ray was that there was "some clearing of right middle consolidation".

55. From then on there appears to be little information about the chest infection. The next significant entry in the man's medical record was made on 15 June when he went to healthcare with a neck abscess which he described as painful. The prison doctor prescribed co-amoxiclav, which is a drug used for the treatment of bacterial infections.

56. On 1 July, the prison doctor saw the man again. The doctor's entry in the medical record noted that "left parotid [part of the salivary gland] swelling persists". The doctor made an urgent referral to an ear nose and throat consultant at hospital. In the meantime the man was prescribed a soft diet and analgesia (pain relief) to help with the pain.

57. The following month, on 4 August, the man went back to the prison healthcare department complaining of severe pain in his right side, middle of his back and chest. It was noted in his medical record that he was "very pale", feeling faint and complaining of severe pain in his kidneys.

58. Next day, the prison doctor saw the man and recorded in the medical record that he may have kidney stones. He prescribed analgesia and Buscopan, which is used to relieve muscle spasms. Additionally, the doctor advised him to drink plenty of fluids.

59. As a result of the urgent referral made in July, the man was taken to hospital on 12 August where he was assessed by Consultant Ear Nose and Throat (ENT) surgeon. He diagnosed a three cm hard mass in the parotid gland and carried out a medical procedure known as "needle aspiration" (a procedure to examine lumps). He also arranged for the man to have an ultra sound examination. Prison healthcare staff developed a care plan for managing his pain, diet, mental and psychological health.

60. On 17 August, the man went to the prison healthcare as he was experiencing what is described in his medical record as "severe pain in his left ear". The prison doctor saw him and prescribed diclofenac, three times per day. (Diclofenac is a pain reliever for the treatment of musculo-skeletal pain.)

61. Three days later, the man returned to the healthcare department and told them that he was coughing up blood. A specimen was taken and sent for analysis. The result did not identify any pathogens, which are the cause of viral and fungal infections. The prison doctor prescribed regular pain relief as the man's pain was continuing.

62. On 27 August, the man returned to hospital and once again saw the ENT consultant surgeon. He diagnosed a malignant lump in the left parotid and associated lymph nodes. He arranged for an urgent Computed Tomography Scan (CT scan) of the man's neck and chest and placed him on the waiting list for a parotidectomy and neck dissection. (Parotidectomy is the removal of the parotid gland.) As well as this, the surgeon increased the man's pain relief medication, which now included morphine.

63. The next day the man was still in pain. A consultant surgeon was contacted at hospital for advice. He advised which pain relief should be administered. In addition, a soft easy chair was provided in the cell to provide extra comfort when he was sitting down.

64. On 30 August, Officer A made a note in the events log that the man was ill and had required pain relief. The officer was the man's personal officer and from that day on, he had almost daily contact with him, recording his interaction in the events log. It is evident from the log that special arrangements were made to ensure that the man's life was as comfortable as possible. As an example, Officer A arranged for his meals to be delivered to him rather than having to collect them. His diet was adjusted to ensure he received soft food. Additionally, the officer arranged for a wall safe to be installed into his cell which was used to store morphine, so that he could administer it himself when he was in pain. (Medication is normally issued by medical staff at specific times of the day. In this case the safe was installed to allow him to administer his own medication as necessary.)

65. Over the next few days the man continued to experience pain. He was offered a stronger pain relief known as MST, which is a drug which he was not allowed to keep in possession. (MST is an opioid painkiller.) He was told that if he wanted the medication he would have to transfer to another prison where healthcare staff are available seven days per week and not five as at Usk. He declined the offer to move.

66. As part of his healthcare management plan, the man was asked to keep a diary noting the level of his pain. In his diary he wrote comments such as "terrible pain" and "really hurting all day". Additionally he was self administering increasingly high amounts of Oramorph, which is liquid morphine used to relieve moderate to severe pain.

67. In September, the man was due to go to hospital for a pre operation assessment with a view to admitting him later that month. However, on 16 September and following the earlier CT scan, a decision was taken to cancel the operation as the cancer had spread. Arrangements were made for a specialist palliative care nurse to visit him the following day.

68. The next day, the consultant surgeon and the specialist nurse met the man at the prison. He was told that his operation had been cancelled

and that he was to be referred to a specialist lung team where he would be seen as an outpatient later that month. Due to his diagnosis healthcare staff arranged for a community psychiatric nurse to support him, as it was felt he might require psychological and emotional support.

