Investigation into the circumstances surrounding the death of a man on 6 March 2011 while in the custody of HMP & YOI Parc

Report by the Prisons and Probation Ombudsman for England and Wales

June 2012

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.

This is the report into the circumstances surrounding the death of prisoner on 6 March 2011 at a local hospital. The man had been in custody at HMP & YOI Parc since 18 January 2011 and was admitted to the hospital on 24 February 2011. The man remained in hospital until his death. He was 79 years old.

The post mortem report shows that the man died of widespread cancer and pneumonia. I extend my sincere condolences to his family and friends.

The investigation was undertaken one of my senior investigators. A doctor was asked by Healthcare Inspectorate Wales (HIW) to undertake a review of the man's clinical care and I appreciate his assistance. I would also like to thank the Director of Parc and her staff for their assistance with this investigation. I apologise for the delay in issuing this report.

The investigation concludes that the man's healthcare was adequate but was below the standard that he might have received in the community. While nothing could have changed the eventual outcome for the man, there are a number of aspects of his care which could have been improved and recommendations are made to address these. It is also disappointing that it is necessary to repeat a recommendation made in a previous death in custody investigation at Parc regarding the need to improve medical record keeping.

The recommendations made in the draft report have been accepted by Parc. I have included the prison's response to the recommendations at the end of this report.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **June 2012**

SUMMARY

1. The man was born in 1931. He was 79 years old when he died on 6 March 2011, at a local hospital. The man died of natural causes as a consequence of widespread cancer.

2. In January 2011 at Crown Court, the man was sentenced to 12 years imprisonment for a serious offence. He arrived at HMP & YOI Parc on the same day. This was his first time in custody.

3. During the man's first reception health screening interview, it was recorded that he had prostate problems and had had a gallstone removed. It was also recorded that he had an outstanding hospital appointment in relation to pain in his lung and heart.

4. Five weeks later, on 24 February, the man was admitted to a local hospital suffering from retention of urine.

5. While the man was in hospital he was supervised by staff on a bedwatch. The initial security risk assessment concluded that restraints were to be used and two officers were to be at his bedside. On 26 February, following the diagnosis that his condition was terminal, the risk assessment was revised and the restraints were removed and not re-applied.

6. The man's health continued to deteriorate while he was in hospital and he passed away at 8.45pm on 6 March 2011. His family were at his bedside when he died.

7. The clinical review carried out on behalf of Healthcare Inspectorate Wales (HIW) considered the care provided for The man. In HIW's view, the quality of care given to the man was not equivalent to that he would have received in the community. HIW makes five recommendations for service improvement, three of which we endorse. We understand that the prison health partnership is considering the findings from the review and is developing an action plan to address them. While HIW refrained from making a recommendation in relation to the quality of healthcare records it should be noted that those seen were often illegible, unsigned and brief. This issue has been raised in previous reports and we have decided to raise it again.

THE INVESTIGATION PROCESS

8. The investigator was formally notified of the man's death on 7 March 2011. Notices were subsequently issued to both staff and prisoners at HMP & YOI Parc to inform them of the investigation process and asking anyone who had information relevant to the investigation to contact the investigator. No responses were received. The investigator also studied all the relevant prison records relating to the man which included his main prison record and his medical records.

9. A clinical review was commissioned from Healthcare Inspectorate Wales (HIW) into the care provided for the man during his time in custody. The purpose of the review is to establish whether the care which the man received in prison was equitable to that he would have been offered in the community and to identify any points of learning. A doctor was appointed to lead the clinical review. We are grateful for the review which was received on 5 October 2011 and is annexed to this report.

10. We apologise for the delay in issuing the draft report. This was due to work pressures at the Ombudsman's office and late receipt of the clinical review.

11. One of our family liaison officers contacted the man's family. They were informed about the purpose of the investigation and offered the chance to raise any concerns or questions that they wanted to be addressed. The family raised the following matters:

    - The medical care the man received whilst in custody.
    - Why restraints were used when clearly the man was not a well man.

    We have attempted to address these issues within the report and hope that this helps the man's family to understand the events leading up to his death. The family received a copy of this report as part of the consultation period and chose not to make any comments on the findings of the investigation.

12. The investigator visited Parc on 8 March and spoke to the Director as well as other staff involved in the care of the man. He returned to Parc on 15 April and he was accompanied by the clinical reviewer and member of HIW staff. They interviewed a number of staff and also visited the local General Practitioners surgery to conduct interviews.

13. The investigation assesses the following aspects of the man' care and treatment:

    - Whether his diagnosis was made in a timely fashion?
    - Whether the man was told about his condition and the treatment which followed?
    - Whether he was treated properly and attended hospital appointments as necessary?
    - Whether the liaison with the man's family was appropriate?
    - Whether the man was accommodated in the most appropriate part of the prison?

