

**The death in custody of
a man at
HMP Cardiff – October 2004**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

December 2005

This is the report of an investigation into the circumstances of the death of a man on 28 October 2004 while he was in HMP Cardiff serving a discretionary life sentence. The man's cause of death was hypertensive and ischaemic heart disease and pneumonia. He was 49 years old.

The investigation was carried out by one of my colleagues. Two separate clinical reviews of the man's clinical care and treatment have been carried out by two qualified nurses both of whom work for my office.

The clinical reviews reveal serious concerns about the level of healthcare afforded to the man.

A further issue arising from this investigation was the fact that, despite the man being in healthcare and apparently deteriorating in health, no consideration seems to have been given to contacting his next-of-kin (his elderly mother). There may be lessons here across the prison estate when managing prisoners who are becoming seriously unwell.

I extend my condolences to his family for their loss. I would like to thank the Governor of HMP Cardiff, and his staff for their help during this investigation.

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Summary

The man was born in East Yorkshire on 27 March 1955. In 1981, he was convicted of attempted murder and a discretionary life sentence was passed. He spent time at a number of different prisons in England until transferred to HMP Cardiff on 28 August 2002. At the time of his death, the man was 49 years-of-age.

The man had extensive health problems, including hypertension (high arterial blood pressure), and he had been diagnosed with temporal arteritis (inflammation of the temporal artery).

On 13 October 2004, the man was escorted to hospital for admission due to his deteriorating physical health. However, he was returned to HMP Cardiff the same day, it having been judged that he did not need immediate surgery. Subsequently, an out-patients appointment was arranged for 4 November.

The man got into difficulties with his breathing in the early hours of the morning on 28 October. Ten minutes passed before staff entered the cell, no ambulance was called and attempts at resuscitation failed. The subsequent post mortem gave the cause of death as hypertensive and ischaemic heart disease and pneumonia.

The man's next-of-kin was his elderly mother, who lives in the north east of England. HMP Cardiff arranged for staff from a prison close to her home to visit and inform her of her son's death. This report commends Cardiff for the way in which it arranged for the man's mother to be told that her son had died.

One of my Family Liaison Officers spoke by telephone to both the man's mother and to his step-brother. Both were concerned that the man had spent a long time in custody, seemingly without psychiatric assistance. I hope this report provides answers to the questions they had.

The report includes a number of recommendations regarding the provision of healthcare within the prison setting to ensure prisoners/patients receive health and social care mirroring that in the community.

Investigation Process

My practice in cases of deaths from apparently natural causes is to conduct an initial review to determine the extent of investigation required.

My investigator visited HMP Cardiff on 5 November 2004 when he spoke informally with the prison Governor, with the Safer Custody Manager and with a number of healthcare staff. The investigator was given access to the man's records, including his medical records.

One of my Family Liaison Officers telephoned the man's mother and subsequently spoke with his step-brother. The man's mother said that she had spoken to her son by telephone the week before he died. He had told her that he had gangrene in his leg, but that he would not be going to outside hospital as he had been told the cost would be too great. She told my Family Liaison Officer that her main concern was why her son was not in outside hospital at a time when he was seriously unwell. The man's mother wanted to know why she had not been told about the seriousness of her son's condition. Had she known he was so unwell, she would have visited him. The man's mother added that she was concerned that her son had remained in prison for such a long time and seemingly without receiving psychiatric help.

Like his mother, the man's step-brother was concerned that his brother had spent so much time in the prison system without receiving treatment for his psychiatric problems. He also wanted to know about his brother's physical care and treatment, and why no ambulance was called when his brother was noticed to be breathing with difficulty on the day he died.

A qualified carried out a clinical review. When the draft investigation report was issued to the appropriate bodies for consultation, comments from the Prison Service resulted in this office arranging for a second clinical review to be undertaken. This review was carried out by a second qualified nurse. Both nurses work for me.

No formal interviews with staff were conducted. This report is based upon a review of all relevant paperwork, including the man's clinical records, and a number of informal telephone discussions with staff.

HMP Cardiff

HMP Cardiff is a category 'B' local/training prison which opened in 1827 and which has accommodation for just under 800 prisoners. It accepts people remanded into custody from the courts in its catchment area, category C prisoners and stage 1 and 2 life prisoners.

Cardiff's regime includes full time education, employment in the prison workshops, and training courses.

The prison's Healthcare unit contains 16 in-patient beds located in single cells. Attached to the Healthcare unit is a day-care centre, which includes an association room for in-patients as well as consultation rooms.

Healthcare is provided by a wide range of professionals, with the nursing staff containing a high proportion of registered mental health nurses. The permanent staff are complemented by visiting professionals such as opticians and dentists.

The report of an announced inspection of Cardiff by Her Majesty's Chief Inspector of Prisons in February 2003, included:

'The delivery of healthcare at Cardiff was characterised by well motivated, professional staff who looked after prisoners in a caring and respectful way ...'