69. The clinical reviewer notes that there is an entry dated 28 September in the man's medical record recording a message from a specialist chest nurse. The nurse had said his cancer was advanced and there was no cure. Arrangements were made for palliative care which could include chemotherapy, pain and symptom control. The healthcare manager tried to find a bed for him at either HMP Parc or Cardiff.

70. On 30 September, the man was told that his illness was terminal and that chemotherapy was not an option. He was prescribed medication to suppress inflammation and reduce nausea and vomiting.

71. As he was in a single cell, arrangements were made for another prisoner to be with him in his cell over the lunchtime periods for support. Additionally, he was allowed to use a telephone to enable him to tell his partner about the diagnosis.

72. In the meantime, discussions took place to see if the man could be transferred to a prison where his medical needs could be better catered for. One consideration was to transfer him to HMP Wakefield, but as he was not considered high risk he did not fit the criteria for that prison. Another option was to transfer him to HMP Norwich, which has the facility to provide palliative care. Norwich was full, but they did agree to reconsider admitting him if a place was not found elsewhere, providing they had a vacancy.

73. On 1 October, the man wrote a note, witnessed by a Community Psychiatric Nurse and Officer B. The note set out what he wanted to happen to his property after his death. After writing the note the two witnesses and the man signed the document.

74. As well as receiving continued support from Officer A and other prison staff, prisoners also assisted. The events log records that prisoners helped by cleaning the man's cell for him and pushing his wheelchair, which had been provided for him.

75. In addition a Senior Officer, the Family Liaison Officer at Usk, supported the man and his family. She kept in touch with his family with his agreement. During her conversations with his family she was able to identify who would be contacted following his death. Due to the distance his family lived from the prison, almost 200 miles, it was agreed that when he died she would be the one to inform his family by telephone.

76. On 7 October, the prison doctor increased the prescribed dose of MST. The man told the doctor that in the event of him collapsing he did not want to resuscitated or transferred to hospital. He signed a note confirming his instructions.

77. One of the considerations regarding the man's care was whether he had any thoughts of suicide. On 12 October, as part of the suicide and self harm prevention procedure, he was assessed. Officer C noted in the events log that the man was not displaying any suicidal thoughts and that he was looking forward to a visit. He was never considered to be at risk of suicide and so no special arrangements were made to monitor him.

78. Part of the man's care plan was that a pressure relieving mattress and cushion was supplied. The purpose was to prevent him from developing pressure sores. Palliative care nurses and community psychiatric nurses visited him regularly. They were supported by nurses from the Hospice Centre who provided help over the weekends.

79. On 16 October, the man signed a letter to say that in the event of cardiopulmonary collapse (heart failure) he did not want to be resuscitated. In that same letter he gave specific instructions that his family and partner were not to know of his instructions.

80. The man received a number of visits from his family and special arrangements were made to accommodate his needs. The Governor gave instructions for any arrangements to be made to facilitate his visits. As well as visits, he was given access to a telephone and allowed to speak to his son in Germany.

81. Seven days later, on 23 October, an officer made an entry in the events log to say that the man had received a visit that day from his partner. They spent two hours outside, sitting in the sports field, and also walking in the grounds of the prison. Additionally, the prison supplied lunch for them both, which they were able to eat outside. The officer adds that he and his partner told prison staff it was a day they would "cherish".

82. To ensure the man was able to obtain assistance, he was given a panic alarm. This was because it was proving difficult for him to leave his bed and use the in cell emergency call button.

83. On 7 November, the man received a visit from his brother. Officer A noted in the events log that arrangements were made for the visit to take place in his cell and that he had arranged for sandwiches to be provided.

84. Planning for his funeral, the man recorded a tape and wrote a letter to his family. The items were sent by post so that they be used at a

private family service, which he had asked to take place on moorland close to his home.

85. Due to a deterioration in his medical condition, the man asked to be transferred to Cardiff, where he could receive 24 hour palliative care. On 13 November, he was taken to Cardiff and admitted into the healthcare unit.

86. When the man arrived at Cardiff, a reception screening document was not completed. (Reception screening should be carried out for all receptions.) However, a healthcare care plan was completed, although the clinical reviewer has said that it did not address his poor appetite, breathlessness, anxiety or pressure area care. It did, however, include notes on maintaining his personal hygiene and managing his condition.

87. On 20 November, a consultant in palliative medicine and a palliative care nurse from the hospice assessed the man. Following that assessment, the doctor changed his medication.

