Investigation into the circumstances surrounding the death of a man in March 2010 at Quay House Approved Premises in the South Wales Probation Area

Report by the Prisons and Probation Ombudsman for England and Wales

May 2011

This is the report of an investigation into the death of a man, a resident of Quay House Approved Premises which is in the South Wales Probation Area. The man died in his room in March 2010, just two days after arriving from HMP Cardiff. He was 57 years old. A post mortem established the cause of death as myocardial infarction (heart attack). I offer my sincere sympathy and condolences to the man's family for their loss, as I do to all those who have been affected by his passing.

The investigation was carried out by my colleague. I would like to thank the staff at the Quay House, HMP Winchester and HMP Cardiff for their full and ready co-operation with the investigation.

An independent review of the man's medical care in prison was carried out by a clinical reviewer on behalf of Healthcare Inspectorate Wales. I am grateful to her for her assistance with this matter. Regrettably, the completed clinical review was not received from Healthcare Inspectorate Wales until mid-December 2010, leading to a delay issuing my report for which I must apologise.

The man was wheelchair bound and suffered from several chronic diseases. My report makes one recommendation regarding the transfer of disabled prisoners from prison to approved premises. I also raise concerns about the care which the man received in prison, including managing his transfer from Winchester to Cardiff and the care he received during the two weeks he spent at Cardiff.

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 residents involved in my investigation.

Jane Webb
Acting Prisons and Probation Ombudsman **May 2011**

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SUMMARY

When he was sentenced to 13 years in prison in 2001, the man had suffered from back pain for more than a decade. Scans in 2002 revealed that he had a curve of the spine and disc protrusion. In 2004, whilst at HMP Parc, the man began to use a wheelchair permanently. The clinical reviewer notes that there is no evidence of any formal assessment of his mobility needs and makes a recommendation to Parc.

The man moved to HMP Winchester in August 2008 and lived in a cell on the healthcare inpatients' unit. The report considers whether it was appropriate to allocate a healthcare cell permanently to the man at Winchester and, later, at HMP Cardiff. In April 2009 the man signed an advance directive (instructions given by individuals specifying what actions should be taken in the event that they are unable to make such decisions due to illness or incapacity) in which it was instructed that he should not be resuscitated were his heart to stop.

Prior to his scheduled release from prison in March 2010, it was determined that the man should be allocated a place in an approved premises in the South Wales area. Quay House was duly selected as it is the only premises in the area with a room for people with disabilities. Healthcare professionals were not asked to assess whether the accommodation was suitable and I make a recommendation to the Wales Probation Trust about this matter. In addition, the advance directive the man had signed was not reviewed ahead of his release from prison, nor was it highlighted to staff at Quay House.

The man transferred to Cardiff on 24 February 2010 for the last two and a half weeks of his sentence, in preparation for his move to Quay House. He had very little contact with prison healthcare professionals and, on 12 March, he left Cardiff and was taken by taxi to Quay House.

At Quay House, the man was allocated a room for disabled residents. He spent the afternoon the day before he died in Swansea city centre with another resident whom he knew from Parc. The man spent time in the communal lounge during the evening. At around 11.00pm the other resident helped the man to set up a television in his room.

At around 8.10am on the morning of the man's death, staff went into the man's room after hearing his alarm clock ringing persistently. They found him lying on the floor and, on checking for signs of life, concluded that the man had died and that rigor mortis had set in. They telephoned for an ambulance and were advised to administer cardio pulmonary resuscitation (CPR) by the operator. An ambulance crew arrived at around 8.19am and immediately asked for CPR to be stopped.

The report makes ten recommendations, most of which are taken from the clinical review. As well as those mentioned above, the recommendations concern areas including the man's transfer from Winchester to Cardiff.

THE INVESTIGATION PROCESS

1. The investigation was opened on 16 March 2010 when the investigator issued notices announcing the investigation to staff and residents at the Quay House. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known. No one came forward as a result.

2. The investigator visited Quay House on 23 March. During his visit he was shown around the premises, including the room where the man lived. He was also given copies of all documents relating to the man. During his visit, my investigator interviewed three members of staff and one resident.

3. The investigator contacted HMP Cardiff, where the man had lived prior to his arrival at Quay House. He was provided with a copy of the man's prison medical record. My investigator visited Cardiff on 21 June and interviewed the healthcare manager and prison doctor. He had earlier visited HMP Winchester, where the man lived before moving to Cardiff, and interviewed the healthcare manager.

4. My Terms of Reference do not routinely include reviewing the clinical care given to resident of approved premises. However, the service level agreement between my office and Healthcare Inspectorate Wales provides for such reviews following deaths in Welsh approved premises. A review of the man's medical care in prison was carried out by a clinical reviewer on behalf of the Healthcare Inspectorate Wales (HIW). The clinical reviewer accompanied my investigator at both Cardiff and Winchester and contributed to the interviews with staff. Unfortunately the clinical review was not received until December 2010, leading to a delay to issuing my report. The review is invaluable and I am grateful to HIW for producing it.

5. One of my family liaison officers contacted the man's daughter to inform her of the investigation and give her the opportunity to raise any questions or concerns she had about her father's death. The man's daughter did not raise any issues that she wished the investigation to address. Nevertheless, I hope this report helps to clarify any questions that might remain unclear for the man's family and helps them to better understand what happened in the time leading to his death.

