Investigation into the circumstances surrounding the death of a man at HMP Usk and Prescoed in March 2011

Report by the Prisons and Probation Ombudsman for England and Wales

January 2012

This is the report of an investigation into the death of a prisoner at HMP Usk. The man died in March 2011. He was 67 years of age. He died as a result of cardiac tamponade, where fluid compresses the heart. This was caused by an underlying heart problems.

The man was remanded into custody on 18 December 2009 and sent to HMP Cardiff. He was later sentenced to 9 years for serious offences and later transferred to Usk.

The man's next of kin was his sister-in-law, his brother's wife. After the death of his brother, he lost touch with his sister-in-law. She was unaware of her brother-in-law's imprisonment until his death.

The investigation was carried out by one of my colleagues. Healthcare Inspectorate of Wales commissioned a clinical reviewer to review the man's clinical care. I apologise that the report has been delayed.

The clinical reviewer concluded that the man died of heart failure which could not have been foreseen. He went on to find that the treatment of his acute medical conditions was appropriate and timely. However, the care he received for his chronic conditions of diabetes and high blood pressure whilst in Cardiff was not, in some aspects, of the same standard that he would have received in the community.

There are seven recommendations arising from the investigation. These are intended to ensure that lessons are learned from this man's case. In particular, improvements are required to chronic disease management, in-possession medication and record management. It is essential that these issues are addressed to ensure that chronic disease management at Cardiff, in particular, is provided to a reasonable standard.

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.

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Prisons and Probation Ombudsman **January 2012**

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SUMMARY

1. On 18 December 2009, the man was remanded into custody and sent to HMP Cardiff. During his reception health screen, he informed healthcare staff that he suffered from diabetes, high cholesterol, acid reflux, high blood pressure and an enlarged prostate. He was prescribed medication to continue to manage these conditions. Despite suffering from these ailments, healthcare staff failed to refer him to the chronic disease management clinics held at the prison.

2. Three weeks after his arrival, the man was seen by the prison doctor to review his medication. It was noted that his blood pressure was high. As a result, his blood pressure medication was increased and a blood test requested. He was advised that his blood pressure would be re-checked in seven days and blood results reviewed. However, his blood pressure was not reviewed and, due to a communication breakdown, there was a long delay before a blood sample was taken for testing.

3. On 4 February, the man was found in his room by wing staff with slurred speech and loss of power to his right arm. He was taken by emergency ambulance to outside hospital with a suspected stroke. After further examination hospital staff confirmed that he had in fact had a stroke.

4. On 16 March, the man attended court and was convicted of serious offences, and sentenced to nine years. He returned to Cardiff.

5. A doctor from the hospital's stroke prevention clinic saw the man on 6 April. On examination, despite the increase in his medication, his blood pressure was still high. Following the consultation, the doctor wrote a letter to the healthcare department at Cardiff criticising the after care he had received there. The letter said "Looking through his notes, it doesn't appear that he has had any other investigations to look for sources of emboli [causes] for stroke".

6. Although the man had high blood pressure, diabetes and had recently suffered from a stroke, there is no record of him being seen by anyone from healthcare at Cardiff from 23 April to 17 August. He was assessed as being fit for transfer to HMP Usk, and transferred on 19 August.

7. During the reception health screen, it was explained to the man that he would receive his medication in-possession. The rules for in-possession medication were explained. Despite this, on 22 November, it was discovered that he had failed to pick up his medication from the healthcare department for two weeks.

8. In late March, the man complained of chest pains. An ECG was done which suggested that he was having a heart attack. He was taken by emergency ambulance to hospital. He was given an x-ray and a troponin blood test (a test to diagnose a heart attack) and despite a previous ECG reading taken at prison, the troponin blood test and x-ray showed no abnormalities.

9. At 11.05pm that evening the man was escorted to the toilet. He entered the toilet cubicle, and a few seconds later opened the door and collapsed to the floor. Despite continued efforts by hospital staff to resuscitate the man, at 11:30pm it was confirmed he had died.

10. When his cell was searched, eight medication packs were found, most of them unopened. The man had seemingly not been taking his medication as prescribed and, despite a previous instance of not taking his medication in November 2010, this was not discovered by healthcare staff until he died.

11. Seven recommendations result from this investigation. These concern the importance of chronic disease clinics, ensuring that prisoners are taking their medication, record taking and informing healthcare units when prisoners return from hospital appointments.

THE INVESTIGATION PROCESS

12. The investigation was opened on 5 April 2011, when the investigator issued notices announcing the investigation to staff and prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to the investigator.

13. During the opening visit, the investigator collected copies of the man's prison files, including his medical records. She visited the healthcare unit, viewed the man's cell, and introduced herself to the staff on the wing. During the opening visit, the prison liaison officer told the investigator that when an officer went to collect the man's personal belongings from his room a large amount of unused medication was found. A full list of the medication was recorded and this information was passed to the clinical reviewer.

14. The investigator returned to Usk on 27 May 2011, to interview three members of staff. An interview was also conducted with the man's roommate. The investigator met the prison Governor during this visit. Verbal feedback was given, and the Governor discussed a concern he had as to how the man's next of kin was informed about the death. He explained that the hospital had telephoned the man's sister-in-law before the prison had managed to inform her of the news. He informed the investigator that he was due to meet with the local health board to try and agree a protocol regarding next of kin notification. The result of this meeting will be discussed further on in the report. On 19 July, and 1 August 2011, the investigator visited Cardiff to meet with a prison doctor and the healthcare manager.

15. Throughout the investigation, written feedback was given to the Governor. On completion of her investigation, the investigator wrote to the Governor, and to the Governor at Cardiff, highlighting areas of potential concern.