- Whether consideration was given to compassionate release from prison?
- Whether appropriate palliative care was provided?

HMP & YOI PARC

14. HMP Parc is a category B local prison and Young Offender Institution (YOI) which opened in 1997 on the outskirts of Bridgend, South Wales. It is operated by Group 4 Securicor (G4S Justice Services) on behalf of the National Offender Management Service. It is the only privately run prison in Wales. The prison holds up to 1,474 sentenced male adults and sentenced and remand young offenders. In addition, the prison also holds young people (those under 18 years of age.) There are five houseblocks and all cells are equipped with in-cell sanitation. All wings are equipped with showers, laundry facilities and large association area. During 2010, Parc underwent major additions and alterations. These changes included a new wing for 400 prisoners, a vulnerable prisoner unit and a new healthcare facility. All these new facilities became operational in October 2010.

15. During 2010, the General Practitioner (GP) contract at Parc was awarded to a local surgery in Aberdare which provides the GP input to the prison. Initially this was for 10 sessions a week but this increased to 12 and from mid-April 2011 increased to 14 sessions a week in line with the expansion and the change of the type of prisoner at HMP Parc. The GPs provide cover 24 hours a day, seven days a week and provide an emergency surgery on Sundays. There is a full GP services between 9.00am and 5.00pm every weekday. The doctors are on site at the weekends and have emergency surgeries on Saturday and Sunday.

16. Parc has a new healthcare centre that provides 24 hour primary care. The prison has a 14 bed unit dedicated for older prisoners with increased health needs. The unit also has four emergency care beds for use as required for patients who require admittance for both acute mental and physical health needs.

17. The medical records at HMP Parc are still paper based. A new computerised medical record system (SystmOne) has been planned for sometime. Currently there is no implementation date for the installation of SystmOne. This is the most commonly used computerised medical records software used in prisons in England.

18. Healthcare emergencies and those in need of specialist care are transferred to the Princess of Wales Hospital, Bridgend which is part of the Abertawe Bro Morgannwg University Local Health Board.

19. A risk assessment must be completed when prisoners attend hospital inpatient and outpatient appointments. It determines the level of escort and the restraints (handcuffs) required for the safe custody of the prisoner. Restraints are applied if the risk assessment states they are necessary, and prison staff are allocated to carry out an escort for the prisoner. If a prisoner is admitted to hospital, prison staff carry out a bedwatch duty and complete a log of activities. A regular management check of the bedwatch is carried out by a security manager.

20. The risk assessment will consider the following:

    a. The prisoner's medical condition. When there is doubt, the prison's medical officer will be asked to advice on any medical objections to the use of restraints.
    b. Behaviour in prison.
    c. Home circumstances.
    d. The nature of the offence, the risk to the public and hospital staff, including the risk of hostage taking.
    e. The prisoner's motivation to escape, likelihood of outside assistance and their conduct whilst in custody.
    f. The physical security of the hospital.
    g. Assessment of visits restrictions.

21. According to the policy for performing hospital bedwatches in place when the man was in custody, the following options were available to the Director:

    a. "Escort and bedwatch with two officers or more, with restraints.
    b. Escort and bedwatch with two officers or more, without restraints.
    c. Escort and bedwatch with one officer, without restraints.
    d. If eligible, release on temporary licence under Prison Rule 9 (YOI Rule 6).
    e. … exceptionally temporary release for remand prisoners if they are so seriously ill or incapacitated as to be incapable of escaping and for who there is no danger of assisted escape (this power is allowed under Section 22(2)(b) of the Prison Act 1952)."

    The level of security necessary for all prisoners should be kept under review to take into account their medical condition, the physical surroundings in which they are located, and any new information.

22. The investigator reviewed the Ombudsman's reports into earlier deaths from natural causes at Parc. He found that the quality of the information recorded in healthcare records has been raised in previous reports into deaths at Parc and this is repeated again in this report.

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Multi-Agency Public Protection Arrangements

23. Multi-Agency Public Protection Arrangements (MAPPA) support the assessment and management of the most serious sexual and violent offenders. The aim of MAPPA is to ensure that a risk management plan that is drawn up for the most serious offenders benefits from the information, skills and resources provided by the individual agencies co-ordinated through MAPPA

24. There are three levels of MAPPA:

    - Level three - Anyone subject to level three is considered as being the highest risk case, where more than one agency will take responsibility for the management of the person concerned.

- Level two - As with level three, anyone who has been identified as falling into the level two heading would be managed by more than one agency, very often limited to probation and the police. However, it is possible to involve more agencies if the circumstances warrant it.
- Level one - An offender on level one MAPPA is normally managed by a single agency. This is the lowest monitoring procedure available under the MAPPA system.

When the man arrived at HMP Parc he was assessed as MAPPA Level 2.