QUAY HOUSE APPROVED PREMISES

6. The purpose of an approved premises is to provide an advanced level of residential supervision in the community, alongside a supportive and structured environment. Whilst residents have to comply with their individual licence or bail conditions, curfews, and the premises's house rules, they are essentially free to come and go from the building. All residents at Quay House are subject to curfew at night.

7. Quay House is one of around 100 approved premises in England and Wales. At the time of the man's death, it was one of two in the South Wales Probation Area. The four Probation Areas in Wales merged on 1 April 2010 to form the Wales Probation Trust.

8. Quay House accommodates up to 25 residents in single rooms. There is one room for disabled people on the ground floor, which is where the man lived during his short time at the approved premises. The room has an en-suite bathroom. There are two alarm points should the resident require urgent assistance from staff. One alarm is next to the bed and is connected to a local monitoring centre. If pressed, the monitoring centre alerts premises staff. The second alarm is through a cord in the bathroom which, when pulled, activates a local alert in the premises.

9. The premises are staffed 24 hours a day by probation employees, whose role is to provide support and to ensure that the rules and licence or bail conditions are complied with. The two premises in the South Wales Probation Area share a manager, who divides their time between them. Each premises has a deputy manager who is based there permanently.

10. Residents are required to register with a doctor at a local surgery. Medication is held by each resident in their room, subject to a risk assessment. Certain medications (such as those with a high potential to be misused) are held in the office and taken by the resident in front of staff at specified times. Each resident is responsible for their own health. If they require a consultation with a doctor or visit to hospital then, unless it is an emergency, the onus is on the resident to arrange the appointment.

11. This is the second death to occur at Quay House since April 2004, when the Ombudsman began investigating all deaths in approved premises in England and Wales. The previous death occurred in January 2010 and involved a suspected drugs overdose. The Ombudsman previously investigated a death at the other premises in the South Wales Probation Area, in September 2008. The report made two recommendations. Firstly, that all staff be trained in basic first aid with consideration given to training all staff in cardio pulmonary resuscitation (CPR). Secondly, the Ombudsman recommended that the Chief Officer should review arrangements for supporting staff following the death of a resident. I am pleased to report that this investigation found that all the staff at Quay House are trained in first aid and CPR and that staff felt fully supported following the death of the man.

HMP CARDIFF

12. HMP Cardiff is a category B local prison with a maximum population of 784 adult men. As a local prison, the majority of the prisoners arrive at Cardiff after making court appearances in South East Wales. As well as prisoners remanded into custody and those serving short sentences, a significant number are serving life sentences.

13. The prison has 24 hour nursing cover and 16 inpatient beds. These beds can be for patients with physical or mental health needs. During weekdays the core healthcare staff work until 5.00pm. Up to four nurses work from 5.00pm to 9.00pm and one nurse remains in the healthcare centre overnight with a member of the prison staff. An out of hours telephone service is also available overnight by which the nurse can obtain medical advice or ask a doctor from a local surgery to attend.

14. HM Chief Inspector of Prisons completed an inspection of Cardiff in January 2008. She found that prisoners were "much more likely to report feeling safe than at other local prisons", in the most part due to "good relationships between staff and prisoners". The support offered to newly arrived prisoners was praised and the healthcare offered to prisoners was thought to generally be of a good standard.

15. The most recent Annual Report by the Independent Monitoring Board (IMB, a body of local people who independently monitor and report on the prison) for 2008-2009 noted that "there is a dedicated and committed workforce [in healthcare]". However, they also noted that, despite an increase in the prison's population, there has been no increase in the number of healthcare staff and a reduction in prison doctor's hours.

HMP WINCHESTER

16. HMP Winchester is a category B prison built in 1846 with a maximum population of 544 male prisoners. As a local prison, the majority of prisoners arrive directly from court appearances and the population changes frequently. Many of the prisoners are either held on remand or are serving short sentences. Those prisoners who are serving longer sentences will often be transferred to a different prison, but part of Winchester consists of a small category C training wing.

17. From October 2008, primary healthcare services at Winchester were commissioned by NHS Hampshire and provided by Portsmouth Community and Mental Health Services. In April 2010, provision transferred to Solent Healthcare. The healthcare department is located separately from the main prison building. It has a 22 bed inpatient facility (mostly for patients with mental health needs plus a few with primary care needs) and provides 24 hour nursing cover. The majority of nurses work between 7.30am and 5.30pm. Three nurses work between 5.30pm and 8.30pm, and two work overnight. Doctors attend the prison from a local practice to hold surgeries in the mornings from Monday to Saturday, as well as offering an all day surgery on Tuesdays.

18. The former HM Chief Inspector of Prisons completed an inspection of Cardiff in April 2007. She found that some prisoners who did not require 24 hour care were held in the inpatient beds and that there was inadequate nursing cover at night. However, the former HM Chief Inspector of Prisons did identify some improvements in health services from her previous inspection.

KEY EVENTS

19. The man was convicted of several serious offences in February 2001 and sentenced to 13 years imprisonment. Having been initially remanded to HMP Swansea, he transferred to HMP Parc shortly after sentencing. He remained at Parc for seven years before transferring to HMP Winchester in August 2008.

