Investigation into the death of a man whilst in the custody of HMP Cardiff in January 2011

Report by the Prisons and Probation Ombudsman for England and Wales

October 2011

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This is the report of the investigation into the death of the man. The man was a prisoner at HMP Cardiff. I would like to offer my condolences to his family and friends for their loss. I apologise for the delay in issuing this report.

The man had been serving a sentence of six years and had been in custody at Cardiff since 5 May 2010. He had never expressed any concerns to staff about being in custody and had taken part in offending behaviour groups. Prior to custody the man had used illicit drugs and this continued while in custody.

At 5.55am on 29 January, staff discovered the man slumped over his cell table. Emergency assistance was immediately requested and staff entered the cell and attempted to resuscitate him. However, it was apparent that the man had been dead for some time. Despite this, nursing staff continued their attempts to revive him until paramedics arrived at 6.20am and confirmed that the man was dead, ten minutes later.

Post-mortem and toxicology tests confirmed the cause of the man' death as Phentanyl toxicity.

The investigation was conducted by my senior investigator. I would like to thank the Governor of Cardiff and his staff for their cooperation. Health Inspectorate Wales (HIW) conducted a review of the medical care given to the man in custody. I am grateful for their report, which is attached in full as an annex to my report.

The investigation found no faults in prison policy or procedures that directly contributed to the man' death, beyond the obvious inability of the prison system to stem the flow of illicit drugs. I am satisfied that, generally, he was managed appropriately and that, when he was discovered, swift and correct action was taken in trying to resuscitate him. However, the clinical review has highlighted areas of concern about the management of the man' healthcare and I endorse HIW's recommendations on these areas. My concern at the problem of illicit drugs in the prison is compounded by the failure of the security department, to share information regarding the man's drug use with other departments – in particular healthcare. I therefore make six recommendations relating to prescribing medications, medical screening, recording and sharing of information between staff.

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.

Nigel Newcomen CBE
Prison and Probation Ombudsman **October 2011**

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SUMMARY

1. The man was 29 years old when he arrived at HMP Cardiff. He had been sentenced to six years and three months imprisonment at Cardiff Crown Court that day. This was not his first time in custody and he had been at Cardiff on previous occasions.

2. As part of his reception process, the man was seen and assessed by a nurse. A brief medical history was recorded, which included information on his previous drug use, and a referral was made for him to be further assessed by a member of the drug detoxification team. In addition to previous illicit drug use, he also told the nurse that he was awaiting a hospital appointment as he had metal in his right arm, as a result of a road traffic accident some years earlier and it had become infected. Despite his previous drug use and ongoing concerns about his arm, he said that he did not wish to be seen by the prison doctor and the nurse made no referral.

3. The man was said to be familiar with the prison regime and on the residential unit he settled in quickly. Staff said that they had no concerns about his behaviour and he was always polite and respectful. He also participated in and successfully completed a number of offending behaviour courses and the tutors said that he was a key member of the groups, always willing to take part in group discussions.

4. Although he never complained to his wing staff about any medical problems or pain and was not seen to be having any difficulties, both nursing staff and the prison doctor regularly reviewed the man, in relation to his arm injury. Shortly after his arrival at Cardiff, he was prescribed opiate-based pain relief, despite his previous drug history, which continued throughout his time there.

5. Although the man was considered to be well behaved, numerous intelligence reports raised concerns about his possible involvement in supplying and using illicit drugs or medication that had not been prescribed. However, searches of his cell by prison staff found nothing. Information obtained during the investigation has also indicated that he was using numerous medications other than those he was prescribed.

6. On the morning of the man's death, just before 6.00am, a member of staff carrying out a roll check of prisoners saw the man slumped across his cell table. The officer tried to get a response by calling to him and banging the door as he thought he may have fallen asleep, but when he did not respond the officer immediately sought help from his colleague. Both officers again tried to gain a response, before requesting medical assistance via their radio.

7. Prison discipline and nursing staff quickly attended the wing and checked to see whether he was breathing or had a pulse but a nurse found him to be 'cold to the touch' with no pulse and rigid limbs. This suggested that the man had been dead for sometime, however the nurse applied oxygen via a mask and remained with him until the paramedics arrived at 6.20am. The paramedics

assessed the man using their own equipment and pronounced him dead at 6.30am.

8. Following his death, a search of the man's cell discovered what appeared to be drug paraphernalia, burnt foil and a smoking implement on the table where he had been found.