16. A clinical review of the man's health care in prison was carried out by a clinical reviewer on behalf of the Healthcare Inspectorate of Wales. The review was received on 21 October. This delay, in turn, led to the investigation report being delayed.

17. One of the Ombudsman's family liaison officers contacted the man's next of kin, his sister-in-law, to inform her of the investigation and to provide her with an opportunity to raise any issues for consideration as part of this. No issues were highlighted at the outset of the investigation. The family liaison officer spoke with the man's sister-in-law about receiving the draft version of the report. The man's sister-in-law was interested to know the findings of the investigation but felt it would be too distressing to receive the report in its entirety. She chose to receive the conclusion and recommendations. No further comments were raised.

18. This report will be forwarded to the coroner to assist in his enquiries.

HMP CARDIFF

19. HMP Cardiff is a large Victorian city centre-based local prison, predominantly serving the Welsh courts and the South-West of England. The prison holds adult convicted and remand prisoners. It is designated to hold category B and C prisoners, including life sentenced prisoners.

20. Healthcare services are commissioned by Cardiff and Vale University Health Board. Cardiff has a new healthcare centre that provides 24 hour primary care. The centre has 22 in-patient beds for offenders with increased health needs. However, this is not considered to be a hospital setting and those in need of specialised care are transferred to outside hospital. The prison doctor is supported by locums from a local medical practice, and offers 13 sessions per week including one on a Saturday morning.

21. The Independent Monitoring Board (IMB) is appointed to each prison by the Secretary of State for Justice as independent watchdogs of the public interest. They are required to produce an annual report to the Secretary of State on the prison, highlighting good practice and flagging up areas of concern. Their latest report was published in August 2010. The IMB commented that:

> "The Board has recognised, and is concerned about an increase in the number of complaints made to the board relating to healthcare, and treatments."

22. The most recent published report by Her Majesty's Chief Inspector of Prisons (HMCIP) was dated June 2010. This report detailed an unannounced follow-up inspection detailing a previous inspection in 2008. In 2008, HMCIP made three recommendations that relate to areas of concern highlighted in our investigation. These were:

- Mental health awareness training should be a regular programme for all prison staff.
- Written entries in clinical records should be legible and a method for identifying the writer and their designation introduced. Entries should be respectful.
- A health services worker should be nominated to assist with the compilation of chronic disease management records.

23. In 2010, HMCIP found that the first two of these recommendations had not been achieved. The recommendation detailing chronic disease management had been achieved, with HMCIP saying "The lead GP was in charge of chronic disease management… There was an electronic register, held in the form of a Microsoft Excel spreadsheet…" However, this issue has again been highlighted as a concern during our investigation.

24. Two recommendations from previous PPO investigations are repeated in this report. These relate to obtaining clinical records from community GPs and the standard of entries in prison medical notes.

HMP USK

25. HMP Usk/ Prescoed is the amalgamation of HMP Usk and HMP Prescoed. Usk has a long and varied history as a penal establishment, opening in 1844 as a House of Correction. In May 1990, it became an Adult Cat C establishment for Vulnerable Prisoners and continues in that role today.

26. Accommodation consists of three wings, A, B and C, in two storey blocks. Most cells are doubles, although there is one dormitory, all of which have simple integral sanitation. Additional accommodation is located on Comber Unit, a 20 bed ground floor unit opened in May 2003. Allocation to Comber Unit is by application. There is wheelchair access to most ground floor areas.

27. Healthcare services at Usk are commissioned by Aneurin Bevan Health Board. Healthcare services are available Monday to Friday 7.30am – 4.30pm, with a GP surgery being available on Monday, Wednesday and Friday mornings. A range of clinics are provided, including specialised clinics for older prisoners.

28. The Independent Monitoring Board (IMB) for Usk published their latest report in April 2010. The IMB commented that:

> "The certified normal accommodation (CNA) is 150, with an operational capacity of 250. Over the past year the number of prisoners has averaged 248.58. The Prison is overcrowded but the number of complaints regarding doubling up in cells has not risen and the Board is therefore confident that the overcrowding is not causing significant problems."

29. At the time of writing their report, new healthcare facilities had not yet been completed. However, they commented that:

> "Healthcare facilities still wait improvement. Building work due in March 2009 has now commenced. The new facilities are now scheduled to be completed summer 2010. However, the new facilities will still not provide any accommodation in healthcare."

30. The most recent published report by Her Majesty's Chief Inspector of Prisons (HMCIP) was dated April 2010. HMCIP criticised healthcare facilities at Usk by saying:

> "Healthcare facilities at Usk were poor and not fit for purpose; although a new building was due to open shortly after the inspection. Currently Usk had only three multi-purpose rooms that were clean, but cluttered with equipment and paperwork. The main nursing office was also the treatment room. It offered no privacy for patients and was the main centre for all healthcare activity."

31. Since the Ombudsman started investigating deaths in custody in April 2004, there have been seven deaths in custody at HMP Usk. All of these have been due to natural causes.

32. We repeat one recommendation from a previous investigation at Usk, from 2009. This relates to in-possession medication.

KEY EVENTS

33. On 18 December 2009, the man was remanded into custody and sent to HMP Cardiff. During his reception health screen later that day, he informed healthcare staff that he had suffered from diabetes for the last six to seven years, and was currently taking medication for high cholesterol, acid reflux (stomach acid coming from the stomach into the oesophagus), enlarged prostate and high blood pressure. He provided the name and address of his local GP. There is no evidence to show that his blood pressure was checked, or previous healthcare records obtained from his local GP.