20. At the time of his move to Winchester, the man had suffered from severe back pain for around two decades. Scans in 2002 showed that he had a curve of part of the spine and disc protrusion (commonly known as a slipped disc) in his lower back. On account of this condition he had used a wheelchair since 2004 and took the medication naproxen (used to treat pain and inflammation). The man was also asthmatic (for which he used a salbutamol inhaler) and had high blood pressure (treated with bendroflumethiazide and adalat) and occasional angina (for which he took isosorbide mononitrate and aspirin). He was a diabetic.

21. On his arrival at Winchester, the man was allocated a cell in the healthcare centre. This was initially so that his condition could be monitored and assessed. However, he remained in a healthcare cell throughout his time at Winchester as it was the only one in the prison which was suitable for a wheelchair bound prisoner.

22. The man settled in well at Winchester. He enjoyed going to education, where he learnt how to play the piano. He was described by the healthcare manager as “having his views” about certain aspects of his care, particularly his high blood pressure. The healthcare manager added that the man did not always take his prescribed medication.

23. In October 2008, it was noted in his medical record that the man experienced regular angina and therefore used his GTN spray (a spray prescribed to angina sufferers to relieve the pain of an angina attack) frequently. This was attributed to the man continuing to smoke against medical advice.

24. The man did not report any symptoms relating to angina for the remainder of 2008. However, on 7 January 2009, he saw a nurse and told her that he experienced angina pains nearly every night and struggled to sleep. The man subsequently saw a prison doctor the following week. He told the doctor that he did not wish to be resuscitated were he to suffer a heart attack. The prison doctor agreed to arrange for the relevant paperwork to be completed.

25. As a result of his request not to be resuscitated, the man was assessed by a consultant psychiatrist on 10 February. The purpose of the assessment was to determine whether the man had the capacity to make an advance directive regarding resuscitation. The consultant psychiatrist described the man as “extremely irritable” and “unco-operative” during the assessment. The consultant psychiatrist asked for a brief additional

assessment to determine whether the man suffered from depression before he would prepare the advance directive. This assessment took place on 13 March, with no sign of depression being found.

26. On two separate occasions in March, the man told nursing staff that he thought his blood pressure should be higher than expected because of his mixed race heritage. The nurses tried to persuade him otherwise but he remained of this view. As a result, he refused to take his blood pressure medication as he thought that he did not need it. Early the following month he refused metformin (to control his diabetes) as he thought it would cause him to have a heart attack. He also refused to eat for a short period around this time in the belief that this would cure his diabetes.

27. The advance directive was subsequently signed by the man, and witnessed by the consultant psychiatrist, on 2 April. The terms of the directive were that the man was not to be resuscitated were his heart to stop. An entry in his medical record explained to staff that this directive only applied were he to suffer a heart attack. In the event of any other life threatening condition, he should receive care as normal.

28. On 21 June, the man was found collapsed and choking on the floor of his cell. His pulse was raised for a while but soon settled. After recovering his breath, the man said that he had choked on an orange. Staff were asked to keep a closer eye on him overnight.

29. At a consultation with a nurse on 30 August, the man said that the pain in his back was getting worse and he could no longer sit in his wheelchair for more than two hours. He said that he did not want to go to hospital for an assessment as four members of his family had died in hospital. He also expressed apprehension about his forthcoming release from prison as there was “nothing for me” in the community.

30. Around three weeks later, the man’s right leg became swollen. He was examined by a prison doctor on 24 September. The prison doctor queried whether the man might have developed a deep vein thrombosis (DVT, the formation of a blood clot in the veins, usually in the leg) or oedema (excess fluid retention). She wanted to send him to hospital for further assessment but he refused and signed a disclaimer to that effect. The swelling reduced over the following days.

31. Other than an increase in his back pain, which was resolved following a change to his medication, the man raised no further concerns about his health in the remainder of the year.

32. In January 2010, an offender manager (formerly known as probation officers) in South Wales completed an approved premises referral form. The man was due to be released from prison in March and he was referred to an approved premises for two reasons. Firstly the referral was for the protection of the public, as the man had not complied with any offence related work and was described by the offender manager as a

"high risk of reoffending and of harm". The second reason for the referral was to work further on the man's rehabilitation and give him further opportunity to complete offending behaviour work in a structured environment.

33. The offender manager sent the referral to the deputy manager at Quay House on the same day. This approved premises was specifically selected as it is the only premises in the South Wales area with a room equipped for disabled residents. The following day a Multi Agency Public Protection Arrangements (MAPPA, a panel to assess and manage the risk a prisoner poses on release) meeting was held to discuss the man. The offender manager attended, along with representatives of South Wales Police and social services. The deputy manager of Quay House, along with a representative of HMP Winchester, were invited but unable to attend. It was noted that the man was not keen on moving to South Wales. He preferred to move to a town on the south coast of England, but this was not permitted as a victim of his offence lived in that area.

34. On 25 January, the deputy manager of Quay House replied to the offender manager and said they were able to accept the man and that the disabled room would be available for him. The offender manager's manager later wrote to the man to inform him of these arrangements.