Independent Monitoring Board Report

25. Each prison has an Independent Monitoring Board (IMB) appointed by the Secretary of State for Justice. IMB members are independent and unpaid. They monitor day-to-day life in their prison and ensure that proper standards of care and decency are maintained. The most recent annual report published by the IMB at Parc covers the period from March 2010 to February 2011. The report does not comment on any issues relevant to this investigation.

Her Majesty's Chief Inspector of Prisons

26. The HM Chief Inspector of Prisons completed a full unannounced inspection of Parc in September 2010. The Chief Inspector commented that:

> "The challenges of scale and complexity that face Parc are immense, but it is commendable that this unannounced inspection found that the prison had many strengths on which to build. However, we also identify a number of weaknesses and a lack of preparedness for aspects of its new role which will need to be addressed if Parc is to meet the huge expectations being placed upon it."

27. The inspection found that sixty-nine prisoners were over 50 years old. There was no policy or action plan to identify and meet the needs of older prisoners and there no assessment in place to identify their individual needs. There were no multidisciplinary care plans for older prisoners and no prisoner carer scheme for those who might require assistance or social care. There was a discussion group for older prisoners on D wing but there no groups or forums for older prisoners elsewhere in the prison.

28. The report comments on the level of healthcare provided at HMP Parc. The Chief Inspector said that:

> "Health services were in crisis with inadequate staffing levels and unacceptable accommodation. Responsibility for the delivery of health services was to change imminently from Primecare Forensic Medical Services to be directly run by G4S. The appointment system was chaotic. Only basic health interventions were delivered and prisoners were extremely unhappy with the overall service. All health care staff were under immense pressure, morale was very low and there was great concern about the inability to deliver a comprehensive health service…

Primary mental health services were inadequate and secondary services were understaffed."

ISSUES

The diagnosis of the man's terminal illness

29. The man was sentenced to 12 years imprisonment on 18 January 2011. He arrived at HMP Parc later that day, it was his first time in custody. His pre sentence report shows that he suffered from moderate depression and was to be monitored.

30. The man had a complex medical history. He told staff during his first reception health screen that he had seen a doctor prior to coming into custody for prostate and gall bladder problems and also had outstanding hospital appointments for lung and heart pains. He had previously suffered from a stroke and was taking many medications to help manage his medical conditions. He was referred to see the doctor.

31. It is good practice when a person arrives in custody for their community general practitioner (GP) to be contacted to request a copy of the person's medical history and for confirmation of their prescriptions. Unfortunately this was not done for the man. This would have been an opportunity for healthcare staff to gain a full knowledge of the man's medical conditions and the hospital appointments and tests he had been referred for. In their response after receipt of the draft report, Parc wrote:

> "Medical records are difficult to gather and often community GPs are resistant to providing information from a community GP record. We would routinely request information for prescribed medication so that prescriptions may be continued but other details are problematic and may take some considerable time to obtain, it at all."

32. On 20 January, the man was reviewed by a doctor. An entry in his medical record summarising the appointment says that the man was confused by his medications and was suffering from dysuria[1], but was not suffering from a fever. The man was asked to provide a urine sample and he was to have a blood test. A note was made that he was to be reviewed with the results once they were available.

33. The following day, the man's urine sample was tested with a "dipstick"[2]. The test was positive for glucose and specific gravity (SG)[3]. Glucose is an indicator of diabetes and is not generally found in urine. If it is, further testing is advisable. The man's SG level indicated that his urine had an increased concentration, which can be the result of conditions such as dehydration or heart failure. Unfortunately there is no record of a blood test being taken.

34. It was recorded in the man's wing history sheet on 25 January that he was a very quiet man who seemed to have difficulty with the English Language. It was also

[1] Painful and difficult urination
[2] A specially treated chemical strip, when put into urine changes colour to indicate the presence of an infection or glucose etc
[3] Indicates the concentration of urine

recorded that he had been helped to complete some forms in regard to his telephone account and arranging visits.

35. On 27 January, an officer spoke with the man and a prison family liaison officer (FLO). An entry in his wing history sheet says that the man was worried about a hospital appointment that had been cancelled and the FLO said she would chase this up for him. The officer said that he had a poor command of the English Language and would become confused at times. There are no further entries in his wing history sheet regarding his cancelled hospital appointment.

36. The man's urine was tested using a "dipstick" again on 31 January. The results of the test showed a trace of protein, which is not significant, and nothing else was present.

37. The following day the man was reviewed by a prison doctor. He had a pain near his left kidney and a further urine sample was requested. On examination, his abdomen was soft and it was thought that he had a urinary tract infection. Trimethoprin[4] was prescribed and he was to be reviewed with the results of the urine test. Unfortunately there is no record of the result of the urine test.