34. The man was deemed fit for normal location and work, and was placed in a shared cell. Cardiff healthcare run a chronic disease management clinic, which includes illnesses such as diabetes and high blood pressure. He was prescribed medication to continue to manage these conditions. Despite suffering from these ailments, healthcare staff failed to refer him to the chronic disease management clinics held at the prison.

35. The man was seen by a prison doctor on 13 January 2010, to review his current medication. She noted that his blood pressure was high (being 188/107). During this consultation the man asked if he could be cleared to attend the gym. The doctor increased his blood pressure medication, lisinopril, from 10mg to 20mg and requested that his bloods and diabetes to be checked. She told him that she would need to see him again in seven days to check his blood pressure. However, the man's blood pressure was not reviewed, nor was a sample of blood taken for testing.

36. A nurse was called to see the man in his room at 3.30pm on 23 January. He was complaining that he had been playing pool and had felt a sharp stabbing sensation in the back of his right arm. As he complained of no other symptoms, he was given paracetamol for muscle pain and advised to see someone in healthcare if the discomfort continued. A note was made in his medical file to say that "evening nurse to visit to check on progress". There is no record to show that he was seen that evening for follow-up, nor is it clear who made the entry in his medical file as the signature is unreadable.

37. On 3 February, the prison doctor saw the man to issue him with a repeat prescription for tamsulosin (for his prostate). When she realised that a blood sample had not been taken (as requested on 13 January) she decided to take the sample herself. However, she failed to check his blood pressure despite this also being previously overlooked.

38. The next day, the man was found in his room by wing staff. He had slurred speech and had lost power in his right arm. He was seen by a nurse who checked his blood pressure, this being normal at 133/76. Due to his slurred speech and loss of power to his arm, he was taken by emergency ambulance to outside hospital with a suspected stroke. This was later confirmed.

39. Outside hospital discharged the man back to prison on 5 February. Prior to his discharge, a referral was made for him to be seen by a doctor at the stroke prevention clinic, and by a speech therapist.

40. The man attended an appointment at the speech and language therapy department at outside hospital on 10 February. A letter (dated 23 February) was sent to Cardiff explaining that the man's speech was mildly dysarthric (slurred). The speech therapist explained that she believed that his speech "would be likely to improve with normal conversational use". In view of this, the speech therapist advised that further speech and language therapy intervention would not be required.

41. Due to high incidents of depression in patients with multiple chronic diseases, on 15 March, the man was seen for a community psychiatric nurse assessment. A note was made by a student nurse to say that the man had "no thoughts of self harm, [was] happy in mood, [and had] no history of previous mental health problems". Other than this appointment, it appears that he was not seen by anyone from healthcare for any kind of follow up for his blood pressure despite recently being released from hospital following a stroke.

42. On 16 March, the man attended court and was convicted of serious offences, and sentenced to nine years in prison. He returned to Cardiff.

43. A doctor from the hospital's stroke prevention clinic saw the man on 6 April. On examination, despite being on medication to control his blood pressure, his blood pressure was high showing 173/90. Following this consultation, the doctor wrote a letter dated 8 April, to the healthcare department at Cardiff. This letter said:

> "Since discharge he has had no further problems and denies any further limb weakness, slurred speech or visual problems. In terms of prevention he is currently on Aspirin and Simvastatin [for raised cholesterol]. He was supposed to be started on Dipryridamole [to prevent blood clotting] but for some reason this hasn't been started. In terms of risk factors, he has high blood pressure, type II diabetes, high cholesterol and is a smoker. Looking through his notes, it doesn't appear that he has had any other investigations to look for sources of emboli [causes] for stroke so I have organised 24hr ECG and ECHO [both non-invasive tests measuring heart activity] today and will see him in 2 months."

44. As a result of the consultation with the doctor, an echocardiogram (a procedure using ultrasound that produces images of the heart to detect defects, also known as an ECHO), and 24hr ECG (a procedure to look at the electrical activity in heart over a set period of time) was arranged. The echocardiogram was booked for 1 June, and the 24hr ECG for 13 August. On return to Cardiff, he was started on dipryridamole, a medication to help thin the blood and prevent clotting.

45. On 12 April, the man was seen in his room complaining of vomiting, being very hot and suffering with loose stools. A blood pressure reading showed a reduction in his normal blood pressure, this being 95/63. He was advised to drink plenty of fluids and to inform staff of any changes in symptoms. It is unclear how long he was unwell for, or if his symptoms worsened as the nurse's signature cannot be identified and there are no further notes relating to this.

46. There is an entry in the man's medical file dated 23 April (some of the contents, and the author's name, is again unreadable). The note details that he had recovered from a stroke, that he needed a 24 hour heart monitor, and that he should stop smoking. (There is no record of any stop smoking treatment or advice being offered to him.) This note also showed that his blood pressure was now 153/ 96, this being high.

47. Prison escort records show that the man had his follow-up appointment at the stroke prevention clinic at outside hospital on 1 June. A letter from the clinic dated 8 June, said:

> "I reviewed on behalf of [doctor's name]. He has no further episodes of right sided facial and upper limb weakness or slurring of speech. BP [blood pressure] 171/95 heart rate 65 b/ per minutes. No evidence of cardiac thrombus."

In his letter, the doctor confirmed an earlier diagnosis of left cerebral peduncle mid brain right lacunar infarct [a stroke]. Despite his blood pressure being high the results of his echocardiogram came back normal. The man was asked to return in two months time for a further follow-up appointment. His attendance at the doctor's clinic was not noted in his medical records, only being recorded in the prison escort record.

48. On 3 August, the man returned to the stroke prevention clinic. The following day a letter was sent to the healthcare department at Cardiff with their findings. The letter confirmed that, as he had not suffered from any further neurovascular symptoms, and that his echocardiogram on 1 June showed no significant abnormality he could be discharged from their care. The man was again advised to stop smoking. There is no record in his personal medical notes to show that he left the prison to attend the stroke clinic.