35. Two days later, the man told the prison doctor who had examined him on 24 September that he had been experiencing pain on the left side of his chest. He said that the pain was not relieved by his GTN spray and he had had it for around two days. The prison doctor took clinical observations and found that the man's blood pressure was high, at 177/87. His chest was clear, however, and his heart sounded normal. The prison doctor suggested that the man should go to the hospital's accident and emergency department for further tests, but he refused. He was monitored over the following days and seemed to improve.

36. The man moved to HMP Cardiff on 24 February, in advance of his scheduled release to Quay House around two weeks later. Two brief entries listed the man's medical conditions as type 2 diabetes, hypertension (high blood pressure) and IHD (presumably meaning ischaemic heart disease). He was given a cell in the healthcare inpatients unit. The man was defined as a 'lodger' in healthcare, meaning that he did not have any physical needs which required him to be an inpatient. The head of healthcare at Cardiff explained that this was because there are facilities for disabled prisoners in healthcare which are not available on the wings.

37. There is no record of the man having any contact with healthcare staff until four days before his death when he saw a prison doctor. The man said that he was constipated, and was prescribed a laxative by the prison doctor. She noted that he was due for release in two days and arranged for a week's supply of medication to be given to him when he left the prison.

38. Two days later, the man left Cardiff and was taken by taxi to Quay House. He arrived at around 11.25am. Following his arrival, the man had an induction meeting with an approved premises services officer in his room. During the part of the induction that involves a health check, the man said he had angina and diabetes. He did not mention the advance directive which he had signed a year earlier.

39. The approved premises services officer showed the man where the alarm buttons were in his room. He listed the medication and, following a discussion with colleagues later that afternoon, the man was allowed to keep all of it in his room with the exception of mirtazapine (an antidepressant). On account of its potential value to other residents, the man was told that the mirtazapine would be stored in the staff office and given to him to take each evening, as prescribed. The man was asked to provide details of his next of kin, but said that he had none.

40. At around 2.30pm that afternoon, the man saw a community psychiatric nurse and her colleague. The community psychiatric nurse visits Quay House each week to undertake mental health screening assessments for all the new residents. During the interview, the man said he had no issues with his medication. The community psychiatric nurse concluded that there was “no evidence of mental health issues” and no further intervention was required.

41. The following afternoon, the man went into Swansea city centre with another resident whom he knew from HMP Parc. They left at around 12.15pm and arrived back at around 2.20pm. On his return the man told his fellow resident that his legs were very cold, which he attributed to poor circulation. The fellow resident gave him some tracksuit bottoms to wear, which were thicker than the trousers he had previously been wearing. The fellow resident told the investigator that he did not mention the man’s cold legs to another resident or member of staff, and did not think that the man did either.

42. That evening the man collected his mirtazapine from the Approved Premises services officer at 7.00pm. He spent the remainder of the evening watching some of the other residents participating in a pool competition. Shortly before 11.00pm, the fellow resident who had earlier accompanied the man to the city centre went to the man’s room to help him set up his television.

43. During this time, the Approved Premises services officer went to the room as part of the check that takes place at 11.00pm every night to confirm that each resident is in the premises. The services officer asked the man how he had settled in, to which the man replied “fine”. The man’s fellow resident left shortly afterwards to return to his own room. This was confirmed by the services officer, who saw the fellow resident coming up the stairs whilst he was completing his rounds. Staff had no more contact with the man during the night and he did not ring his alarm.

44. A male and female officer were rostered to work the day shift at the Approved Premises on the day of the man's death. They arrived shortly before 8.00am for a handover from the night staff. Nothing significant was reported and the male officer recalled that they were told it had been a "quiet night". At around 8.10am, the female officer stood outside the man's room whilst waiting for another resident to collect cleaning equipment. She realised that his alarm clock was ringing persistently. The female officer therefore went to the office to collect the spare key to the man's room.

45. On returning to the man's room, the female officer knocked on the door but received no reply. She therefore went into the room, using the spare key. She found the man lying on the floor and told the investigator that he was "on his back with his arms spread out". She saw that the man was not breathing and therefore examined him more closely. The female officer said the man was "cold, not breathing, had no pulse, was stiff and was blue". She told the investigator that she thought that he had died and that rigor mortis had set in.

46. The female officer returned to the office to tell her colleague what had happened. They both went back to the man's room. The male officer told the investigator that he too thought that the man was dead, an opinion which he based on the dark blue to grey colouring of the man's face and extremities.

47. The male officer immediately returned to the office to collect a telephone to call an ambulance. The female officer told the investigator that she did not start cardio pulmonary resuscitation (CPR) at this point as she "felt it was too late".

48. On his return to the room, the operator asked the male officer whether the man was still breathing. He replied that he was not. The male officer recalled that the operator asked him to tilt the man's head back, but he was unable to do so as the neck was too stiff. The operator advised the male officer to start CPR, which he did.

49. The ambulance crew arrived at around 8.19am. They asked the male officer to stop CPR immediately as they were able to identify the presence of post mortem lividity (the pooling of blood in the body, indicating that death occurred some time before). A post mortem examination later established the cause of death as myocardial infarction (heart attack).

50. The premises manager and deputy, and the assistant chief officer (a manager responsible for approved premises in the area) came to Quay House later that morning. The male officer and the female officer were offered time off work and the use of a counselling facility. They both told the investigator that they were satisfied with the support offered.