9. The investigation has found several shortcomings in the management of the man's clinical care, but none of these failings contributed directly to his death. I have made recommendations on prescribing of medications, medical assessments and care plans, as well as the recording and sharing of information.

10. An inquest was held on 23 May 2011, and concluded that the man had died as a result of Phentanyl toxicity. Phentanyl is a strong pain killing opiate based drug, often used in the form of patches. During my investigation, the investigator was told that these patches could be smuggled into prison, and after warming the patches over a kettle the prisoner would remove the backing before smoking the residue over foil.

THE INVESTIGATION PROCESS

11. The investigation was opened by one of my investigators on 3 February. Notices were issued informing all staff and prisoners at Cardiff of my investigation and inviting anyone with information about the man to contact my investigator. No responses to the notices were received.

12. Another of my investigators visited Cardiff on 4, 5 and 6 April and, along with the clinical reviewer, from HIW, interviewed 14 members of staff. Transcripts of the interviews are attached as annexes to my report. My investigator provided feedback to the Governor both in person and in writing following conclusion of the interviews.

13. One of my family liaison officers (FLO) wrote to the man' family on 18 February, telling them of my investigation and explaining the investigation process. My FLO explained that both she and my investigator would be able to visit them to discuss any concerns that they may have about the man' death. The family raised no issues of concern at this stage. However, they will have the opportunity to receive and comment on my draft report should they wish to do so.

14. Healthcare Inspectorate Wales (HIW) was asked to conduct a clinical review into the medical care the man received while at Cardiff. HIW's report was received on 1 August 2011.

15. My investigator wrote to HM Coroner to inform them of the nature and scope of my investigation, and to request a copy of the post mortem report. The post mortem has not been received, but the inquest into the man' death was held on 23 May and the cause of death was given as Phentanyl toxicity.

HMP CARDIFF

16. HMP Cardiff is a large Victorian city centre-based local prison, predominantly serving the Welsh courts and the south-west of England. The prison holds adult convicted and remand prisoners and those awaiting sentence. It is designated to hold category B and C prisoners, including life sentenced prisoners. Like other prisons in England and Wales, Cardiff is expected to accommodate more prisoners than it was designed for. It has had an operational occupancy of 824 since December 2009.

17. The prison also holds vulnerable prisoners (those at risk of bullying) and sex offenders on a separate unit and there is also a dedicated wing for prisoners serving life sentences. In addition to receiving new prisoners from the courts, Cardiff provides a training function, with workshop, education and offending behaviour programmes.

18. The local health board commission's healthcare but all staff are employed by the Prison Service. These include registered nurses, hospital officers and healthcare assistants. The General Practitioner (GP) medical service contract is delivered by the local health board which also employs a consultant psychiatrist for seven sessions a week to provide mental health clinical work to the prison. The 22 bed healthcare centre offers 24 hour nursing and medical cover.

19. There is a detoxification wing where prisoners undergo initial detoxification from drugs. Wales does not use the Integrated Drug Treatment Service (IDTS) now available in the prison estate in England. The aim of IDTS is to provide a broader range of options for those with problematic drug use. If they arrive at Cardiff without a community prescription of methadone or Subutex (both used in the treatment of drug addiction), the only option is to go through a 14 day detoxification. Once this has been completed, and the prisoner is regarded as stable, they are moved to an ordinary residential wing. The Counselling, Assessment, Referral, Advice and Throughcare service (CARATs) provide longer term support for drug users.

20. An unannounced follow-up inspection of Cardiff in June 2010, by HM Chief Inspector of Prisons, commented that:

> "…Despite a tragic spate of deaths in custody, Cardiff continued to provide an essentially safe environment. An appropriately heightened focus had been given to suicide prevention work and to learning lessons that might prevent future fatalities. Early days in custody were satisfactorily managed, although reception staff struggled to deal with the churn of prisoners that they faced. Anti-bullying work was sound and levels of assault were low …"

21. The Prisons Act 1952 and Asylum Act 1999 require every prison to be monitored by an independent board, appointed by the Secretary of State, from the community in which the prison is situated. The local Independent Monitoring Board (IMB) published their last annual report in August 2010. They commented:

> "…During the reporting year, just like the last, there have been continuing financial constraints that have brought more pressure on the service, but the officers and staff are handling it in their own professional way, ensuring that the effort that has gone into their work to make HMP Cardiff a safe and worthwhile place to work and reside is not affected.
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> "The Board has recognised, and is concerned about an increase in the number of complaints made to the board relating to healthcare, and treatments. This has been discussed at Board level and the Senior Management team of HMP Cardiff have undertaken a review of healthcare provision at the Prison.
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> "We also had 5 deaths in custody during the reporting period, which was very sad for family, friends, cell mates and staff who were affected by the deaths. The prison did all they could to help those affected and were open and cooperated with the ensuing investigations and with the Board.
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> "Board members also attended 3 Coroner's Inquests during the reporting period, and were impressed to see both management and uniformed staff members also in attendance …"

22. Since this office was given responsibility for the investigation of all deaths in prison custody in 2004, there have been nine previous deaths at Cardiff. Recommendations following these investigations have focused on healthcare issues such as record keeping, medications and staff training. Some of these issues have been highlighted again in this investigation.

KEY EVENTS

23. The man was sentenced to six years and three months in prison on 5 May 2010, at Cardiff Crown Court. He arrived at HMP Cardiff the same day. It was not his first period in prison custody. The man was 29 years old and it was five days before his 30th birthday.

24. On arrival at Cardiff, reception staff interviewed the man and completed all the relevant documentation. He was then assessed by a nurse from the healthcare team who completed a health screen. The man told the nurse that he had seen his GP recently as he had 'infected' metal work in his right arm following an operation after a road traffic accident (RTA) around five years earlier. He said that he was awaiting an appointment at Prince Charles Hospital to have the metal work removed. He reported no other concerns with his physical health. When asked about his use of alcohol and drugs, he said that he drank varying amounts of alcohol most days. He also told the nurse that he used opiates and benzodiazepines occasionally, and had last used both a few days earlier. He also used cocaine and crack along with cannabis daily and had last used that day.

25. As is normal procedure, the nurse carried out a urine test to confirm whether or not the drugs the man had mentioned were in his system. This indicated a positive reading for all the drugs he had mentioned apart from heroin. On further questioning, the man said that he had not taken any of the substances intravenously, but had used in this way in the past. He said that he had not had any previous mental health problems and the nurse recorded that there was no need for an onward referral to the mental health team. The man said that he had never tried to harm himself either in custody or the community and that he did not wish to see the GP, or attend a secondary health screen.

26. The health screen is completed in two parts. The initial health screen aims to record the immediate concerns of the prisoner and any ongoing treatments or medications. The secondary screen, often completed the following day, is more in-depth and records any family history of illness, previous vaccinations and provides advice on smoking cessation and other services. A referral was made by the nurse for him to be seen by a member of staff from the substance misuse team.

27. Following the initial health screen, Nurse A assessed the man. Nurse A is a Registered Mental Health Nurse (RGN) whose role at Cardiff is a substance misuse nurse. He recorded that the man said that he used heroin and occasionally drank alcohol, but had not had any substances for three days, and there was no evidence of 'acute' withdrawal. He then prescribed the man with medication that could be taken if he developed any symptoms of withdrawal. The investigator and clinical reviewer interviewed nurse A. They asked him to clarify the entry in which he had written that the man had not had any substances for three days, as this differed to the entry recorded in the health screen. He replied that at Cardiff detoxification is provided for alcohol and heroin, so he would have been referring to the heroin at that time and not other substances.

28. Although Nurse A recorded his assessment of the man, there were no documents to show how he had assessed his level of withdrawal. The nurse said that he did use such tools and would have completed a withdrawal scale. He explained that these are hand written records and would have been placed in the man' medical file. When asked for an explanation as to why they were not in the record, the nurse said that it was possible that they may have fallen out or been mislaid.

29. Following the assessment by Nurse A, the man was prescribed 'rescue' medication. This treatment is given in case the prisoner develops stomach cramps or diarrhoea, the usual early signs of withdrawal. Nurse A confirmed that as the detoxification nurse he would discuss the medication with the doctor, but there was no requirement for the prisoner to be seen before the treatment is given. He confirmed that prisoners would be given the opportunity to see a GP if they so wished, but as no doctor is available in the afternoons this would not take place until after 6.30pm. The man chose not to see a GP.

30. Nurse A was asked about the other drugs that the man had been taking before he went into prison. He said that although the treatment immediately provided was for heroin and alcohol he would have had an in-depth discussion with the man about his entire drug history. He added that due to the volume of prisoners he assesses on reception it is difficult to record a complete history.