38. A letter dated 24 January from a local hospital had been sent to the man's home address. The letter arrived at Parc on 3 February. The letter said that the man was to book an appointment to have an ultrasound scan. The clinical review shows that the healthcare practice manager told the clinical reviewer that she remembered seeing this letter and that some telephone calls were made to the local hospital. A decision was made in mid February that the scan was not required as the man was going to be treated at another local hospital. This information was not recorded in his medical record and it is not clear who made this decision. In their response after receipt of the draft report, Parc wrote:

> "With regard to the man's missed hospital appointment, we made contact with the hospital to find that the family had already cancelled the appointment on behalf of the man and a further appointment was made. The entry made by the GP at Parc and suspicions regarding a malignancy would have overtaken the existing appointment arrangements. An urgent scan was arranged locally and referral to the local consultant was confirmed on 22 February 2011."

39. Wing staff requested a member of healthcare to assess the man on C wing at 3.00pm on 6 February (the name of the member of staff is illegible in the record). He was vomiting after eating food and was resting in bed. He said that he felt nauseous when he smelt food and had been constipated for the past three days. He was given a laxative and was told he would be put on the list to see the doctor. The man also told staff that he had had a medical investigation done on his stomach prior to coming to Parc. His medical record shows that he did not vomit anymore that afternoon, however he did not eat his dinner.

[4] An antibiotic

40. The man was assessed by another prison doctor in healthcare on 8 February. He said he had felt unwell for the last two weeks and had been vomiting for two days. The man said he had been constipated and confirmed that he had not suffered from any diarrhoea. There were no urine sample results available to be reviewed. Records show that on examination his prostate was large and craggy, although there was no blood present. He was to have a blood test taken after he had fasted and he was referred to the urology department at outside hospital. A note was made that the man would be reviewed in two weeks time, or sooner if his condition worsened.

41. The prison doctor was interviewed by the investigator and the clinical reviewer. The clinical review shows the doctor said during interview that:

> "He [the prison doctor] has critically reviewed this case and is sure that he did not feel any mass or lump in the upper part of the man's abdomen when he examined him on 8 February 2011. He finds it very difficult to practice good medicine at HMP Parc as there are no good computer records or recall system. He writes detailed notes because there have been occasions when things have not happened and so he ensures that his notes make clear what he found and the next steps and actions he intended to take place. He found the man to be an ill man and didn't quite know what was happening but, like many GPs in a similar position, set in motion investigations and made a referral to a specialist to ensure the man received the best possible treatment. He intended to review the man with all the results of his investigations."

42. There is no evidence that the blood tests that were requested were carried out and there are no further entries in his medical record relating to this time period.

43. An entry in the man's wing history sheet on 18 February says that a member of staff had a conversation with the man while he was waiting to receive his medications in the morning. Another prisoner who had been helping the man with his care needs said that the man had been passing blood in his urine and was being sick after eating. A member of healthcare staff (the name of the member of healthcare staff is illegible in the record) was spoken to, who said they would try and arrange an urgent doctor's appointment.

44. The man's medical record shows that he was reviewed by another prison doctor later that day. The entry says that he looked awful, said he had a poor appetite and had last vomited three days previously. He said he did not have any abdominal pain and his bowel movements had not changed. It was recorded that he had a rapid weight loss (7kg) over the last three weeks and his abdomen was then examined. A hard, craggy mass was felt which was possibly linked to his pancreas or liver. The doctor suspected that it was possibly an underlying malignancy[5] and requested urgent blood tests to be taken that day. An urgent referral was made to the local hospital for an ultrasound of his stomach.

[5] The term "malignancy" refers to cancerous cells that have the ability to spread to other sites in the body or to invade and destroy tissues.

45. The clinical review shows that, although the blood tests were taken and the results were available later that day, healthcare staff did not appear to have chased them and so they were not received at Parc until almost two weeks later. The man was an inpatient in hospital by this time.

46. The review also says that the doctor who had examined the man:

> "… was on call for HMP Parc over the weekend of 19th and 20th February 2011 and decided to review his condition the following week. However, *Doctor 1* only works on Fridays and at weekends and unfortunately she did not pass on her concerns, either in writing or verbally, about the man to any other member of the primary care team who were working in the intervening Monday to Thursday."

47. The man was reviewed by another prison doctor in healthcare on 24 February. The man said he was unable to pass urine and had abdominal pain. He had some shortness of breath, but was not vomiting or producing sputum. The man was sent to the Accident and Emergency (A&E) department of the local hospital. The doctor who had examined the man prior to him going to hospital wrote a letter to take to the hospital for the surgical team. The letter said that he had a suspicious surgical mass (lump) and was unable to pass urine with ongoing abdominal pain.

48. Once the man had been admitted, he was moved to a ward and was put on an antibiotic drip. The following morning healthcare staff contacted the hospital for an update on The man's condition. They were told that he was settled at that time and was due to have a review with the consultant later that morning.