49. Prison escort records show that on 13 August, the man attended outside hospital for his 24 hour ECG. The results of this procedure are unknown, as again there is no mention of his attendance at hospital or of any results in his medical record.

50. Despite the man having uncontrolled blood pressure, diabetes and having recently suffered from a stroke, there is no record of him being seen by anyone from healthcare at Cardiff between 23 April to 17 August, when he was assessed as being fit for transfer to HMP Usk.

51. The man was transferred to Usk on 19 August. On arrival he was seen by a member of healthcare who completed a reception health screen. During this it was noted that he had previously suffered from a stroke, and a note of ”slurred speech” was made. His blood pressure was noted to be high, this being 155/89. It is unclear if the note made detailing slurred speech referred to the effects of his previous stroke, or about his presentation at that time. The health screen form was not signed by the nurse.

52. During the reception health screen it was explained to the man that he would receive his medication in-possession, and that this would be given to him in weekly ‘V packs’ (Venalink packs or blister type packs that are divided into days of the week, and the time of day the person should take their medication, for example Sunday morning/ afternoon/ evening). He was given a ‘HMP/YOI Usk and Prescoed medication compact’ to read and sign. This medication compact gave a list of rules and instructions that he must follow. Two of the rules that were of particular importance were:

> “The container or card issued to me must be returned to the health care centre when empty; the course of treatment has finished or is due for renewal”.

and,

> “I will return any medication container or pack that contains medication that I have chosen not to take. I understand that failure to comply with this may constitute unauthorised possession”.

The healthcare manager confirmed that reading and signing the medication compact was part of the reception process. She explained that, although the man’s compact had not been signed, it was their normal practice that the compact would be explained to the prisoner during the reception health screen. However, despite the healthcare manager’s assurances, it is unclear if the man read or agreed this medication compact, as it was not signed.

53. The man was seen by a nurse on 15 September after complaining of numbness in his right hand. His blood pressure was taken and shown to be high, at 161/89. There are no further entries in his medical record until 13 October, when he was seen by an unknown doctor (the name of the doctor was not recorded in the notes).

54. On 19 October, a prison officer asked healthcare to see the man as he was feeling unwell. He was escorted to healthcare and was seen by an unidentified nurse. It was noted that he had previously had a stroke, but he denied that he was suffering from any other symptoms, such as chest pains, blurred vision or headache. His blood pressure was still high, this being recorded as 164/93. During this consultation, the man admitted that he hadn’t been eating. His blood sugar was tested and this showed a level of 5.1(an acceptable level). It was suggested to him that he may be coming

down with a cold, and that he should eat regularly with his medication, and to report any further problems.

55. The next day, 20 October, he was reviewed by the same nurse from healthcare. His blood pressure was recorded as 164/88, and a note was made to say “not so light headed today”. Again the name of the nurse who saw him is unclear.

56. On 22 October, the man was reviewed by the prison doctor. During this consultation he informed the doctor that he was having dizzy spells, but did not feel unsteady on his feet. His blood pressure was checked, this being high at 169/109. The doctor also carried out a plantar test (a clinical examination of a reflex to help identify a stroke), and also tested the man’s reflexes and strength. The doctor made a note to say “no evidence of stroke now, TIA [transient ischaemic attack, more commonly known as a mini stroke]”. The doctor who examined him did not sign the medical records.

57. The man’s blood pressure was next reviewed on 29 October by an unnamed person from healthcare. It was noted that he was feeling better and he was on the right treatment. His blood pressure was now slightly reduced at 145/88.

58. The man went to healthcare on 22 November complaining that he felt unwell. He was examined by an unnamed nurse who took his blood pressure, this being high at 140/97. His blood sugar was 7.1. As a result of this consultation, it was discovered that he had not collected his medication from the healthcare department for two weeks, from 8 November. It is unclear how this had gone unnoticed.

59. A nurse completed a ‘care of the elderly screening’ with the man on 24 November. This screening is completed with all prisoners who are over 60 years old, during which the nurse discusses with the prisoner any issues they have in regards to their mobility and general health. As a result of this screening, he was referred to see the prison doctor to have an ulcer of his left foot treated. He was seen by the doctor on 26 October.

60. Three days later, the man had his foot checked and dressing changed. He was given a flu vaccination. Although a nurse tried to take a ‘fasting blood’ sample (to test the bloods sugar levels without the sugar from food affecting the reading), she was unable to as he had eaten prior to his appointment.

61. On 1 January 2011, the man’s blood pressure was reviewed. His blood pressure was again high at 157/87. It was also noted that the ulcer on his foot had now healed.

62. The next time the man was seen in healthcare was on 19 January, when he complained that he had felt giddy all day, and had been suffering with a migraine. However, by the time he got to see the doctor that afternoon his symptoms had disappeared. On the same day, he had a full podiatry (an assessment of foot health, important in diabetics) assessment.

63. On 7 March, the man was seen in healthcare for his blood pressure to be checked. A reading was taken from both arms (a big difference between the left and right arm blood pressures can indicate a blockage in the heart or arteries. It is important to take readings of both arms to rule out any problems). His left arm showed a reading of 142/76, and his right 138/78, these both being acceptable. However, when this was checked four days later his blood pressure was now high, having risen to 167/86.

64. After the man's blood pressure was checked on 11 March, he was seen on a weekly basis to have this reviewed. He was seen on 18 and 25 March, when it was recorded that his blood pressure continued to rise. His blood pressure on 25 March (a Friday) was 190/106. As a result of this high reading, an appointment was made for him to see the doctor after the weekend on 28 March.