51. The man had said in the course of his induction to Quay House that he had no next of kin. However, following contact with his offender manager, staff at Quay House discovered that he had a daughter. The offender manager found an address for her through their records. The news of her father's death was later broken to the man's daughter by staff at the coroner's office. The man's funeral was held on 31 March.

ISSUES

Provision of a wheelchair

52. At the time of his arrival in prison in February 2001, the man had suffered back pain for several years. His condition was formally diagnosed following MRI scans in 2002. These scans showed part of his spine was curved and he had disc protrusion in his lower back. He began to use a wheelchair permanently in February 2004. Wheelchairs should meet the specific needs of an individual, such as their height, weight and ability to propel themselves. However, the man's wheelchair was loaned to him by the healthcare department at HMP Parc.

53. The clinical reviewer notes:

> "There is no evidence of what precipitated the use of a wheelchair, who ordered it, or if he was ever assessed for the requirement of one. The wheelchair does not appear to have been ordered specifically for [the man] as there was no record of him being measured and fitted by an occupational therapist … There is no evidence to suggest that [the man's] mobility needs were ever assessed or advice sought from either an occupational therapist or physiotherapist."

54. The clinical reviewer quotes from the guidance document 'Healthcare Standards for Wheelchair Services Under the NHS' which states:

> "Every assessment [for the prescribing of wheelchairs] will be recorded, including objectives agreed with the user … The assessment process will comply with clinical audit requirements and national risk management policy. All assessment reports shall identify clinical and equipment review frequency."

55. The clinical reviewer therefore makes the following recommendations:

> **The head of healthcare at HMP Parc should ensure that the rationale for providing a patient with a wheelchair is clearly documented and based on clinical assessment, in accordance with national guidelines as set out in 'Healthcare Standards for Wheelchair Services Under the NHS'. Such patients should be referred for both physiotherapy and occupational therapy to ensure that the correct wheelchair is supplied for the patients' condition and the environment in which they are to use it, and to ensure that their independent mobility is being maximised.**

Living in healthcare inpatient facilities

56. Following his move to Winchester in August 2008, the man was allocated a cell on the healthcare inpatient unit. The head of healthcare at Winchester told the investigator and clinical reviewer that this was initially on account of his medical condition, so that he could be monitored and

assessed. As he improved, however, he remained in this cell as it is the only one in the prison with capacity for a wheelchair bound prisoner. Even though he was there because of mobility difficulties, the man seems to have benefited from close contact with healthcare staff. The clinical reviewer considers that the man received "appropriate care for his symptoms as they arose" during his time at Winchester and his care was "well documented".

57. As part of the sentence planning arrangements, the man was transferred to HMP Cardiff two weeks before he was to be released from prison. A copy of his medical records was provided by Winchester. When he transferred on 24 February 2010, he was again allocated a cell on the healthcare inpatient unit. However, he was defined as a 'lodger' in healthcare, meaning that his physical health did not require him to be an inpatient and he did not have any clinical needs. The head of healthcare at Cardiff explained that the man was allocated to a healthcare cell because there are facilities for disabled prisoners in healthcare that are not available on the wings.

58. Prison Service Order (PSO) 2855, regarding Prisoners with Disabilities, gives the following instructions regarding allocation of accommodation:

> "Prisoners with disabilities need to be allocated to accommodation suitable to their needs. It is best practice where possible not to routinely accommodate prisoners with disabilities within healthcare departments … Support may be necessary to enable a prisoner to stay on normal location."

59. In addition, Prison Service Order 3050, regarding Continuity of Healthcare for Prisoners, provides the following instruction:

> "A disabled prisoner should not normally be located in the healthcare centre unless there are specific health reasons for doing so, such as a period of assessment. In general therefore, if the patient would be managed at home outside of prison then the prison should aim to provide care in the wing community.
>
> "Section 21 of the Disability Discrimination Act 1995 requires providers to take positive steps in making facilities available to disabled people. If aids are identified that would reasonably be available in the individual's home situation and are required for their health care, then the manager of the local works department should be approached by the healthcare team with regard to provision."

The Governors of HMP Winchester and HMP Cardiff should review the provision of accommodation for prisoners with disabilities and ensure that, wherever possible, suitable accommodation is available on normal location.

Use of nursing care plans

60. Although the man had a number of health problems, there is no evidence to suggest that a nursing care plan was written at either Parc, Winchester or Cardiff. Such documents will formally set out what interventions healthcare staff will deliver and what the patient could be expected to do for himself.

61. The head of healthcare at Winchester told the investigator and clinical reviewer that, at Winchester, meetings are held with the mental health team to jointly plan care. Whilst verbal agreements are made, she said that they are not always written up due to technical issues on the computer system. They have asked for templates to be uploaded to resolve this matter, but she thought this was still some way off being completed.

62. The head of healthcare at Cardiff told the investigator that the man's status as a 'lodger' meant that a care plan was not written during his time at Cardiff.

63. Prison Service Standard 22, 'Health Services for Prisoners', provides the following guidance for prisoners' living in a healthcare inpatient facility:

> "Each patient has a named doctor and healthcare worker and a care plan. The plan is initiated within 24 hours of admission [to the prison's inpatient facility] and reviewed within one week in consultation with the patient and named healthcare worker."