88. The man's condition deteriorated over the next week. Seven days later, on 27 November, the Head of Healthcare asked a palliative care nurse to review him. Part of that assessment was a discussion about whether to transfer him to the hospice. However, his preference was to remain at the prison. A care pathway for "Last Days of Life" was started and prescription charts developed which sat alongside the care plan.

89. On 29 November the man was visited by his brother. As at Usk, special arrangements had been made for the visit to take place, which on this occasion was in healthcare.

8 December

90. On duty in healthcare on 8 December were a nurse and three officers. The nurse was responsible for the healthcare needs of all the prisoners that night and not just those in healthcare.

91. Officer D was on duty as the night patrol officer for healthcare and was responsible for the security of the unit. The other officers were on duty to monitor two high risk suicidal prisoners who required constant observation. The two officers sat directly outside the two gated cells.

92. Officer D said he took over responsibility for the unit at about 8.30pm. He began by ensuring that all the cell doors in healthcare were locked. At interview he said that at about 9.30pm, the nurse had asked for permission from the night manager to enter the man's cell. The officer said that this was because he was unwell. He went on to say that the Night Manager, a SO, arrived and unlocked the cell door. Officer E said that, due to the man's condition, the cell door remained unlocked to enable the nurse to enter and nurse the man. However, although he

was unable to remember when it was, he said the cell door was relocked and believes the night manager had locked it during one of his routine visits to the unit.

93. At interview, the SO said he first went into healthcare sometime between 10.00pm and 11.00pm. He said he went there as part of his normal duties and not because he was asked to go. The SO said he had unlocked the man's cell door to allow the nurse to attend to him, but relocked it as soon as they left.

94. The investigator asked the SO if he had considered allowing the man's cell to remain open all night. He said he had, but that the nurse preferred it to be locked.

9 December

95. At about 4.45am. Officer D was temporarily covering the duties of Officer F, as she had gone to the toilet. He said that on her way back from the toilet, she looked into the man's cell He said she asked him to check him as she could not see him breathing.

96. At that point, Officer D went to the cell and looked inside. He said the man was slumped over and so he asked the nurse, who was dealing with another prisoner, to assist.

97. Officer D said the nurse looked into the man's cell and decided to go inside. He said the nurse unlocked the cell door and they both went inside, whilst Officer F returned to her own duties. He said the nurse checked for signs of life but did not detect any and, having decided that the man had died, they laid him down. The officer said there were no signs of rigor mortis and from his recollection, believes his body was still warm.

98. As part of this investigation, the investigator interviewed Officer F and she confirmed Officer D's recollection of events. She thought that the man was lying on his back when she looked into the cell, although she was not certain.

99. The nurse said that when he entered the cell, he checked the man's condition and could find no evidence of life. The nurse said he checked for a pulse and also noted that the pupils were fixed and dilated. He believed that the man had died and so asked Officer F to inform the night manager. He then telephoned the on call doctor and told him what had happened. At interview, the nurse said the doctor told him he would come in later to certify death.

100. The nurse told the investigator that he was under the impression an ambulance had been called. He believed it was an automatic requirement whenever there was a death in custody, but that it was not

his responsibility to call one. The nurse said it was his understanding that the night manager would be dealing with it.

101. The SO told the investigator that he was in an office in the main part of the prison when he received a telephone call from Officer F. He said the officer told him that the nurse believed the man had died. The SO then made his way to healthcare but, before doing so, told the communications officer to start the death in custody contingency plans.

102. When he arrived into healthcare the SO spoke to the nurse. He said the nurse told him that he had telephoned the duty doctor who had refused to attend. The investigator, referring to the SO's written statement, asked why he had not reported the doctor's refusal as part of his report. The SO could not explain, but recognised that he ought to have done.

103. The investigator asked the SO if he was aware of the local contingency plans. He said he was. Asked why he had not asked for an ambulance, the SO said it was because the doctor had refused to attend. He said he tried to contact the Duty Governor for advice as he had already been notified of the death. The SO said the duty governor did not answer his telephone, presumably as he was driving to the prison.

Following the man's death

104. At about 6.10am, the Governor and two police officers arrived at the man's cell. The Governor asked the SO who had certified his death and was told by the SO that the doctor had refused to attend. He said the Governor told him she would deal with the issue later, but wanted an ambulance called.