65. When the man was seen by the prison doctor, it was noted that his blood pressure was high. It is unclear how this was determined as there is no record of any blood pressure reading being taken that day in the man's notes. As a result of this consultation, he was prescribed Adizem, a medication to lower blood pressure.

66. The man was seen in healthcare on a morning in late March complaining of chest pains. He had high blood pressure of 194/110 and it was noted in his records that he was 'grey and clammy' [sweaty]. He was given an ECG (a tracing of the electrical activity in the heart) which showed an inferior infarct, which the ECG machine interpreted as a heart attack. An ambulance was called and he was given aspirin and two puffs of GTN (a medication to treat a heart attack or angina) spray. It is unclear what time he went to healthcare complaining of chest pains, what time the ambulance arrived, or what time they arrived at hospital, as the prison and ambulance service have conflicting records. The prison occurrence log and Ambulance Service records show that an ambulance was called at 9.28am. However, the handwritten prison healthcare records show that an ambulance was called at 10.25am.

67. The prison vehicle search sheet and the man's personal escort record (PER) notes that the ambulance arrived at 9.40 am, (healthcare records show 10.50am) and then left for hospital at 10.05am.

68. The man was taken by emergency ambulance to outside hospital. The officers were advised that, during escort to hospital, an escorting chain (a long chain with a handcuff at both ends) was to be used.

69. On arrival at hospital, the man was seen by the triage nurse and given medication to stop any possible clotting. The escort records show that, at 12.30pm that afternoon, the man had a chest x-ray which showed no abnormalities. After being reviewed by a doctor, it was explained that he would have a troponin blood test (a test to diagnose a heart attack) and if this also came back as 'normal' he would stay in overnight so the test could

be repeated after 12 hours. Hospital records show that despite the previous ECG reading taken at prison, the troponin blood test was normal.

70. A further two officers arrived at outside hospital at 8.00pm to take over the bedwatch duties. There are no entries in the bedwatch record to show that the man's health had deteriorated, with a record being made by one of them to say at 8.40pm "led on bed resting".

71. At 11.05pm that evening, the officers escorted the man to the toilet. He entered the toilet cubicle, and a few seconds later, opened the door and shouted "Gov", and collapsed to the floor. One of the officers shouted for assistance and removed the escorting chain from the man's wrist. When medical staff arrived a few seconds later the officers were asked to leave the toilet area to allow hospital staff to try and resuscitate him.

72. Despite continued efforts by hospital staff to resuscitate the man, at 11:30pm it was confirmed he had died. Bedwatch records show that the registrar informed one of the officers that "[the man] had died of a massive heart attack". The officer contacted the night orderly officer (who was in charge of the prison that night) informing him that he had died.

73. Hospital staff attempted to contact the man's next of kin by telephone at 12.30am, but were unable to gain a response. At 1.15am, the officers returned to the prison and briefed the night orderly officer of what had occurred.

74. It was decided by the prison Governor that the man's next of kin, his sister-in-law, should be notified in person, as he thought that a telephone call would be inappropriate. The Governor and the prison's family liaison officer left Usk at 8.30am that morning to travel to her home, arriving at 10.00am. When they arrived, the Governor was told that she had already received a call from the hospital at 8.15am that morning informing her of the news.

75. Later that afternoon, two officers were asked to attend the man's cell to collect his personal belongings. Eight 'V packs' were found with dates ranging from 5 January to 16 March, most of them left unopened. It appears that the man had not been taking his medication as prescribed, and despite the medication compact rules (explained at the reception health screening), and his previous non compliance in November 2010, was not discovered by healthcare staff until he died.

76. The man was cremated on 12 April and his ashes were later placed at the foot of his parent's grave. Funeral costs were covered by Usk prison.

ISSUES – HMP CARDIFF

Chronic Disease Management.

77. During his reception health screen at Cardiff, the man informed healthcare staff that he had suffered from diabetes for six to seven years, and was currently taking medication for high cholesterol, acid reflux, and enlarged prostate and high blood pressure.

78. Cardiff runs chronic disease management clinics for conditions such as COPD (chronic pulmonary obstructive disease, a chronic disease which affects breathing), high blood pressure, diabetes, and stroke prevention. The prison doctor explained that when someone arrives into prison they are seen in reception, and if they suffer from a condition covered by the clinic they would be entered onto the chronic disease list. The administrator in healthcare then gives the names to the specific nurses who runs each individual clinic, and they would then make the appointments and run their own clinics. However, despite him suffering from two of the conditions covered by the clinics, healthcare staff failed to refer the man for any of the clinics held at the prison. The prison doctor commented at interview that:

> "All the systems failed in [this man's] case. He did not have his nurse-led chronic disease clinics – I can't tell you why, I don't know. Yes I mean [the] care was very poor, I do admit that for him. If everything had worked fine, it would have been optimal, but nothing did."

In response to this we make the following recommendation:

The Head of Healthcare at Cardiff should ensure that robust systems are in place to identify patients with chronic diseases on admission to prison and should also ensure that they are able to attend appropriate services such as diabetes and high blood pressure clinics.

79. The man provided healthcare staff at Cardiff with the name and address of his local GP. Despite the man providing this information, there is no evidence to show that his previous healthcare records were obtained from his local GP. The healthcare manager said at interview that:

> "If it's complex and significant we do [obtain previous records]. But because of the throughput it would be impossible and GPs are very reluctant to give you any information. But you would check their medication with the GP. So you might not get their full medical notes from the GP but anything significant you would find out".

80. Despite the comment made by the healthcare manager, there is no record in the man's medical notes to say that the prison had any contact with his previous GP, either to check his previous medication, or to enquire about his medical notes.