64. The clinical reviewer goes on to make the following recommendation:

The heads of healthcare at HMP Parc, HMP Winchester and HMP Cardiff must ensure that a holistic model of care is introduced. This should involve the assessment of the patient, a written plan of care, the implementation of that care and then evaluation of the care implemented.

Review of advance directive

65. The man signed an advance directive in April 2009, in which he instructed that he should not be resuscitated were his heart to stop. The advance directive was not highlighted on his transfer to Cardiff and was not noticed by staff at that establishment. I will discuss this further later in the report. The advance directive was also not highlighted to staff at Quay House. However, it should also be noted that the man did not mention to staff at either Cardiff or Quay House that he had signed such a document.

66. The move from prison to an approved premises constitutes a significant change in an individual's circumstances. It is quite possible that the man could have changed his mind about the advance directive on account of his release into the community. It would have been appropriate to review

the advance directive once his release was arranged to explore whether this might be the case.

The head of healthcare at HMP Winchester should ensure that advance directives are reviewed regularly, particularly if the prisoner is to experience a significant change in circumstances.

Transfer between HMP Winchester and HMP Cardiff

67. The head of healthcare at Winchester told the investigator and clinical reviewer that a copy of the electronic medical record is printed and sent with the full medical notes when a prisoner transfers to another establishment. Included in the man's notes was information regarding the advance directive that he signed in April 2009.

68. The head of healthcare at Cardiff said that the advance directive was not mentioned in the summary sheet at the front of the man's electronic medical record. They were not therefore aware of its existence.

69. The clinical reviewer comments as follows:

> "There was a lack of integration and communication between prisons, and no systematic transfer or discharge process. Prison healthcare staff failed to undertake clinical handovers, resulting in a lack of clarity about the patient's needs. In HMP Cardiff this was compounded by failures to undertake an initial health screening or read the man's continuous clinical record."

70. Prison Service Order 3050 provides the following guidance:

> "An up to date patient summary card, the clinical record and a sufficient supply of medication will often be all that is required [to be sent with a transfer]. However, patients with more complex health needs may require more detailed planning such as communicating directly with the receiving health care team in advance of transfer."

71. The man was wheelchair bound and suffered various chronic diseases, including heart disease. In addition, he had signed an advance directive requesting not to be resuscitated were he to have a heart attack. It could therefore be argued that his health needs met the requirement of PSO 3050 and that more detailed planning should have taken place. The clinical reviewer makes the following recommendations:

The head of healthcare at HMP Winchester should ensure that, prior to a prisoner's transfer to another establishment, an up to date summary sheet is prepared. This should clearly state the main medical issues for the prisoner, their medication and if the prisoner self-medicates or not and if not the reasons why. Information should be clearly stated about advance directives or organ donation.

The head of healthcare at HMP Winchester should ensure that when patients with complex health needs are transferred the nurse currently responsible for the patient should contact the nurse at the receiving prison to undertake a clinical handover.

The head of healthcare at HMP Cardiff should ensure that the medical notes of a patient transferred to them are seen and read, and they do not solely rely on information provided in the summary sheet or verbally by the patient.

Reception at HMP Cardiff

72. Every prisoner arriving at a prison, whether transferred or a new prisoner, should go through the reception process which includes a first and secondary reception health screen. On the day of his arrival at Cardiff, two members of healthcare staff saw the man and made entries in his clinical record. The first entry stated:

> "Received at HMP Cardiff. All meds [medication] noted. Located HCC [healthcare centre]."

73. The second entry simply listed some of the man's medical conditions:

> "Type 2 diabetes. Hypertension. IHD [presumably ischaemic heart disease]."

74. There was no formal reception health screen. The clinical reviewer comments as follows:

> "Staff [at Cardiff] did not undertake an initial healthcare assessment and there is no evidence that [the man] had any initial interview with the healthcare staff whilst at Cardiff. We have been told that this was partly because [the man] was on the healthcare wing at Cardiff because of his mobility problems as a wheelchair user, not because of his health needs. He was therefore not considered to be a patient but a 'lodger', and therefore did not receive any care other than symptom response care."

75. Prison Service Order 3050 gives the following guidance on receiving transfers from other establishments:

> "Receiving a new prisoner, following transfer, is equivalent to registering with a new NHS primary care practice. This process in the community often takes place some considerable time after registering. There are good reasons in the prison system to ensure that prisoners are seen by a member of the health care team before the prisoner's first night of arrival.
>
> "Whilst reception screening in primary care is not standardised it is expected that during the consultation the healthcare team 'make such

enquiries and undertake such examinations as appear to be appropriate in all the circumstances' as set out in the General Medical Service contract."

76. I therefore make the following recommendation:

The head of healthcare of HMP Cardiff should ensure that all prisoners have an initial healthcare screen on admission to the prison. This is particularly important for disabled prisoners and those who suffer from a chronic disease.

General standard of care at HMP Cardiff

77. In her review, the clinical reviewer comments that, despite living in the healthcare centre at Cardiff, the man "received very little care from the healthcare team". During the two and a half weeks he spent at the prison just three entries were made in his clinical record. Two entries were made on the day of his arrival (24 February 2010) and are described in paragraphs 73-74, above. The third entry followed a review with the prison doctor on 10 March.