49. The man had a computerised tomography[6] (CT) scan at 12.50pm. He awaited the results of the scan, which would then determine if he was to be moved to a surgical ward.

50. At 1.50pm on 26 February, hospital staff told the man that he had incurable cancer of the pancreas that had spread to his liver. He was told that due to the advanced stage of the cancer, there was very little that could be done in terms of medical intervention and he would be kept in hospital until he stopped vomiting and could eat again. He would then be discharged to Parc. An entry in his bedwatch log says that he was upset at the news, but was talking to the bedwatch officers.

51. The man had a complex medical history when he arrived at Parc in January 2011. He was seen on various occasions throughout January and February as he had been feeling unwell. He then presented to healthcare staff with weight loss, abdominal pain and problems urinating in mid February. As a result of the doctor's examination, it was thought that he may have underlying malignancy so an urgent referral was made for further tests to be done at outside hospital and a blood test was done. The results of the blood test were not chased or reviewed for two weeks, which is unacceptable.

[6] A scan that uses x-rays and a computer to create detailed images of the inside of your body.

52. The man was admitted to hospital six days later as he was unable to urinate. A diagnosis of cancer was then made while the man was an inpatient in hospital. It is not within the Ombudsman's remit to comment on a person's care while they are an inpatient at outside hospital. In regard to the man's diagnostic tests and care, Healthcare Inspectorate Wales (HIW) say within their clinical review that:

> "While we believe that nothing could have changed the eventual outcome for the man we do consider that certain aspects of the man's care could have been improved:
>
> - Had contact been made with the man's GP upon his admission to HMP Parc the seriousness of his condition may have been identified earlier;
> - On two occasions an MSU[7] was requested but we saw no evidence of the MSU's being undertaken;
> - Two doctors requested blood tests which were never done;
> - The results from the blood tests undertaken on 18 February 2011 were not received in HMP Parc until 3 March 2011;
> - Despite *Doctor 1* being concerned about the man on 18 February 2011 and over the subsequent weekend, this concern was not passed on to other members of the primary care team when she had completed her sessions for that week; continuity of care was not as good as would be expected in the community.

HIW considers that a lack of timely communication with the man's GP and a series of breakdowns in communication between prison healthcare staff and prison GPs led to a lack of timely care."

53. As a consequence, HIW make the following recommendation's within their clinical review which we endorse and slightly amend:

The G4S Head of Healthcare should ensure there is a robust process which ensures that all requested blood tests and mid stream urine (MSU) checks are completed in a timely manner within HMP Parc.

HMP Parc should liaise with the Pathology Laboratory at Princess of Wales Hospital to ensure an improvement in the service, including ensuring that pathology results, x-ray results and scan results reach HMP Parc as swiftly as they reach other general practices in the area.

The G4S Head of Healthcare should develop a system to ensure that patients who are causing concern are brought to the attention of all healthcare staff each day.[8]

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[7] A mid-stream specimen of urine (MSU) is tested to look for infection.

[8] This could be a 'day book' or a computerised equivalent where messages about patients are entered and it is clear that the messages have been seen by the relevant staff. Many general practices have a similar system to ensure there is excellent continuity of care.

54. As mentioned previously, problems relating to record keeping have been raised in previous investigations and the recommendation was accepted by the National Offender Management Service (NOMS). In their response to a previous investigation when they accepted this recommendation NOMS wrote:

> "Defensible documentation training will be provided for all medical staff. All staff are to receive a copy of NMC [Nursing and Midwifery Council] guidelines and policies and procedures."

It is therefore disappointing to find there are continuing problems with record keeping at Parc, and we repeat this recommendation:

The G4S Head of Healthcare should ensure that the entries made by healthcare staff in medical and nursing records are legible, signed, lines are not left blank and that abbreviations are not used in accordance with the standards set out in the Nursing and Midwifery Council Guide to Record Keeping.

Informing the man about his condition and treatment

55. The man was an inpatient at a local hospital when he was told that he was terminally ill on 26 February. He was told by the hospital staff that were investigating the cause of the symptoms he was presenting. This provided the man with the opportunity to ask the medical professionals questions regarding his diagnosis and prognosis, ensuring that he was fully aware of the seriousness of his condition.

56. A member of the chaplaincy team at HMP Parc visited the man later that afternoon and discussed the news he had received from the doctor. He was waiting for a visit from his wife so that he could break the news to her himself. The man said that he wished to be visited by a priest and an entry in his bedwatch log said that this would be arranged.

57. On 28 February, the man had an endoscopy[9]. The results of the procedure confirmed that the man had pancreatic cancer. A note in his medical record says that there was a possibility he might receive palliative chemotherapy, although his prognosis was thought to have been just weeks.