31. Guidance is provided on the management of prisoners identified as requiring drug or alcohol detoxification when they are received into prison. In Wales, prisons have their own internal systems for providing this service, rather than the service-wide approach taken in England. Nurse A was asked whether prisoners are routinely monitored during the first 24 hours in custody as part of the detoxification process. He said that prisoners such as the man would be told during the assessment that they were not showing symptoms of withdrawal and the rescue medication would be explained. They would also be told that if they felt that they were developing further symptoms in the following days they should tell one of the healthcare staff and a substance misuse nurse would complete a further assessment. However, such prisoners would not be otherwise monitored. Nurse A said that the man did not mention any other medical concerns during the assessment.

32. This was not the first time that the man had been in custody, and he was familiar with the prison system. He settled in well on the residential wing. The wing staff told the investigator that he raised no concerns and they did not consider him to be a problem. Despite this view, a number of security reports were submitted during the man's time at Cardiff that suggested he may have been involved in using illicit drugs in custody. Security Information Reports (SIRs) are reports that can be submitted by anyone working within a prison that sees or hears something, or is given information that may lead to a breach of security within the prison. The reports are completed, detailing the concern and passed to the security department, who analyse the information and decide on further action to be taken.

33. The first SIR regarding the man was submitted on 9 May 2010, and raised concerns that he may be in possession of cannabis and Subutex. Subutex is the trade name for buprenorphine hydrochloride, and is used in the treatment of heroin and methadone withdrawal. However, within a custodial setting Subutex is seen as a valuable commodity and is widely used illicitly for its ability to create the same affects as other morphine-based medications.

34. As a result of the SIR, staff searched the man' cell, but nothing was found. On 20 May, the man was assessed by a nurse as he told her he was having some pain in his right arm as a result of an earlier road traffic act. The nurse recorded that he had previously been prescribed tramadol by his community GP, and referred him to be assessed by the prison doctor. Tramadol is an opiate based painkiller. The medical record does not make it clear who assessed the man on this occasion and he was seen again on 8 June, but again the signature on the medical notes is unreadable. However, it is believed to have been Dr A, a GP at Cardiff and she was interviewed during the investigation.

35. Dr A confirmed that she had referred the man to the orthopaedic department at Prince Charles Hospital on 8 June. However, she said that as it was an old injury it would not have been considered as urgent and it would not be unusual for a patient to wait between six to 18 months for an appointment. The man was prescribed co-codamol, another opiate based pain relief medication used to treat short term conditions. Guidelines indicate that co-codamol should not be used long term as it can be addictive. It was still being prescribed to the man in July. At the end of July he was reviewed again, but as with other entries on the medical notes it is unclear who saw him. On this occasion he was prescribed tramadol 100mg and trazodone 150mg. Trazodone is used to treat depression. It may also be used for relief of anxiety disorders (eg, sleeplessness, tension) and chronic pain.

36. During the investigation, my investigator asked for Nurse A's views on prescribling such medication to a prisoner who had a history of illicit opiate use. He replied that it is a difficult situation as when prisoners first arrive into custody they will often be on opiate medication. However, as a rule they would avoid prescribing this on the detoxification wing unless the prisoner has clear, acute symptoms of pain. This would be assessed by observing both non verbal signs as well as verbal reports of pain.

37. Nurse A said that opiate based medication would be rarely used on the detoxification wing, as it would be counter productive. He considered that it would be more difficult for a GP assessing someone on a residential wing to make the same assessment and if the wing doctor believed that the prisoner had signs of pain they may prescribe it.

38. The man began offending behaviour work and attended a Prison Addressing Substance Related Offending (PASRO) course, which ran for five weeks and concluded in October 2010. The course is a cognitive behavioural therapy based programme, looking at the thinking and behaviour of the prisoner, how that links with their drug use and, in turn, how that links with offending. The

tutor on the PASRO course said that it is a case of trying to get prisoners to examine and analyse themselves in the way they think and the way they behave and hopefully by changing that, it will help them to reduce or abstain from drugs and consequently reduce offending.

39. In a report completed by the tutor on the PASRO course at the end of the course, she commented that the man had not used drugs for three months prior to going into custody. She explained that this information would have been obtained verbally from him and they rely on the participants to be as truthful as possible about their drug use. During the course the man had done well and she had not had any issues with him. As a requirement for attendance on the course, all prisoners have to provide a negative drug test. The man had complied with this. However, the opiate based medication that he had been prescribed would have accounted for any positive indication for opiates in his system, and therefore it was impossible to ascertain whether he was taking any other opiates illicitly. As he was familiar with the prison drug tests and had a knowledge of drugs, it is likely that the man would have been aware of the effects his prescribed medication would have on any urine test he was asked to provide.