The Events Leading up to the Man's Death

The man was transferred to Cardiff on 28 August 2002, when he was seen by a healthcare doctor. The doctor's record includes: '*... Frequent attempts at self-harm ...*', before going on to list the man's physical problems as including temporal arteritis and hypertension.

From early after his arrival in Cardiff, the man's medical record contains frequent references to elevated blood pressure and complaints from him about pain, particularly in his legs, and headaches.

On 2 March 2004, the man attended an outpatient appointment at hospital. Following this appointment the consultant physician at the hospital wrote to a doctor at HMP Cardiff casting doubt on the diagnosis of temporal arteritis. He referred to the man's long term use of high dose steroids, which had caused side effects including hypertension.

On 27 September, a doctor at HMP Cardiff sent a referral letter to a vascular surgeon at hospital to say that the man had no pulses in his feet and poor blood flow. The doctor asked for a scan to be arranged urgently. On 28 September, a note was made in his medical record that he had had prolonged pain in his legs.

On 5 October, the man went to hospital for an outpatient appointment for a 'Lower Limb Doppler Scan' (a scan to check blood flow within the lower legs). The scan showed that he had a very poor blood flow in his legs.

On 13 October, an entry in the man's medical record referred to him having complained of unremitting pain all night. A separate record stated that a healthcare doctor was going to arrange for his admission to hospital due to the progressive deterioration in his physical health. In his referral letter to hospital, the healthcare doctor wrote: '*Thank you for taking this man who has severe peripheral vascular disease affecting his lower limbs. He had gangrenous changes on his [foot and toe], a large ... ulcer ... and sacral pressure sores ...*'

The man was taken into hospital on 13 October, but was sent back to HMP Cardiff later that same day. The discharge notification from the hospital stated: '*No need for surgical intervention tonight. We will arrange [an] outpatient appointment for him.*' An appointment was later given for him to see a vascular surgeon on 4 November.

From the point of his return from hospital on 13 October, up until his death two weeks later, the man's medical record contains repeated

references to him complaining about being in pain and asking for more analgesia.

On 27 October, an entry in the medical record in the morning refers to the man having great pain in both of his legs. By 1pm his pain was noted to have eased and at 3pm an entry was made that he had: *'Slept for most of [the afternoon], states pain free ...'*

During the night of 27/28 October, the man was being observed at 15-minute intervals. There were two officers on duty in the healthcare unit. Cell doors were not usually unlocked at night-time, but the officers carried keys in a sealed pouch and, if necessary, the seal could be broken and a cell entered in the case of an emergency.

One of the Healthcare Officers (HCO) told the investigator that he knew the man well. The man had been peaceful that particular night, but at 3.05am the HCO noticed that his breathing had suddenly become laboured and shallow. The HCO maintained observations and noticed, at about 3.15am, that the man's breathing seemed to have ceased altogether. The HCO radioed the control room to say that he was going into the cell. He called to the second Officer for assistance, and broke his sealed key pouch.

On entering the cell, the officers checked the man for signs of pulse and respiration and, finding no such signs, commenced CPR (cardiopulmonary resuscitation). It became apparent to one of the HCOs that the man was dead and that resuscitation would not prove successful so he ceased his attempts to resuscitate. The HCO recorded the time of making this decision as 3.25am.

The HCO said that local policy was that a 999 call should be made immediately when a major medical incident was discovered and that, if a person had ceased breathing, CPR should continue until paramedics pronounced death. The HCO said that in subsequent internal discussions about staff's actions that night, he acknowledged that he could have requested that a 999 call be made, and he could have continued with CPR until the arrival of paramedics. But based on his clinical experience, the HCO did not believe that either of those steps would have affected the outcome. He added that he did not believe it was very dignified to continue CPR when the person was clearly dead.

Following the man's death, a post mortem was carried out and the report included the following:

'... examination showed evidence of sufficient natural disease to account for death. In particular, the heart was mildly enlarged, which along with the appearance of the kidneys would be

consistent with the history of hypertension. In addition there was evidence of triple vessel coronary artery disease (atheroma) and there was some suggestion of a recent thrombus completely occluding the right coronary artery. Despite any naked-eye evidence of old or recent myocardial infarction it seems likely that a sudden fatal cardiac arrhythmia occurred due to the combined effects of hypertensive and ischaemic heart disease ...'

After the Man's Death

The man's mother lives in Humberside and she was noted in prison paperwork to be 85 years old and frail. Due to the distance between Cardiff and Humberside, and due also to her age and state of health, Cardiff contacted the prison closest to her home, HMP Hull, and asked if staff from that prison could visit to break the news in person to the man's mother. Hull arranged for two of its chaplains to make this visit.

Cardiff paid for the man's body to be transported to Humberside for the funeral service and burial.

When my investigator visited Cardiff, all the necessary information had been gathered together for the purposes of the investigation. Arrangements had also been made for my investigator to speak to relevant members of staff.

Level of Compliance with Prison Service Requirements

Standards of clinical care in prison are intended to mirror those available in the outside community. The man's care and treatment is described in the two clinical reviews which indicate that his health care needs were not addressed as adequately as should be expected.