58. The man was visited by a member of the chaplaincy team again on 1 March. An entry in his bedwatch log says that he had been visited by the doctor who had said they did not believe there was anything that could be done for the man in terms of medical intervention. It was also recorded that the man had accepted his prognosis. The local priest had not visited, despite being asked to do so a few days previously, so it was arranged for this to be chased up that afternoon. When he was visited by another member of the chaplaincy team on 3 March and it was recorded that the man was in good spirits, although he remained weak.

[9] A procedure where the inside of your body is examined internally using an endoscope, which is a thin, long, flexible tube that has a light source and a video camera at one end.

59. The man was informed of his terminal illness while he was an inpatient at hospital. The clinical review records that once he was in hospital "the appropriate care pathway was followed and pain relief was provided" for the man. The review lists all of the actions taken by hospital staff after the man was taken to a local hospital and only comments generally on his care after he was admitted. As it is not within our remit to investigate the level of care provided while a prisoner is in hospital, we are unable to comment on whether the man's diagnosis was given in an appropriate manner and if he was informed of ongoing tests, treatments and his prognosis.

60. Once the diagnosis had been made, a member of the chaplaincy team visited the man regularly, offering him support. This is evidence of good practice.

61. The clinical review shows that:

> "The GPs who treated and advised the man in HMP Parc spoke about how they had told the man that he was seriously ill. The GPs felt that the man knew, and had known for some time, that he was seriously ill but he was very reluctant to seek medical advice. Doctor 1 discussed with the man the options available to him on Friday 18 February 2011. When the man was in hospital he was told the final diagnosis and prognosis and staff discussed with him what he wanted his family to be told."

The man's medical appointments and treatment

62. The man had outstanding hospital appointments when he arrived at Parc. He told staff of this and it was recorded in his medical record. A letter from a local hospital was sent to Parc asking him to make an appointment for an ultrasound scan, however it was decided that it would not be necessary to have the scan done as he was referred to another local hospital for tests on 8 February. A record of who made this decision in not recorded in the medical record. This is not acceptable, problems relating to record keeping has already been raised previously in this report and we have made a recommendation about this. The man did not have any hospital appointments or diagnostic tests prior to being admitted to hospital on 24 February. On 3 March a hospital doctor told the man that he was to have a biopsy[10] taken.

63. The man was put on a nebuliser[11] at 6.30pm on 5 March. One of the officers on of the bedwatch officers at that time spoke with the nurse who was involved in the man's care. The nurse said that the man's condition had got worse throughout the day and that he might not make it through the week. Officer Lewis informed the staff at Parc of this information.

64. The bedwatch officers were told by a nurse at 9.30pm that the man could pass away that evening or at any point during the coming week. Staff at Parc were

[10] A medical procedure that involves taking a small sample of tissue so that it can be examined under a microscope.
[11] A device used to administer medication in the form of a mist inhaled into the lungs.

then updated. An entry in his bedwatch log at 9.45pm says that his breathing was very laboured.

65. The man became unresponsive at 11.40am on 6 March. His breathing remained laboured and his family were at his bedside. The man's breathing and condition continued to deteriorate and he passed away at 8.40pm that evening.

66. Although the man had outstanding medical appointments, it appears that they were not rescheduled as he was instead referred for other tests at a local hospital. He did not attend any outside hospital appointments while he was at Parc, he was then admitted to hospital on 24 February. Besides the medications he was taking for his medical conditions, the treatment he received following his diagnosis was provided in hospital. The clinical review records the treatment the man received while in hospital but only comments generally about his care. As mentioned previously, it not within this office's remit to comment on the level of care the man received at that time.

The man's pain relief and medication

67. When the man arrived at Parc, he was taking many medications to help manage the symptoms of his medical conditions. This included aspirin[12], mirtazapine[13], dipyridamole[14], cyclizine[15], lansoprazole[16], indapamide[17] and simvastatin[18]. He suffered from a urinary tract infection in February for which he was prescribed antibiotics, which appeared to have been sufficient in controlling the infection.

68. During the evening of 5 March, the man was put on a nebuliser to help aid his breathing. An entry in his bedwatch log shows that his breathing was very laboured. The man was administered paracetamol at 1.20am on 6 March as he had a temperature. His condition continued to deteriorate and his breathing remained laboured.

69. The man appears to have been prescribed appropriate medications to help manage his medical conditions while he was at Parc. Once a diagnosis of cancer had been made while in hospital, he was provided pain relief and medications as an inpatient. HIW comment in their review that:

> "The man was given pain relief in hospital and this is well documented."