81. In response to a previous death at Cardiff in April 2010, a recommendation was made in relation to obtaining community medical records. The recommendation made on that occasion was, “The Head of Healthcare should ensure that every effort is made to trace a prisoner’s medical and mental health history”. This recommendation was partially accepted, and Cardiff responded that “[they] do attempt to obtain relevant medical information which includes confirmation of medication”.

82. Despite this previous recommendation, we are disappointed to have to highlight this issue again. In response to this we make the following recommendation:

The Head of Healthcare should ensure that prisoner’s medical records are obtained from their previous GP in a timely fashion.

83. The man was reviewed by the prison doctor on 13 January 2010, two weeks after his arrival at Cardiff. During this consultation, his blood pressure was found to be high, this being 188/107. The clinical reviewer commented that “an appropriate management plan was instigated which included increasing his blood pressure medication and arranging for him to have blood tests and a repeat blood pressure measurement.” However, the blood test and repeat blood pressure checks were not performed. He was seen by the prison doctor two weeks later who, after realising that the blood test had not been done, took a sample herself. However, despite the blood sample being taken his blood pressure was again not checked. There is no evidence in the medical notes to show that the results of these blood tests were checked by anyone from healthcare. The prison doctor commented that “because there were never any results nobody was aware of what his diabetes was like”.

84. Prior to the interview with the healthcare manager on 19 July 2011, healthcare staff were unaware that the blood results were even missing. After her interview, the healthcare manager contacted the hospital to see if she was able to obtain these results. Further to this a printout of these results was provided to the investigator. The printout clearly show that the blood sample was received on 23 April 2010, with the ‘time of report’ (when the report was printed) being 19 July 2011. This was seemingly the first time the results were ever printed. In response to this we make the following recommendation:

The Head of Healthcare should ensure that systems are in place to ensure that requested investigations, such as blood pressure and blood tests, are performed and the results are then made available to the doctor so they can be acted upon.

85. The man was admitted to outside hospital in February 2010, with a stroke. Upon his discharge he did not have his blood pressure checked or have a review with the prison doctor for approximately nine weeks. When his blood pressure was checked on 23 April 2010, it was found to be high (153/96).

Despite this, no further monitoring or follow up took place for a further four months before he was transferred to HMP Usk.

86. During his time in Cardiff, the man did not have access to chronic disease management support or advice to help manage and monitor his diabetes. The clinical reviewer commented in his review that:

> "The management of his high blood pressure was sub-optimal, especially considering he had suffered a stroke in custody, after which his blood pressure monitoring should have been intensified. In this respect the care would be considered below the standard expected in the community".

87. The prison doctor agreed that these aspects of the man's care were not of an acceptable standard. There was also a breakdown in communication between the prison GP and nursing staff regarding requests for blood pressure checks and blood tests, some of which were not acted upon.

88. Before the man was discharged from hospital following his stroke, the hospital made a referral for him to see a doctor from an outside hospital's stroke prevention unit. After the consultation, the doctor wrote to Cardiff commenting that, "Looking through his notes, it doesn't appear that he has had any other investigations to look for sources of emboli [causes] for stroke so I have organised 24hr ECG and ECHO today and will see him in 2 months".

89. The prison doctor and the healthcare manager confirmed at interview that they were unaware of the details of the man's ECG and echocardiogram. They were also unable to explain why there was a delay in prescribing him dipryridamole. As a result of the interview with the healthcare manager on 19 July 2011, the investigator was provided with a copy of an email dated 28 July 2011 from outside hospital (sent to the healthcare manager) confirming the dates of the man's ECG and echocardiogram, and asking her to contact the doctor from the outside hospital's stoke prevention unit's office if she required the results. The results of the ECG and echocardiogram should have been on the man's medical file, and it is unacceptable that the healthcare manager had to call the hospital over a year later for this information.

90. Further to this email, the healthcare manager contacted the hospital asking them to confirm what medication the man was supplied with on discharge after his stroke. A member of staff from the pharmacy department from the hospital confirmed with the healthcare manager that they did not dispense dipryidamole for the man as requested by the doctor from the stroke prevention unit, thus causing the delay. This highlights that there was a lack of communication between the hospital and Cardiff. The clinical reviewer commented that:

> "Appointments for monitoring and follow up, in particular for his blood pressure were inadequate. This is especially true following his stroke

on 4 February 2010, when his monitoring should have been intensified. This failure was due in part to poor communication between [outside hospital] and HMP Cardiff. Following his discharge from [outside hospital] after his stroke there was no communication until he returned to [outside hospital] for a follow up appointment. There is no evidence in the medical notes that HMP Cardiff received a discharge summary from [outside hospital] detailing the diagnosis reached or treatment given during that admission".

91. This problem was highlighted as a common one by the prison doctor. She commented that it was a huge problem that had been discussed on numerous occasions. She explained that:

> "People come back from hospital; they go back to the wing. They don't get seen by, sometimes, or most of the time a reception nurse because they might come in at a time when there's no reception nurse there. Wing staff or reception staff don't call medical staff. Sometimes it takes days to track down the [discharge] letter, it could sit in reception or I may find it in pharmacy or it turns up days later in my in-tray. Nobody is aware the patient is back, it's a huge problem".

In response to this we make the following recommendation:

The Governor should ensure reception and wing staff are aware of the importance of informing the Healthcare Manager or Doctor on duty of a prisoner's return from outside hospital. The prisoner's hospital discharge paperwork should also be given to the doctor on duty the same day to allow them to follow up on the care required.

Recording of information in the man's medical notes

92. The man's medical records were handwritten. Entries by healthcare staff were often illegible, unsigned and undated. It was also not clear who had made the entries as signatures were hard to read.