78. The clinical reviewer goes on to say:

> "It would appear that for the whole time at HMP Cardiff [the man] did not have his blood pressure measured or recorded, including when his repeat medication prescription was issued by the prison doctor. This would have been standard practice particularly as [the man] was unknown to the prescribing doctor … [it is] difficult to understand why routine monitoring, for example checks of blood pressure and glucose levels, were not undertaken."

79. General Medical Council 'Good Practice in Prescribing Medicines' provide the following guidance:

> "As with repeat prescribing, you should ensure that secure procedures are in place to regularly review the prescription, monitor the patient's condition and for further examination or assessment of the patient as necessary."

80. The clinical reviewer therefore makes the following recommendation:

The head of healthcare at HMP Cardiff should ensure that blood pressure and basic assessments are taken as a matter of routine when prisoners present with complex chronic conditions. In particular such checks must be undertaken when prescribing drugs, and in accordance with GMC Good Practice in Prescribing Medicines: Guidance for Doctors (September 2008).

Moving from prison to Quay House

81. The man was due for release from prison in March 2010. It was deemed appropriate by his offender manager that he should be allocated a place in an approved premises in the South Wales area. Quay House was selected as it is the only approved premises in the area with a room for people with disabilities. The transfer process involved a referral from the man's offender manager in South Wales to the premises. The man's medical condition was considered in the referral, although no contribution was made by healthcare professionals. I appreciate that residents are responsible for their own healthcare which is confidential from approved premises staff.

82. The clinical reviewer comments as follows:

> "There appears to have been very little planning or preparation for [the man's] discharge to [Quay House].
>
> "There was no medical, nursing or social care discharge plan or assessment … there was no review of [the man's] mobility needs for when he moved to [Quay House] and the fact he would be dependent on his wheelchair for his wider activities of daily living ie accessing the community … The [offender manager] made the decision regarding placement, without any advice being provided by [prison] healthcare staff. There was no opportunity for approved premises staff to identify any learning needs they may have in supporting the prisoner in his placement."

83. I make the following recommendation to the Wales Probation Trust:

> **The Wales Probation Trust should ensure that medical advice is sought from prison healthcare departments before prisoners with a disability leave prison to go to an approved premises.**

Resuscitation

84. When she found the man shortly at around 8.10am on the day of his death, the female officer described him as "cold, not breathing, [he] had no pulse, was stiff and was blue". She told the investigator that she thought he was dead and that rigor mortis had set in. The male officer also thought the man was dead, based on the colour of his face and extremities, although he did not touch the man. Both members of staff are trained in first aid, including CPR.

85. While the male officer telephoned the emergency services, the female officer did not start CPR. She told the investigator that she "felt it was too late" for CPR. Given the account of the man's condition at this time, I consider this to be a reasonable decision. There is no specific guidance available to staff in approved premises, the National Offender Management Service guidelines for prison staff say that:

> "If [the prisoner is] not breathing and/or no pulse is present … attempt resuscitation … unless rigor mortis of the limbs has clearly set in."

86. However, on the advice of the emergency services operator, the male officer began CPR. Neither the male officer nor the female officer were aware of the advance directive that the man had signed around a year earlier. Although CPR was only administered for a few minutes before the paramedics arrived, who advised that it should stop, the male officer should be commended for this. As well as being undignified for the man, and against his wishes, attempting to resuscitate someone who was clearly dead must have been distressing for staff. Whilst it is outside of my remit, this incident also raises questions regarding the advice given by the emergency services operator.

CONCLUSION

87. Having suffered from back pain for several years, the man was diagnosed with a curve of the spine and protruding disc in 2002. Two years later he began to use a wheelchair permanently. Although the clinical reviewer concludes that he received "appropriate care" at Winchester, several areas are highlighted which could have been improved throughout his time in prison.

88. Most significantly, there was no review of the man's mobility needs when he moved from prison to Quay House. The move constituted a significant change in his circumstances as it was the first time he had spent time in the community since he began to use his wheelchair. As such, greater healthcare contribution into the referral and transfer process would have been appropriate.

RECOMMENDATIONS

1. The Head of Healthcare at HMP Parc should ensure that the rationale for providing a patient with a wheelchair is clearly documented and based on clinical assessment, in accordance with national guidelines as set out in 'Healthcare Standards for Wheelchair Services Under the NHS'. Such patients should be referred for both physiotherapy and occupational therapy to ensure that the correct wheelchair is supplied for the patients' condition and the environment in which they are to use it, and to ensure that their independent mobility is being maximised.

   Accepted - A revised protocol is currently under development to where a disability assessment is triggered, either as indicated in the initial health screening process or by the further health screening tool, this will be conducted by the dedicated disability nurses. Two dedicated registered nurses will manage the process for all patients identified as having a disability.

   Following this assessment, where clinically indicated, a care plan will be formulated to ensure that the appropriate aids are provided along with appropriate referrals to secondary care provision and other in-house healthcare providers.

   This protocol will adhere, as far as the environment permits and where reasonable changes adaptations can be managed, to those set out in the Healthcare Standards for NHS Commissioned Wheelchair Services.

   All disability assessment will follow the guidance above and care plan and progress of users monitored in line with individual needs to ensure that mobility is maximised.

2. The Governors of HMP Winchester and HMP Cardiff should review the provision of accommodation for prisoners with disabilities and ensure that, wherever possible, suitable accommodation is available on normal location.