105. At about 6.30am, paramedics arrived and carried out their own checks. They left the cell at 6.50am after confirming the man had died.

106. Just over two hours later, 8.15am, the duty doctor arrived at the man's cell. At 8.30am, the prison chaplain went into the cell to say prayers. After completing their work, police officers agreed that the body could be removed from the prison. At 10.55am, he was taken to the local mortuary.

107. In the meantime, the SO was contacted at Usk and told of the death. As arranged, she telephoned his family to break the news. I understand she continued to support the family and ensured his wishes were carried out. She arranged his funeral and went as a representative of Usk and Cardiff prisons, at the request of the man.

108. Following the man's death, all the prisoners in healthcare were spoken to and told that he had died. The two prisoners under constant monitoring were reassessed to ensure that they were safe. Prison staff told the investigator they had been well supported by their managers and felt they had the opportunity to speak to members of the care team.

ISSUES

Record of events log

109. The information contained in the events log whilst at Usk is informative and well documented. It is clear that a great deal of effort went into ensuring that all the man's needs were catered for. The notes made after he was told that he was terminally ill are thorough and show a high level of compassion and decency, which are worthy of special mention.

110. There are a number of contributions made by several different members of staff, all of which are good quality. However, in particular, there are consistent good quality notes made by Officer A. The officer has documented what was being done for the man and equally important, he has recorded how he was feeling.

111. Although I make no formal recommendation, I invite the Governor of Usk to share my comments with Officer A.

Video monitoring

112. Within the healthcare department at Cardiff there are closed circuit television cameras with recording facilities. The cameras monitor movement along two of the three ground floor corridors and images are stored automatically by the recording equipment. If required, the images can be played back and give a clear account of what occurred in the corridors.

113. In order to clarify where prison staff and the nurse were when it was realised that the man was not breathing, the investigator asked to see the video. Unfortunately, when the images were played back they showed a picture of the ceiling. The investigator was told that whenever there is a power cut, or when the generators are tested, the cameras move to a default position, which in this case is the ceiling. He was also told that only a member of the prison maintenance staff can re-set the cameras to the correct position.

114. Video monitoring is a useful tool and protects staff as well as prisoners. However, it is of no use whatsoever if, after a power cut, the cameras are not returned to their proper position. It is odd that although this was well known, no one had thought to include resetting the cameras in procedures following a power cut. It is for this reason that I make the following recommendation:

The Governor must ensure there is a procedure for resetting the cameras immediately following a power cut or generator test. Additionally there should be a daily audited check of the video monitor to ensure the cameras are in the correct position and working.

115. As I have already said, the cameras do not monitor all of the ground floor corridors. Because of this, the area outside the office and, very importantly, the two cells used to monitor high risk prisoners are not covered. I accept that the two cells have internal cameras, but they do not have the capability to show images outside of the cell. Irrespective of whether either of the two cells are occupied, there is no way of checking what happened along that area, which leaves an obvious gap in an otherwise useful system.

The Governor should consider installing an additional camera into the unmonitored area of the healthcare ground floor.

116. The work of a family liaison officer is a difficult and often understated one. Their work can have a huge impact on how the family of the deceased person feels, especially at a time when information is confusing. It is a role that requires particular skills and on this occasion worthy of recognition.

117. I have been pleased to learn of the level of support given to the man and his family by the SO. Despite him moving to Cardiff, she decided to continue her commitment to him and ensure that his wishes were taken care of. Equally important is the relationship she built up with his family. It was clear to the investigator that the SO had developed a level of trust and honesty with the family which enabled them to have full confidence in her. She is an extremely enthusiastic and dedicated family liaison officer and I invite the Governor to share my comments with her and her line manager.

Clinical care

118. The clinical reviewer said in her report that the man's medical records show that when he was at Usk his care was provided in a sensitive way. She added that healthcare were doing all they could to keep him pain free.

119. In addition to this, the clinical reviewer said his preferences for personal care, psychological, spiritual and physical support had been met at both Usk and Cardiff. She went on to say there had been good partnership working to support the man from :

- Community psychiatric nurses
- Clinical nurse specialist
- Palliative care specialist nurses
- Usk and Cardiff
- Specialist consultants
- Chaplaincy
- Family liaison officer
- Hospice Centre
- Hospice

Reception screening at Usk

120. Although outside the main body of this investigation, when the man arrived at Usk on 30 June 2008 the reception health screen was not completed correctly. The clinical reviewer said that the mental health section of the document had not been completed and, although he was recorded as having a disability, no details were recorded and no indication was given as to whether he wanted to see a doctor. The clinical reviewer said it is not clear what his mental state or disability was.