The man's location

70. The man underwent a cell sharing risk assessment (CSRA) when he arrived at Parc. During the CSRA process the prisoner's medical history, offence and level of risk are taken into consideration when deciding the most suitable

[12] Used for pain relief, to treat inflammation and to help thin the blood to prevent clots forming.
[13] An anti-depressant.
[14] Used to prevent blood clots.
[15] An antihistamine used to treat nausea, vomiting and dizziness.
[16] Used to reduce the amount of acid produced in the stomach.
[17] Used to treat high blood pressure.
[18] Used help lower cholesterol.

accommodation for that person, as well as if they are suitable to share a cell. Following the man's CSRA, he was deemed as being medium level of risk[19] and was to be provided accommodation on the ground floor due to his medical and health problems.

71. Following his CSRA, he was provided accommodation on C wing. C wing is a single unit holding 55 men in single cells. A CSRA review on 24 January reduced his level of risk to "low"[20].

72. The man stayed in cell accommodation until he was admitted to hospital on 24 February. This appears to have been appropriate as, although he was unwell, he was able to mobilise independently and was able to look after himself with some assistance from a carer. It was not clear how unwell the man was until after further tests had been completed while he was in hospital. The man remained in hospital until he passed away.

Compassionate release

73. One of the prison doctors completed the relevant section of the compassionate release process on 28 February. He wrote that he and his medical colleagues had examined the man on 18 and 20 February regarding compassionate release. It was said that he had been diagnosed following a CT scan and his prognosis was very poor. Further test results were awaited, however the prison doctor felt that the man would not be capable of committing further offences given his condition at that time. The prison doctor suggested that if the man was to be released, his care would have been provided by the local palliative care services and his own general practitioner (GP) in the community.

74. The following day, the Senior Manager of the Offender Management Unit at Parc completed the Governor's section of the report. She wrote that due to the nature the man's offence he was deemed high risk, however he was low risk of re-offending if he were to be released on license. She felt that he should be released early given his medical condition.

75. On 2 March, she forwarded the compassionate release paperwork and a copy of his pre-sentence report to the Early Release and Recall Section of the National Offender Management Service.

76. An email was received from the Public Protection Unit on 4 March. They confirmed they had received the compassionate release forms and requested a copy of the doctor's report that was written prior to the man being sentenced, as they felt it may have had some useful information in it.

77. PSO 6000 – Parole, Release and Recall, states that:

> "Any other reports which are available, for example from hospital consultants, must also be forwarded. It is essential that an indication of

[19] No immediate risk of harming themselves or others, but the person's situation will need to be reviewed regularly.
[20] No current indication or evidence of risk, suitable for multi-cell location

likely life expectancy is included in the report… a decision will usually be made within two weeks, but more quickly if the circumstances require it. If there is a medical application involving a very short life expectancy, the Early Release and Recall section must be alerted by telephone at an early stage."

78. The compassionate release process was started in a timely manner following the man's terminal diagnosis. Relevant information was included such as his prognosis and other medical reports. This was then sent to the Early Release and Recall Section to be processed, however due to a request for further information, unfortunately a response was not received by Parc before the man passed away.

Palliative care plans

79. Palliative care is the active holistic care of patients with an advanced progressive illness, such as cancer. A palliative care pathway is used to help manage a patient's pain and any other symptoms that they may be experiencing. It also helps to provide psychological, social and spiritual support. Overall, it aims to provide the best quality of life for patients and their families.

80. As the man was not diagnosed as terminally ill until he was admitted to hospital in late February, staff at Parc would not have implemented a palliative care pathway. As he remained in hospital until he died, Parc were not responsible for his medical care at the time of the man needing palliative care, therefore it is entirely appropriate that no palliative care pathway was put in place by Parc.

81. HIW commented in their clinical review that:

> "The only pathway used in the man's care was the end of life pathway and this was used sensitively and appropriately when he was in hospital."

Restraints, security and bed watch

82. We are satisfied that the risk assessment for the man was regularly reviewed and revised during his time outside Parc. While he was an inpatient in hospital, the man was initially restrained by an escort chain. An escort chain is a 1.8 metre length of chain with one cuff attached to an officer and the other to the prisoner. It was in line with standard procedures that the man was handcuffed in the first instance. At the time the restraints were first applied, the man was conscious and could have posed a security risk. The risk assessment was revised on 26 February after the staff on escort duty were informed that the man's condition was terminal.

83. The man's bedwatch log shows that on 26 February the Director of Parc authorised for the restraints to be removed from the man given his poor health and to enable him to rest properly. He was to remain to be supervised by two bedwatch officers and he was to be reviewed daily. Once removed, the restraints were not re-applied. While the man was in hospital two officers always remained on bedwatch duty. The investigator found that the bedwatch notes

84. While we have concluded that the balance of security and protecting the dignity of a dying man was generally achieved in the man's case, we note that HIW remained concerned about the use of restraints and the presence of officers when his family said their goodbyes. They recommend that the Head of Healthcare uses this review to discuss how prisoners are cared for in hospital.