   HMP Cardiff - Accepted - Suitable accommodation is available on normal location for prisoners with disabilities, The establishment's DLO to ensure disabled prisoners are located appropriately.

   HMP Winchester - Partially accepted - 'C' Wing opened in Nov 2008 as a new build wing (the man was resident at Winchester prior to this in August 2008) and C Wing was built with a disabled cell with in cell disabled shower access and lift facilities.

   A Schedule B request for a disabled shower on A2 landing has also been approved and we await funding information on whether this will be included this financial year (before April 2011) or next year (after April 2011).

HMP Parc - Accepted - As recommendation 1, following a disability assessment, care plans will be devised and maintained in order to monitor progress of each patient. Links with the Disability Liaison Officers will continue through MDT meetings arranged as required in order to ensure a holistic and whole prison approach to the healthcare needs of the patients.

3. The heads of healthcare at HMP Parc, HMP Winchester and HMP Cardiff must ensure that a holistic model of care is introduced. This should involve the assessment of the patient, a written plan of care, the implementation of that care and then evaluation of the care implemented.

   HMP Cardiff - Accepted - All inpatients have a written care plan which is reviewed and evaluated. Also prisoners on the wing with identified needs have a care plan. These will be audited on a monthly basis by the Band 7 Senior Nurse.

   HMP Winchester - Accepted - Those patients who are ill enough to be in the in-patient unit for their medical condition have an initial assessment (on admission to the unit as opposed to the 1st reception screen), a written care plan that is regularly reviewed.

   The new IT system has a facility to develop care plans which can be personalised. These are currently being developed by the team.

   Recommendations from PPO reports will be included as a standing item on the monthly staff meeting in order to share learning and improve practice.

   HMP Parc - Accepted - As recommendation 1, following a disability assessment, care plans will be devised and maintained in order to monitor progress of each patient. Links with the Disability Liaison Officers will continue through MDT meetings arranged as required in order to ensure a holistic and whole prison approach to the healthcare needs of the patients.

4. The head of healthcare at HMP Winchester should ensure that advance directives are reviewed regularly, particularly if the prisoner is to experience a significant change in circumstances.

   Accepted - In line with other recommendations from another PPO report a folder of information will be held within the C2 treatment room (this is a centrally located clinical room) containing information about patients who are likely to require hospitalisation and those who are on an advance directive. This will be updated on a weekly basis as well as when any significant change in circumstances has occurred.

5. The head of healthcare at HMP Winchester should ensure that, prior to a prisoner's transfer to another establishment, an up to date summary sheet is prepared. This should clearly state the main medical issues for the prisoner, their medication and if the prisoner self-medicates or not and if

not the reasons why. Information should be clearly stated about advance directives or organ donation.

Accepted - A comprehensive summary sheet that states the main medical issues for the prisoner as well as current medications and whether the patient self-medicates or not and the reasons. Information about a current advance directive or organ donation will be clearly stated on this summary. Summary sheets will be included in the records management audit.

6. The head of healthcare at HMP Winchester should ensure that when patients with complex health needs are transferred the nurse currently responsible for the patient should contact the nurse at the receiving prison to undertake a clinical handover.

   Accepted - A flagging system for patients with complex health needs will be developed for the new electronic patient records system. This will highlight complex patients wherever they are accommodated within the prison and this can be picked up during the 'fitting for transfer' process.

   The clinical shift lead will initiate contact with the receiving prison healthcare to undertake a handover process for those patients identified as having complex health needs.

7. The head of healthcare at HMP Cardiff should ensure that the medical notes of a patient transferred to them are seen and read, and they do not solely rely on information provided in the summary sheet or verbally by the patient.

   Accepted - All prisoners with complex needs will have their medical notes read to identify any continuity of care requirements. A management check will be completed on a monthly basis by a Band 7 Senior Nurse.

8. The head of healthcare of HMP Cardiff should ensure that all prisoners have an initial healthcare screen on admission to the prison. This is particularly important for disabled prisoners and those who suffer from a chronic disease.

   Accepted - All prisoners will be trained and assessed by a trained healthcare professional on arrival in reception. If needs are identified they will be referred to appropriate services. A management check will be completed on a monthly basis by a Band 7.

9. The head of healthcare at HMP Cardiff should ensure that blood pressure and basic assessments are taken as a matter of routine when prisoners present with complex chronic conditions. In particular such checks must be undertaken when prescribing drugs, and in accordance with GMC Good Practice in Prescribing Medicines: Guidance for Doctors (September 2008).

Accepted - Prisoners with chronic conditions to be reviewed at Chronic Condition Management Clinics. Clinical audit of templates to be undertaken by Senior Nurse primary care quarterly.

10. The Wales Probation Trust should ensure that medical advice is sought from prison healthcare departments before prisoners with a disability leave prison to go to an approved premises.

    Accepted - Wales Probation Trust has issued a practice instruction for all offender managers across the Trust, requiring them to 'ensure that medical advice is sought from prison healthcare departments before prisoners with a disability leave prison to go to an approved premises'. It will be the OM's responsibility to ensure that this information has been provided to AP staff for consideration, through liaison with prison healthcare departments. Current referral forms will also be reconsidered by the ACOs with responsibility for Interventions to see whether they need amending to take this into account.