Healthcare staff at Usk should be reminded to fully complete the reception screening documents, highlight any changes and identify what risk assessments are required.

Prescription charts at Usk

121. The clinical reviewer noted that prescription charts completed at Usk were unclear in places, in particular when relating to controlled drugs. She added that the man had held his own medication and administered increased amounts of opioids, which she said increases the potential for error or overdose.

HMP Usk should undertake a review of its processes and procedures for the dispensing and monitoring of controlled drugs.

Pain management at Usk and Cardiff

122. The clinical reviewer has also noted that the man experienced many different pains which affected pain receptors in his skin, internal soft tissues, bone, glands and abdominal organs. The reviewer noted that, overall, his pain management had been good. However, the type of pain he experienced, its location, and severity had not routinely been assessed once the prognosis was clear. She went on to say that it was evident there had been informal discussions with him and that this had prompted changes and increases in his analgesia. However there was no regular pain self assessment such as the Visual Analogue Scale (a pain self rating out of ten) nor a specific assessment documenting the sites, number, and types of pain. The reviewer said it was clear to her that there were, on occasions, days of prolonged pain. In making her recommendation, she has quoted to several source documents, and I suggest that the recommendation is read with reference to them.

HMP Usk and Cardiff should review symptom assessment needs to ensure the type of pain experienced, location, and severity are assessed and documented and that guidance is in place.

Medical record keeping at Usk and Cardiff

123. The clinical reviewer said the medical records were generally in good order, however had found that some entries were illegible with abbreviations being used throughout. She adds that contrary to Nursing and Midwifery Council Guide to Record Keeping, medical entries were often unsigned and lines left blank between entries. At Usk in particular, I have made similar recommendations in the past.

Healthcare staff at Usk and Cardiff should be reminded that entries made in medical and nursing records are legible, signed and that abbreviations are not used.

Reception screening at Cardiff

124. On 13 October 2009, the man transferred to Cardiff, but when he arrived a reception screening document was not completed. However, a care plan was developed which identified his needs. Referring to the Guidance for Nurses and Midwives 2009 document, the clinical reviewer made the following recommendation:

Medical records should identify any risks or problems that have arisen and show the action taken to deal with them.

End of life pathway at Cardiff

125. In her clinical review, the clinical reviewer said the man had experienced symptoms such as nausea, reflux and fatigue. Fatigue is not commonly reported by patients, as they are often unaware that it can be treated. She said this meant it was an ongoing challenge for palliative care provision and that assessments should take place when ongoing pain and other symptoms have been identified.

126. In the man's case, the clinical reviewer said the Liverpool Care of the Dying Pathway had been correctly initiated. However, the recommended daily physical assessment which the Pathway recommends was not completed every day. That said, she added that it was clear that his problems with pain and breathing problems had been informally monitored.

HMP Cardiff should develop a protocol for "End of Life Pathway" for palliative patients.

Certifying death

127. Suspecting that the man had died, the nurse telephoned the on call doctor and told him what had occurred. At interview, the nurse said the doctor told him that he would be in later. This is contrary to what the Night Manager, the SO, recalled. During his interview he said the nurse told him that the doctor had refused to attend.

128. The clinical reviewer noted that there had been some confusion about the doctor's response. She said the duty doctor told her he had said he would be at the prison later that morning to certify the death, which she added supported the nurse's account of events.

129. Investigations often show that recollections of events are not exactly the same, and that discrepancies frequently occur. I am satisfied that this is the situation here. However, that said, there was a need to certify death as quickly as possible. The duty doctor and his employer SERCO should have been aware that, for any death in custody, there is a need to certify death in accordance with the prison contingency plans. Although the doctor does not appear to have refused to attend, by not attending immediately there was confusion about what should be done. It was some considerable time before the man's death was confirmed. It was confirmed by paramedics after an emergency ambulance was called, which was then unavailable to attend any emergency in the Cardiff area. There has to be clarity about what is expected from the doctors and for this reason I make the following recommendation.

The Governor, in partnership with the Local Health Board, should ensure there are clear guidelines in place on the timely and appropriate certification of death.

CONCLUSION

130. I am satisfied that when the man first began showing signs of illness in January 2009, his medical treatment was well managed and appropriate. It is clear that he was kept fully informed of the prognosis and that he and his family were included in the decisions taken.