Liaison with the man's family

85. Parc appointed a chaplain as the prison's family liaison officer. The man's wife was able to visit him in hospital. This provided the man with the opportunity to discuss his diagnosis and prognosis with his wife personally. It was the man's wish as he did not want prison staff or a member of chaplaincy to break the news about his condition and prognosis to his wife.

86. On 5 March, when the man's condition began to deteriorate significantly, his family were made aware of the situation by the prison's chaplain family liaison officer and that he could pass away at any time. It was authorised by the Director that his family could be at his bedside as they wished and his grandson could visit and say his goodbyes. A member of the chaplaincy team told the man's family of the support that was available to them and provided them with a contact number, should his family have wished to contact them.

87. The man's family were able to stay for as long as they wished and stayed overnight at his bedside. At 9.30am on 6 March, bedwatch officers moved to the outside of his room to allow his family some private time and to allow the man to die with dignity, with his family at his side. The bedwatch officers were still able to observe the man's room, without imposing on the family.

88. The man's family remained at his bedside until he passed away at 8.40pm that evening. A member of the chaplaincy team arrived at the hospital to offer the family support. The man's family left at 1.08am on 7 March. A nurse then confirmed the man's death at 1.20am.

89. After the man's death the prison's family liaison officer maintained contact with the family and Parc also offered financial assistance with the costs of the man's funeral. She and the Head of Safer Custody and Violence Reduction represented the prison at the man's funeral.

90. The man's family were offered appropriate visits while he was in hospital and authorisation was given for them to stay at his bedside during the final stages of his life. Appropriate and sensitive liaison and support was offered to the family by a member of the chaplaincy team. It is good practice for staff to have moved out of the man's room when his condition began to deteriorate, giving his family privacy while still maintaining a level of security that is mandatory when a prisoner is in hospital. There are clear and informative notes about the liaison with his family in the man's records.

CONCLUSION

91. The man arrived at HMP Parc on 18 January 2011. Just over a month later, on 24 February, he was referred to hospital for urgent medical investigations when it became apparent that he was unwell. Two days later, on 26 February, the man was diagnosed with terminal cancer. He did not return to Parc but he was accompanied by two officers on bedwatch duty while he was in hospital. The man died during the evening of 6 March 2011 with his family at his bedside.

92. HIW conclude in their clinical review that:

> "On the whole, the care the man received was adequate both at HMP Parc and at outside hospital. However, this review has identified aspects of the man's care which were less that optimal.
>
> Breakdowns in communication between the prison GP and healthcare staff hindered timely care and diagnosis. This was compounded by inadequate systems for ordering, chasing and reviewing blood tests, not helped by the use of paper-based (rather than electronic) records which were of a poor standard.
>
> We have made recommendations for improvement in relation to these areas, which should be implemented as soon as possible to ensure the best possible care for prisoners at HMP Parc in the future."

93. We make four recommendations, three based on the findings of the clinical review. They will need to be addressed by Head of Healthcare in partnership with the Director of HMP Parc. Although HIW refrained from making a recommendation in relation to the quality of healthcare records it should be noted that the records we reviewed were often illegible, unsigned and brief. We have made recommendations regarding healthcare records in previous reports and find it disappointing that there appears to have been no improvement. We therefore repeat our recommendation regarding healthcare records in this report.

RECOMMENDATIONS

At the draft report stage, the National Offender Management Service (NOMS) responded to the recommendations. That response is included in italics below the recommendation.

1. The G4S Head of Healthcare should ensure that the entries made by healthcare staff in medical and nursing records are legible, signed, lines are not left blank and that abbreviations are not used in accordance with the standards set out in the Nursing and Midwifery Council Guide to Record Keeping.

   Accepted: System One (a computerised medical record) has been implemented since the death of the man and has assisted with improving the entries made by medical staff. However, all healthcare staff will be reminded of the necessary requirements and that they must adhere to them.

2. The G4S Head of Healthcare should ensure there is a robust careful process which ensures that all requested blood tests and mid stream urine (MSU) checks are completed in a timely manner within HMP Parc.

   Accepted: Procedures will be put in place to ensure that these requirements are met. Revised procedures will be forwarded by 31 May 2012

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3. HMP Parc should liaise with the Pathology Laboratory at Princess of Wales Hospital to ensure an improvement in the service, including ensuring that pathology results, x-ray results and scan results reach HMP Parc as swiftly as they reach other general practices in the area.

   Accepted: System One has been implemented since the death of the man and has improved procedures as we are now able to access the required information electronically from hospitals as in the community.

4. The G4S Head of Healthcare should develop a system to ensure that patients who are causing concern are brought to the attention of all healthcare staff each day.

   Accepted: A risk register for medically vulnerable patients who require additional medical/nursing input is being developed. It is planned to hold regular "at risk" meetings and these, along with the register, will facilitate the development of appropriate care planning.