93. This is not in line with Nursing and Midwifery Council Guidelines. The guidelines state that:

> "Good record keeping is an integral part of nursing and midwifery practice, and is essential to the provision of safe and effective care. It is not an optional extra to be fitted in if circumstances allow."

94. Medical professionals are expected to follow the guidelines and the principles of record keeping are clearly set out within the guidance, for example:

- Handwriting should be legible
- All entries to records should be signed

- The person's name and job title should be printed alongside the first entry
- Records should be accurate and recorded in such a way that the meaning is clear
- Entries should be factual and not include unnecessary abbreviations or jargon

95. The man's medical records were also incomplete. Important test results and visits to outside hospital were not noted in his medical file. We are disappointed to see that this is the third time that this issue has been raised in investigations carried out at Cardiff this year. We once again make a recommendation on this matter:

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

ISSUES – HMP USK

Medication in-possession

96. During the reception health screen it was explained to the man that he would receive his medication in possession, and that this would be given to him in weekly 'V packs'. He was given a 'HMP/YOI Usk and Prescoed medication compact' to read and sign outlining the rules and instructions that he must follow. This compact was never signed by the man, and therefore it is unclear if he read this document.

97. On 22 November, it was noticed that the man had failed to pick up his medication from the healthcare department for the previous two weeks. (This was from 8 November.)

98. Usk's in-possession medication policy dated June 2010, states, "There should be regular monitoring of IP [in-possession] medicines to ensure their correct use. If non-compliance or any abuse is discovered the prisoner will be reviewed by healthcare staff using the approved assessment tool". The healthcare manager at Usk confirmed at interview that, in addition to being reviewed by the doctor, a cell search may be undertaken to look for any stored medication. Unfortunately there is no evidence in the man's medical or prison record to show that either his cell was searched or that he was seen by the doctor for a medication review at this time.

99. After the man's death, two officers were asked to go to his cell to collect his personal belongings. They found eight Venalink medication packs, most of them left unopened. The man had not been taking his medication as prescribed, and despite the medication compact rules (explained at the reception health screening), and his previous failure to collect his medication in November 2010, this was not discovered by healthcare staff until he died.

100. The man was never required to produce empty medication packs before new ones were issued. This resulted in him accumulating a large quantity of medication as he was not taking it as instructed.

101. We understand that since the man's death, a new in-possession medication policy has been introduced. The new policy, introduced in April 2011, states "at the time of issue all prisoners will be informed that IP [in-possession] medication will only be issued as an exchange system. They must return the empty V-Pack before the next will be issued."

102. We are pleased to see that Usk has taken action on this issue and updated their policy. However, we note that following a previous death in June 2009 a recommendation was made that: "The Head of Healthcare should ensure that staff make an entry on the medication chart and/or clinical record whenever medication has not been collected as required, in line with the Nursing and Midwifery Council standards." This recommendation was accepted. The man also failed to collect medication and after this was discovered he was not monitored for future compliance. Because of this we make the following recommendation:

    The Head of Healthcare should ensure that prisoners with in-possession medication are regularly monitored and, if non-compliance is suspected, immediate action should be taken to address the problem.

Notification of next of kin

103. The man was pronounced dead at 11.30pm on a day in late March 2011. The prison Governor and family liaison officer left Usk prison at 8.30am the following morning, arriving at the man's sister in law's house at 10.00am. The Governor was told by her that she had already received a call from outside hospital at 8.15am informing her of the news.

104. PSO (Prison Service Order) 2710 describes the action to be taken following a death in custody. While the PSO does not give definite instructions as to how the news should be broken to next of kin, it does advise of the need to: "arrange notification to the next-of-kin and any other person reasonably nominated by the prisoner as soon as possible in a suitable manner giving an accurate factual account of what has happened". Despite not giving specific instructions, it does say that the preferred method would be face to face.

105. While we agree with the Governor's decision to try to break the news to the man's sister-in-law in person, it is unfortunate that this was not possible. The Governor spoke to the investigator during the investigation, following up his concerns in an email. He commented that:

    "The issue from my perspective (as recorded in my decision log) was that the NOK was notified of the death by the ward nurse, by telephone. The trauma of the bereavement was amplified as she did

not know that the deceased, her brother-in-law was in custody. When the Family Liaison Officer and I attended the NOK home we observed first hand the impact as she was confused and didn't have any support available."

106. The Governor also informed the investigator that he had spoken to the Local Health Board partners who have "acknowledged the benefits of the prison holding 'the duty to inform role'". He further stated that following on from a meeting, the Prison and Local Health Board had now agreed that the notification of the Next of Kin would be undertaken 'in person' by the Prison Governor or their nominated representative. He confirmed that all local prison and hospital policies would be endorsed with this agreement by the end of July 2011, and the managers of the relevant hospital divisions will also be informed to ensure the agreed policy is implemented effectively.

107. We are pleased that the Governor has been proactive in his response to this issue, and that a solution seems to have been found. Because of this, we do not make a recommendation about this issue.

Recording of information in the man's medical notes

108. As with Cardiff, entries in the man's medical records at Usk were hand written. Entries by healthcare staff were often illegible, unsigned and undated. Because of this, important information such as the treatment he received, and the emergency response cannot be relied upon. It is unclear what time the man went to healthcare on the day of his death complaining of chest pains, what time the ambulance arrived, or what time they arrived at hospital, as the prison and ambulance service have conflicting records.

109. As detailed above this is not in line with Nursing and Midwifery Council Guidelines and needs to be addressed. Because of this, we make the following recommendation:

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

Family Liaison

110. The man's sister-in-law had not had any contact since the death of her husband three years earlier. She did not know he was in prison and only became aware of this when she received a phone call from the hospital. She said that his death had come as a complete shock and had been very upsetting. She spoke positively about the help and support she had received from the prison, particularly her family liaison officer who she described as having been 'brilliant'. The man's sister-in-law said she was particularly grateful to the prison for their help with her brother-in-law's funeral arrangements.