40. Although he continued to be prescribed high doses of pain relief for his arm injury, staff on the man' wing said that he had never mentioned having any pain or showed any signs of having difficulty with his arm. On 21 September and 18 October, the prison doctor assessed the man. As he had not yet been seen following the earlier referral, she made a further referral to the Trauma Unit at University Hospital Wales (UHW), and this was sent on 21 October. The man' prescription chart also indicates that he started to be prescribed dihydrocodeine, at the start of November. Dihydrocodeine is a synthetic version of the opiate codeine, again used for pain relief. In addition to this, he continued to receive co-codamol and trazodone. The entry on the medical record indicates that the initial prescription for dihydrocodeine was for two weeks.

41. The man attended for an appointment at UHW on 15 November. The doctor at the UHW sent a letter detailing his consultation with the man to the prison doctor at Cardiff. The doctor's letter at UHW's says that on examination, even though the plates appear broken, they are well fixed and in his opinion should cause The man no problems whatsoever. He also says that the man was given a steroid injection into his shoulder during the consultation and was seen by a physiotherapist, who gave him some exercises that he could do to improve the movement in his arm. The doctor at UHW closed the letter by saying that the man would benefit from a period of physiotherapy that could be arranged through Cardiff Royal Infirmary, but he would not need to see him again. The prison doctor received the letter on 24 November. Despite the doctor at UHW saying that the man should not have any problems with his arm, his medication regime remained unchanged.

42. In fact, on 25 November, the man was prescribed 75mg once daily of pregabalin, (an anti-convulsant used to treat partial seizures and pain relief) which continued into January 2011. Pregabalin is prescribed widely within

prisons. In a number of recent investigations by my office, pregabalin has been found to be used, illicitly, by prisoners. It is not clear what effects prisoners experience from taking this drug, but there is information which suggests the possibility that when used in conjunction with other medications it can provide the individual with a drug induced 'high'.

43. On 27 November, the man submitted an application to speak with a member of staff from the CARATs team. (CARATs is the acronym for the service provided in all prisons offering initial assessment after referral, advice to prisoners with substance misuse problems, liaison with healthcare, both in prison and in the community, care plan assessments, one-to-one group work and counselling services, assessments for intensive treatment programmes, throughcare linking with community drug treatment services and ensuring, where required, prisoners are offered post release support for up to a maximum of eight weeks.) It is usual for CARATs workers to be employed independently by the service, but at Cardiff the team consists of half civilian staff, employed by the Drug Strategy Team, and half uniformed staff.

44. Following his application, the man was seen and spoken to by Officer A, a member of the CARATs team. The officer explained that when he took on the man's case he had already completed a lot of the work including the PASRO course. He said that his interaction with the man was dealing with relapse prevention and harm protection advice. The man was also keen to complete the 12 Step programme, and he provided him with information on this. (The 12 Step programme was originally devised by Alcoholics Anonymous as a set of guiding principles to help those with addictions address their problems. This has been adapted and 12 Step courses are now provided in some prisons as a recognised offending behaviour course.)

45. Officer A said that the man was always polite and he never had any reason to be concerned about him. When asked by the investigator whether information obtained about a prisoner believed to be involved in drugs in the prison would be shared with the CARATs team, he said that in his opinion it would not happen. He said that while it may be useful to have information passed from security, the CARATs team would be unable to do the same, due to client confidentiality.

46. During December, further information was submitted to the security department indicating that the man was either in possession of illicit drugs or involved in getting them into the prison. Officer B submitted one of the security information reports suggesting that the man had received Subutex from another prisoner. The officer said that the information had been obtained from another prisoner and when staff approached the man in order to conduct a search it was believed that he had swallowed the item. A search of the man' cell was carried out by staff, but nothing was found. Officer B said that he worked regularly on the wing where the man was living and that he had never been a problem. He added that the man had a close circle of friends and he would never have described the man as 'vulnerable'. Officer B said that in fact the man was very aware of the prison rules and regime and what he was required to do.

47. The investigator also asked Officer B whether, in the time that he had known him, the man had ever complained about any pain with his arm. He said that it was unusual for a prisoner to mention that kind of problem to staff on the wing as they know they cannot provide medication, but he had never known the man to have any problems.

48. In addition to the other offending behaviour courses he had been doing such as PASRO, the man also completed an Enhanced Thinking Skills (ETS) course on 18 December. The ETS course consists of 15 group sessions and also four one to one sessions with a key worker. The man's key worker was Officer C. The officer said that he had no knowledge of the man prior to him starting on the course. He described him as a physically large person, quite imposing and prepared to speak his mind.