131. It pleases me to learn that the Governors of both Usk and Cardiff made special arrangements to accommodate visits from the man's family. Additionally, I have been pleased to read that the man and his family had been well supported by the family liaison officer at Usk.

132. Although I have made several recommendations, they should not detract from the level of care and support given to the man. His request to remain in prison rather than a hospice is testament to that care and something both establishments can be proud of.

RECOMMENDATIONS

1. The Governor must ensure there is a procedure for resetting the cameras immediately following a power cut or generator test. Additionally there should be a daily auditable check of the video monitor to ensure the cameras are in the correct position and working.

   The recommendation has been accepted: "The Healthcare operational manager has been tasked with interrogating the system and arranging for modifications as necessary."

2. The Governor should consider installing an additional camera into the unmonitored area of the healthcare ground floor.

   The recommendation has not been accepted: "The use of CCTV monitoring systems can be a useful adjunct to staff observation and interaction in the care of prisoners. CCTV is used within designated healthcare cells for this purpose. Senior Management is of the view that installing additional cameras in the corridors would not substantially add to the care of prisoners and would be perceived as primarily for the observation of staff."

3. Healthcare staff at Usk should be reminded to fully complete the reception screening documents, highlight any changes and identify what risk assessments are required.

   The recommendation has been accepted in principle: "It is the practice of healthcare staff to fully complete the reception screening documents and take any required action as appropriate.

   The staff will be reminded of the importance of doing this in all instances."

4. HMP Usk should undertake a review of its processes and procedures for the dispensing and monitoring of controlled drugs.

   The recommendation has been accepted: "A full review of procedures concerning the dispensing of controlled drugs is being undertaken and advice is being sought from the LHB. Once these procedures have been reviewed all staff will be fully trained in the correct action to take."

5. HMP Usk and Cardiff should review symptom assessment needs to ensure the type of pain experienced, location, and severity are assessed and documented and that guidance is in place.

The recommendation has not been accepted: “The man was very closely monitored at HMP Cardiff by the Palliative Care Team and Prison Nursing/ Medical Staff.

It is documented that the Palliative Care Consultant visited the patient on more than one occasion and gave considerable support and expert guidance on pain management. This included a multi-agency case conference held 3rd December where the end of life pathway was discussed.

The Palliative Care Consultant also visited 20th November 2009, 3rd December and also faxed detailed information dated 1st December advising on pain management.

Her palliative care nurses also visited and gave specialist advice.

It is also noteworthy that the pharmacy staff were able to contact the Palliative Care Consultant to verify unfamiliar medication regimes a ensure Prescription Chart in place as suggested by the palliative care team.”

6. Healthcare staff at Usk and Cardiff should be reminded that entries made in medical and nursing records are legible, signed and that abbreviations are not used.

   The recommendation has been accepted: “Head of Prison Health will issue a Notice to Staff referring to medical note entries.”

   Head of healthcare will issue a Notice to staff regarding this issue.

7. Medical records should identify any risks or problems that have arisen and show the action taken to deal with them.

   The recommendation has been accepted in principle by HMP Cardiff. It has not been accepted by HMP Usk: “HMP Cardiff – the man was transferred accompanied by a Registered Nurse from HMP Usk to the Inpatient unit at HMP Cardiff. A comprehensive handover which included a nurse from HMP Usk working at Cardiff the following Day to ensure continuity of care. He was physically unwell and was admitted directly to In-patients. The reception assessments took place in Healthcare as more appropriate. He was not a new prisoner but a transfer in, so would not have had a new reception screen.

   “HMP Usk - A comprehensive care plan was completed for the ma and outside agencies involved with his care including palliative care nurses. A comprehensive handover was given to the staff at HMP Cardiff.”

8. HMP Cardiff should develop a protocol for “End of Life Pathway” for palliative patients.

The recommendation has been accepted: “Care Pathway for the last Days of Life in Place was in place. However it would be good practice to explore a more local agreed Prison.

“End of Life Pathway: Head of Health to explore this with the Palliative Care Consultant and produce a draft protocol.”

9. The Governor, in partnership with the Local Health Board, should ensure there are clear guidelines in place on the timely and appropriate certification of death.

The recommendation has been accepted: “Clarification of expected performance in this area and in line with HMP Cardiff local contingency plans for DIC will be discussed at the Local Health Partnership Board.”