CONCLUSION

111. The man died following a rupture of his heart caused by weakening of the muscle by a heart attack. The clinical reviewer commented that "this is a catastrophic event and could not have been foreseen". The reviewer further commented that, although heart attacks are not completely preventable, the risk of their occurrence could be reduced by modification of risk factors. The man's risk factors were addressed by his medical team with appropriate medications. However, he frequently chose not to take his medication. The reviewer commented that "this may have contributed to his heart attack and is almost certainly the reason his blood pressure was so hard to control."

112. Apart from the areas of care outlined in the report (management of blood pressure, blood tests, medication review and checking that he was taking his medicine), the clinical reviewer believed that the general medical care provided to the man was appropriate and timely. When he showed early symptoms of stroke, appropriate and timely measures were taken by Cardiff in transferring him to hospital.

113. Similarly, when he had chest pains, his management was appropriate and timely in Usk. However, the care the man received for his chronic conditions of diabetes and high blood pressure whilst in Cardiff was not, in some aspects, of the same standard that he would have received in the community.

114. The man was identified as a patient suffering with the chronic diseases of diabetes and high blood pressure. The reviewer commented that these carry a higher risk of heart attack and stroke. Despite there being a facility for nurse led diabetes and high blood pressure clinics in Cardiff, he did not have access to them. The prison doctor at Cardiff commented that,

> "All the systems failed in [this man's] case. The blood pressure wasn't done when I ordered it and then of course nothing got fed back to the GP. He did not have his nurse-led chronic disease clinics – I can't tell you why, I don't know. Yes I mean [the] care was very poor, I do admit that for him. If everything had worked fine, it would have been optimal, but nothing did."

115. The clinical reviewer commented in his review that "it is unclear whether any additional medical treatment could have prevented his heart attack, however it is unlikely given we now know that [the man] was not taking his prescribed medication". Notwithstanding this, however, the standard of care provided to him was unacceptable, and the provision of treatment for chronic

diseases must be improved at Cardiff to ensure that there is no repeat of these circumstances.

RECOMMENDATIONS

HMP Cardiff

1. The Head of Healthcare at Cardiff should ensure that robust systems are in place to identify patients with chronic diseases on admission to prison and should also ensure that they are able to attend appropriate services such as diabetes and high blood pressure clinics.
   National Offender Management Service responded with,

   Accepted - System one is now in place at HMP Cardiff and all prisoners coming into reception are screened for physical and mental health. The following morning prisoners are offered a secondary health screen. Any identified chronic disease is referred to the relevant clinics to ensure ongoing treatment and monitoring.

2. The Head of Healthcare should ensure that prisoner's medical records are obtained from their previous GP in a timely fashion.
   National Offender Management Service responded with,

   Partially Accepted - Any prisoner coming into custody who is on medication or has a chronic disease automatically has a GP check. This is normal procedure and has always been part of the reception process.

3. The Head of Healthcare should ensure that systems are in place to ensure that requested investigations, such as blood pressure and blood tests, are performed and the results are then made available to the doctor so they can be acted upon.
   National Offender Management Service responded with,

   Accepted - With the new IT system there is a facility which enables individual nurses/GPs to be allocated the task of BP monitoring, ECGs and blood tests. The results of blood test which are sent to outside hospital can be accessed via System one which enables the GP to treat appropriately

4. The Governor should ensure reception and wing staff are aware of the importance of informing the Healthcare Manager or Doctor on duty of a prisoner's return from outside hospital. The prisoner's hospital discharge paperwork should also be given to the doctor on duty the same day to allow them to follow up on the care required.
   National Offender Management Service responded with,

   Accepted - During Reception working hours the Reception manager will inform HCC of a prisoners return from outside hospital and to ensure the prisoners hospital discharge paperwork is handed to the duty nurse.

   When Reception is not working i.e. during night state and Sunday the Orderly Officer will ensure that the HCC staff are informed.

   Governors Order ref the above to be put out

5. The Head of Healthcare should ensure all medical staff are aware of the importance of recording all information and ensure that all documentation is completed in line with the Nursing and Midwifery Council Guidelines.
National Offender Management Service responded with,

   Accepted - Global e-mail has been sent to all Healthcare staff highlighting the importance of recording information of all prisoner consultations in line with the Nursing Midwifery Council guidelines. Managers will audit record keeping through System one.

HMP Usk

6. The Head of Healthcare should ensure that prisoners with in-possession medication are regularly monitored and, if non-compliance is suspected, immediate action should be taken to address the problem.
National Offender Management Service responded with,

   Accepted - A protocol has been written and is currently being evaluated by our Local Health Board to ensure it is suitable before implementation at HMP Usk and Prescoed. **Target date for completion February 2012**.

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

   National Offender Management Service responded with,

   Accepted - The recently appointed Healthcare Manager has made staff aware of the expectations regarding documentation. 'System One', the IT system used by the NHS has recently been installed at HMP Usk and Prescoed. This system will assist in the recording and quality assurance of information. The Healthcare Manager has on-going responsibility for quality assurance.

GOOD PRACTICE

Family Liaison

The man’s sister-in-law had not had any contact since the death of her husband three years earlier. She did not know he was in prison and only became aware of this when she received a phone call from the hospital. She said that his death had come as a complete shock and had been very upsetting. She spoke positively about the help and support she has received from the prison, particularly her family liaison officer, who she described as having been 'brilliant'. She said she was particularly grateful to the prison for their help with her brother-in-law’s funeral arrangements.