49. Officer C explained the format of the course and said that the four one to one sessions were an opportunity for him and the man to get to know each other better. When asked, the officer said that he had not been aware of any information in relation to the man' involvement with drugs or any other problems. They had talked about his previous drug use, but he had never mentioned any current problems, and the officer's impression was that he was 'clean' and drug-free. The officer was asked whether he felt that the man was on the course for genuine reasons. His impression was that the man was committed to the course and had completed other offending behaviour groups successfully.

50. The investigator asked Officer C whether the man had ever mentioned any problems with his arm while on the course. He recalled that there was an issue early on in the course where the man had talked about not being able to use the gymnasium due to the medication he was taking. The man had mentioned stopping the medication so that he would be able to attend the gymnasium.

51. The psychologist at Cardiff and a facilitator on the ETS course. At interview with the investigator, she was also of the opinion that the man had been committed to the course. She said that there was never any concern that he was under the influence of any substances. He was always alert, clean and tidy and engaged in the sessions.

52. During January there was further security information indicating that the man may be in possession of a mobile telephone, and also linking him with possible involvement in trying to get Subutex into the prison via visits. (Mobile telephones are banned within prisons, but are smuggled into prisons via many means, and used by prisoners to contact family without having to buy credits to use the approved telephones. However, they are also widely used for illicit reasons, such as organising drugs to enter the prison and witness intimidation.) A search was carried out on the man but nothing illicit was discovered.

53. On 28 January, an end of ETS course presentation was held at the prison and the man' mother attended to see him receive his certificate. Later the same day he had a visit with his mother.

54. Unsubstantiated information obtained by the investigator claimed that the man was taking various drugs illicitly on the wing including carbamazapine (an anti-convulsant and mood stabilising drug used primarily in the treatment of epilepsy), gabapentin (again used to treat epilepsy, and also for pain relief.) It was also said that the man would take any other prescription medication that he could obtain, which would alter his mood. The investigator was told that on 28 January, the man had taken 21 carbamazapine tablets, 18 gabapentin tablets and two and a half pregabalin tablets.

55. In addition to these medications, it was said that the man had also smoked the residue from a 'morphine patch'. (The patches actually contain Phentanyl which is said to be around 100 times stronger than morphine. They are used to treat severe pain and often used as pain relief pre-surgery.) The investigator was told that prisoners have these patches smuggled into prison, and then warm them over a kettle to remove the backing containing the drug. This would then be rolled into a ball and smoked over foil in the same way as 'crack cocaine' or heroin. However, none of this information is substantiated as the source did not wish his identity to be revealed in this report.

56. The man was not subject to any additional monitoring and, apart from routine roll checks, would not have been observed by staff at any other time during the night. At 5.52am on 29 January, Operational Support Grade (OSG) was carrying out a count of all prisoners as part of his night duties. (An OSG is a member of prison staff at a grade below prison officer. They work in many areas of the prison, normally where there is little contact with prisoners.) On reaching the man cell he looked through the observation panel and saw him sat at his cell table, slumped forward as if he was asleep. The OSG called to him and banged on the door to gain a response, but no response was obtained. The OSG then asked Officer D who was also assisting in counting prisoners on C wing if he would check the man as he had been unable to gain a response. Officer D also attempted to get a response by calling to the man and when this failed, he told the OSG to use his radio and request assistance from both the orderly officer (the officer in charge of the prison at night) and healthcare staff.

57. During the night state prisons are at a level of minimum staffing and, apart from the orderly officer, officers and OSG's do not carry keys. However, they are provided with an emergency pouch which contains a single cell key, which can be opened in the event of an emergency. Officer E heard the radio call and immediately made his way to C wing where the OSG and Officer D were still trying to gain a response from the man. Officer D said that he arrived around 5.58am. He looked into the cell and saw the man in a seated position and he looked as though he had fallen asleep at the table. It was decided that as the orderly officer was now entering the wing that the sealed pouches would not be opened.

58. Senior Officer (SO) was the orderly officer and on his arrival he quickly assessed the situation and opened the cell door. Officers E and D entered the cell and lifted the man back in his chair. Officer E described the man as 'very cold' and said that his jaw appeared locked which made any attempts at cardio

pulmonary resuscitation (CPR) impossible. The SO used his radio and asked the control room to request an emergency ambulance.