The post incident response by HMP Cardiff was fully compliant with Prison Service instructions and policies on managing a death in custody. Furthermore, the arrangements made to break the sad news to the man's mother, and the subsequent arrangements regarding his funeral arrangements, were an example of best practice.

Findings and Conclusions

The man had been in continuous prison custody since 1981. He spent time at a number of different prisons and was transferred to his final prison, Cardiff, in August 2002. The man had a personality disorder and had been a prolific self-harmer from an early age. He said that he self-harmed as a way of coping with stress.

The man spent two periods of time at Grendon, which operates as a therapeutic unit, and where he engaged positively and responded to treatment programmes. In 2002, he was assessed by a hospital with a view to transferring to the Personality Disorder Unit there. The consultant psychiatrist could find no evidence of mental illness and therefore did not feel that a transfer to hospital was appropriate.

On arrival at Cardiff, at which time the man was 47 years old, his diagnosed medical conditions were recorded as: temporal arteritis, hypertension, chronic insomnia and recurrent acidity. He was receiving multiple prescribed medications, including high dose steroids that he had been receiving since 2000, following the diagnosis of temporal arteritis. There was a suggestion from a consultant at the hospital that this diagnosis might not have been correct, but that possibility remains unanswered.

The man's care and treatment is discussed in detail in the clinical reviews. These indicate that, during the course of his final year in particular, the man's various clinical conditions were becoming progressively more debilitating. In the final two months, he was referred to hospital on five separate occasions: for an investigation into a possible heart attack, for a problem with urinary retention that arose when some of his medication was stopped; and on three occasions in connection with increasing problems with blood flow in his legs. The man was sent an appointment to see the vascular surgeon on 4 November, following his referral to the hospital on 13 October. Had he still been alive by then, there is no question that cost implications would have prevented this referral from occurring.

The man's records also contain frequent references to him complaining about pain. His complaints included pain in his feet (presumably linked to the lack of blood flow in his legs) which towards the end of his life became gangrenous.

What emerges from the clinical reviews is that he was a man with numerous, long-standing, clinical conditions, yet no-one seems to have taken on the responsibility for a proper follow through of the investigation and treatment of his conditions. Instead, much of his care seems to have been reactive, with treatment given as and when

problems arose. Perhaps one of the clearest examples of this was in respect of the man's long history of uncontrolled hypertension where there seems to have been no change in his prescribed medication. It is more than possible that his health was compromised through the long term use of high dose steroids.

As in other cases I have investigated, the man's death has highlighted the difficulty faced by a prison healthcare unit when attempting to provide high intensity nursing care to a person who is seriously ill. The nursing records contain references on both 25 and 26 October that providing adequate care at night was hampered through staff not holding cell keys.

My investigation has also revealed questionable decision making by the HCO. I am unclear why an ambulance was not called at 3.05am when it became apparent that the man was experiencing difficulties with his breathing. Instead, he was left alone in his cell for a further 10 minutes before the HCO took the decision to enter using the key contained in his sealed pouch. When the HCO and a second officer entered the cell they commenced attempts at resuscitation. When they had continued for ten minutes without success, the HCO decided that the attempts should cease as it was clear that the man was dead. The HCO acknowledged that he did not follow local procedures about contacting emergency services and about continuing attempts at resuscitation until death has been pronounced by an appropriately qualified clinician.

The man was a significantly unwell and his condition deteriorated rapidly from September 2004. However, there is nothing to indicate that any thought was given about when or whether the man's mother should be contacted to let her know about the situation.

Local Recommendations

1. Healthcare professionals should be reminded of the need to evaluate and review care on a daily basis in order to ensure the highest possible standard of care is provided. The daily record of nursing care should reflect care prescribed in the care plan.
2. The prison doctor in charge of the patient's care should take responsibility for undertaking of investigations. Referrals to other members of the multi-disciplinary team should be made as soon as required, and followed up. Results of all investigations and tests should be documented clearly. Treatment and care should be reviewed in light of results.
3. Healthcare staff should be reminded of their professional responsibilities for standards of record keeping in accordance with their professional bodies.
4. Cardiff should review its local policies to ensure that, when it is recognised that a patient's health is compromised or deteriorating, his next-of-kin is notified and, if required, is involved in the care planning process.
5. The Governor should review his policy on response to serious clinical incidents and remind staff of its contents. Staff should be reminded that the emergency services should be contacted immediately. Staff should also be reminded about when, and upon whose authority, resuscitation attempts should cease.
6. The Governor should consider a simple enquiry into the actions of the HCO on the night of 27/28 October with respect to the failure to summon emergency assistance when the man first had breathing difficulties, and the subsequent decision to cease CPR without the authority to do so.

Good Practice

The method used by Cardiff to notify the man's mother of her son's death – to arrange for staff from a prison close to her home to visit her to break the news in person – was an example of best practice. I commend both Cardiff and Hull for their sensitive handling of this important but daunting duty. It was also good practice on Cardiff's part to pay for the man's body to be taken to Humberside for his funeral and burial.