59. The first nurse on the scene, who had been in the healthcare centre when she heard the emergency call, arrived with emergency equipment at 6.05am, and began to assess the man. She said that he was 'cold to the touch' and there was no pulse. She also said that his limbs were 'rigid'. Despite these indicators which would suggest that the man had been dead for sometime, the nurse applied oxygen via a mask to the man, and remained with him until the arrival of paramedics at 6.20am. Upon their arrival, the paramedics assessed the man using their own equipment and pronounced him dead at 6.30am.

60. Following the man' death, Officer F, a member of the staff care and welfare team, attended the wing and spoke to all the staff involved to check that they were alright. The Governor was notified of the man' death. He arrived at the prison at 8.10am and, along with the reverend drove to the home of the man's mother to inform her of her son's death.

61. The Governor and the reverend explained the circumstances of the man's death as they were known at that time and the reverend provided the family with his contact details and told them that he would be acting as liaison for the prison.

62. An inquest into the man's death was held on 23 May 2011, and concluded that he had died as a result of Phentanyl toxicity. A finding of accidental death was given by the jury.

ISSUES

Reception medical screening

63. When the man arrived at Cardiff he was assessed by a nurse and an initial health screen was completed as required. However, it is a concern that the form was incomplete, key information was not entered and the signature of the nurse completing the assessment was illegible. No referral was made for him to be seen by the doctor, although, the medical notes do indicate that the man did not wish to be seen by a GP. However, the nurse completing the screening process did make a referral to the detoxification nurse.

64. In addition to the initial health screen, there is provision for a secondary screen to be carried out within 72 hours of a prisoner arriving into custody. This is intended to gain a more in-depth medical history. The man did not have this health screen, but again there is documentary evidence that indicates he declined it.

65. While it is accepted that the man had declined to be seen by a GP on reception and to participate in the secondary health screen, there was a history of drug use, and a pre-existing injury for which he was taking pain relief. Given this history, a more formal approach to the man' care should have been taken. In view of this, the clinical reviewer has made the following recommendations which I endorse:

    The Head of Healthcare should ensure that during assessments, the reasons for taking medication should be properly assessed, recorded and used to help formulate a risk assessment.

    The Head of Healthcare should ensure that individual care plans are formulated for all prisoners presenting with healthcare issues following assessment on admission.

    The Head of Healthcare should ensure that prisoners taking pain relief for pre-existing injuries and who have co-occurring alcohol or substance misuse issues are referred to a doctor for a full physical examination, assessment of the need for further investigations and a review of medication.

Drug and alcohol assessment

66. As previously mentioned, the man was seen and assessed by the detoxification nurse as part of his reception process, following the referral by the nurse. However, the investigator and clinical review team could find no documentary evidence to indicate what had been discussed, or how the levels of withdrawal were checked. The detoxification nurse who completed the assessment told the investigator that substance misuse scales and alcohol scales were used and should have been included in the medical notes. He added that these are often placed inside the notes and he surmised that they may have slipped out. The nurse also said that a more in-depth discussion would have taken place

with the man than recorded on the medical record, but he would not have time to record everything in detail.

67. During the investigation both the investigator and the clinical reviewer had difficulty in deciphering entries made on medical notes or trying to find relevant information. It is unacceptable for important information to 'slip out' and, equally, all information taken from a patient for whatever reason should be recorded, as it may prove useful to other professionals. The Healthcare Inspectorate Wales has indicated that they have made recommendations previously regarding healthcare records at Cardiff and while they have not repeated these in this review, I make the following recommendation:

The Head of Healthcare should remind all medical staff of the importance of recording all information and ensure that all documentation is completed in line with the Nursing and Midwifery Council Guidelines.

Prescribing of medication

68. Throughout his time at Cardiff, the man was prescribed regular doses of opiate based pain relief, despite his history of substance misuse, and continued security information relating to his possible involvement in the misuse of drugs. There are no clear indications for the reasons that some of the medications, including anti-depressants, were prescribed and insufficient reviews. For example, a consultant at UHW treated the man and indicated that there should be no further problem with an old injury to his arm, yet no change was made to his medication for this condition. Again, I refer to my earlier recommendation about the importance of fully documenting decisions in the medical notes. It is likely that the man would have been aware that any legitimate opiate-based medication prescribed would mask anything he took illicitly, should he be tested by prison staff. The clinical reviewer has also raised this as a concern and makes the following recommendation which I recast and endorse:

The Head of Healthcare should conduct a review of the prescribing policy for opiate-based medication to ensure that there are sufficient safeguards in place to prevent unnecessary prescribing for prisoners with a history of substance misuse problems. Where such medications are required all, decisions should be documented.

Sharing of information

69. During the investigation, it was clear regular information had been passed to the security department at Cardiff suggesting that the man was believed to be involved in either using or supplying illicit drugs. However, during interviews with healthcare staff and staff who engaged with him as part of treatment programmes the investigator and clinical reviewer were told that this information had not been passed to them.

70. I consider the failure to share important information between departments to be unacceptable. If staff working with the man had been made aware of the intelligence reports, then questions could have been asked about his suitability

for such programmes. Furthermore, questions could have been raised about his suitability to attend group sessions with other prisoners who may have been vulnerable to relapsing back into drug use if he was indeed involved in supplying drugs. Medical staff, if told of the concerns that were being raised on a regular basis, would also have been able to review the medication the man was being prescribed. Again, I concur with and endorse the following recommendation by the clinical reviewer, which I have slightly recast:

The Governor should conduct a review of how security information is shared with healthcare and drug treatment staff responsible for formulating assessments and facilitating treatment groups and implement a procedure to ensure that relevant aspects of such information are shared with key staff.

CONCLUSION

71. Evidence obtained during the investigation suggests that during his time at Cardiff, the man may have presented differently to various staff with whom he had contact. Wing staff did not see him as a problematic prisoner, and described him as a prisoner who got on with prison life and was polite and respectful. He never complained of having any medical problems to wing staff and they never observed any problems with his arm. Despite this, he was seen regularly by healthcare staff and talked of constant pain and was prescribed medication.

72. He engaged with treatment programmes where it was said he made good progress, and was a key member in group sessions. However, numerous intelligence reports indicated that he was involved in illicit drug use. That said, the man was never actually found in possession of illicit drugs. All drug tests performed, although positive were recorded as being due to his prescribed opiate based medication.

73. The clinical reviewer has concluded that the man death was neither foreseeable nor preventable, a view which I share. However, improvements are clearly required in respect of some aspects of the clinical care of prisoners taking medication, the sharing of information and, more broadly, the tackling of illicit drug use in prisons.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that during assessments, the reasons for taking medication should be properly assessed, recorded, and used to help formulate a risk assessment.

   The Prison Service accepted this recommendation and said:

   Medical staff including GPs when they assess a patient will record the consultation and reasons for prescription, this will help formulate the risk assessment

   A Notice to all healthcare staff will be sent. Target October 2011

2. The Head of Healthcare should ensure that individual care plans are formulated for all prisoners presenting with healthcare issues following assessment on admission.

   The Prison Service accepted this recommendation and said:

   Individual care plans will be formulated based on clinical assessment.

   Relevant paperwork to be available in all clinical areas. Target October 2011

3. The Head of Healthcare should ensure that prisoners taking pain relief for pre-existing injuries and who have co-occurring alcohol or substance misuse issues are referred to a doctor for a full physical examination, assessment of the need for further investigations and a review of medication.

   The Prison Service accepted this recommendation and said:

   A notice to staff will be issued reminding staff of this.

4. The Head of Healthcare should remind all medical staff of the importance of recording all information and ensure that all documentation is completed in line with the Nursing and Midwifery Council Guidelines.

   The Prison Service accepted this recommendation and said:

   A further notice to staff reminding them of the importance of recording all information in the clinical record, and that all documentation is completed is to be sent.

   Monthly management checks to be completed by Band 7 Senior Nurse. Target October 2011.

   Introduce System One Clinical I.T. Target January 2012

5. The Head of Healthcare should conduct a review of the prescribing policy for opiate-based medication to ensure that there are sufficient safeguards in place

to prevent unnecessary prescribing for prisoners with a history of substance misuse problems. Where such medications are required, all decisions are documented.

The Prison Service accepted this recommendation and said:

Currently this is being reviewed by the Medicine Management Steering Group in partnership with the UHB. The group is chaired by the Principal Pharmacist and membership includes prescribers. An audit of opiate prescribing continues to be carried out on a monthly basis.

This information will be shared with prescribers. Target November 2011.

6. The Governor should conduct a review of how security information is shared with healthcare and drug treatment staff responsible for formulating assessments and facilitating treatment groups and implement a procedure to ensure that relevant aspects of such information are shared with key staff.

The Prison Service accepted this recommendation and said:

The Head of Security to ensure that all interested parties are supplied with any intelligence regarding illicit drug taking by prisoners, in-line with the Security Information Report (SIR) "Actions completed" section. Target October 2011.