Circumstances surrounding the death of a man on 20 October 2006 at Llandough Hospital whilst in the custody of HMP Cardiff

Report by the Prisons and Probation Ombudsman for England and Wales

October 2007

This is an investigation into the circumstances surrounding the death of a man on 20 October 2006. The man had been diagnosed with lung cancer on 19 September and died as a result of his illness. He was a prisoner at HMP Cardiff, and was 76 years old when he died.

I extend my condolences to the man's family and to all those touched by his death.

The investigation was undertaken by my colleague. Both my colleague and I would like to extend our thanks to the Governor of HMP Cardiff, and his staff for their cooperation during the investigation. Particular thanks go to the prison liaison officer for gathering all relevant documentation and ensuring it was made available in a timely way.

The Health Inspectorate for Wales carried out a clinical review into the healthcare the man received at HMP Cardiff. I extend my thanks to the Inspectorate for completing the review so speedily and for the recommendations drawn from the findings.

The man was elderly and in poor health when he arrived at HMP Cardiff, having been remanded in custody in December 2005. He was described by staff as someone who generally kept himself to himself, albeit he did challenge the prison regime on occasion. The man found the adjustment to prison life difficult and chose not to mix with the wider prison population. He had a history of chronic heart disease, and was, understandably for his age, frail in appearance.

The man came into contact with healthcare staff regularly between January and September 2006. He presented symptoms of coughing and breathlessness each time and had a series of examinations by the prison doctor, followed by prescriptions to alleviate what were thought to be chest infections. The medication failed to address his symptoms, and he was referred for a chest x-ray. Additional tests at the hospital confirmed he had terminal cancer of the lungs. He was admitted to hospital in October for palliative care.

Hospital staff witnessed a rapid deterioration in his condition during the evening of 19 October. The man died a few hours later, on the morning of 20 October.

In addition to those in the clinical review, I make two recommendations of my own. I also draw a number of housekeeping matters to the attention of the Governor.

This final version of my report has been amended in light of comments received on an earlier draft.

Stephen Shaw CBE
Prisons and Probation Ombudsman **October 2007**

CONTENTS

SUMMARY

The man was charged with arson and criminal damage and remanded in custody by Cardiff Magistrates' Court on 22 December 2005. He was taken to HMP Cardiff where, on arrival, he went through the normal reception process before being allocated a cell in the Victorian part of the prison.

Healthcare staff determined from police custody documents, and from their own first reception health screen, that he was a man in poor health with a history of chronic heart disease and asthma. The nurse who carried out his first health screen also established the amount and type of medication he was prescribed. It was extensive. The man was referred to see the prison doctor.

Due to his age and poor physical health, he was allocated a single cell on the ground floor of A wing. This meant that he would not have to negotiate any stairs to collect meals and participate in association. The single cell occupancy granted to him was temporary. The man had not been assessed as high risk and eventually he did have to share a cell due to population pressures at Cardiff. This was something he initially resisted but grew accustomed too.

Between January and September 2006, he presented himself in the healthcare centre with symptoms of coughing and breathlessness. He was also seen on a number of occasions on the wing, at his request, and at the request of wing staff. The man was treated for a chest infection and was regularly prescribed antibiotics to treat the condition. In June, and at the request of wing staff, he was admitted as a healthcare in-patient for respite care. He remained in healthcare for approximately two weeks before returning, unwillingly, to his cell in the main prison.

The man displayed a number of behaviours whilst on the wing. These ranged from anger to anxiety as he struggled to adapt to the marked change in his environment. His health remained poor, and on 1 September and 18 September he was seen by the prison doctor in the GP surgery. The man was sent to an outside hospital for a chest x-ray after his second examination. (He had refused to go after his first examination.) The x-ray results showed suspected cancer of the lungs and a CT scan in the weeks that followed confirmed a diagnosis of terminal cancer.

He was transferred back to hospital on 9 October under escort. He spent the first three days under restraint, and received chemotherapy treatment on 10 October before the use of restraints was removed. Throughout his time in hospital, he was on bedwatch with uniformed escort officers. His family visited him on a number of occasions.

On 19 October, the man's condition deteriorated rapidly. At approximately 1.50am on the morning of 20 October, he suddenly died.

The clinical reviewer has concluded that the healthcare he received at Cardiff, up until his diagnosis was confirmed, was adequate in the main. The clinical review does highlight that his blood was not monitored for potassium levels and concludes that his primary care, in this regard, was not adequate.

The man was transferred to hospital in a speedy way and, once Cardiff realised he was to remain in hospital, he was generally managed well. He was left in restraints to receive chemotherapy treatment despite the doctor's request for them to be removed. Having said that, I also recognise that, in the days that followed, Cardiff reduced his security from two bedwatch officers to one and authorised the removal of restraints.

THE INVESTIGATION PROCESS

1. The investigation was opened on 25 October 2006. My investigator began by requesting all relevant prison records relating to him. These included his medical and core records covering the time he spent in prison.

2. Notices to staff and prisoners were supplied and displayed around the prison. These invited anybody with information to talk to my investigator. In this instance, nobody came forward. My investigator examined the records and recorded significant events. Given the circumstances, she did not feel it was necessary to attend the prison and interview staff. However, a visit to Cardiff's healthcare centre was made on 3 July 2007 when she discussed the man's healthcare with one of the prison doctors.

3. The Health Inspectorate for Wales was invited to undertake a review of the clinical care the man received while in custody. The clinical review is included as an annex to this report.

4. The Coroner was informed of the Ombudsman's investigation. The post mortem report was not available at the time of the investigation. The Coroner will receive a copy of this report when it is completed to assist with his enquiries.

5. One of my Family Liaison Officers, contacted the man's family to discuss the purpose of the investigation, and to offer them the opportunity to raise any concerns or questions about his time in prison. The man's family raised the following concerns about his healthcare:

    - Why was he not reviewed by a doctor as recommended by a Nurse on 20 May 2006?
    - He was a proud man and not one to make a fuss about his health. It would have taken a lot for him to admit to feeling unwell.
    - On 1 September 2006, he complained he was coughing blood. However, he was not referred for further tests until 18 September, over two weeks later. It was then another eight days before he received the results of his x-ray. This process took almost a month. Why were there such delays?
    - As well as physical symptoms, there were other signs of his deteriorating health, such as withdrawing from the regime, being reclusive and showing aggression towards staff. Why were these not picked up on?
    - The clinical review states that standard healthcare checks, such as blood pressure checks, were not made on him during his respite care in the healthcare centre. Why were these not carried out given his age and recent poor health?
    - He presented as unwell from 20 May 2006, but did not receive any tangible medical examinations until 18 September.
    - The first recommendation in the clinical review mentions that healthcare staff should always request and chase medical notes for

prisoners who present with illnesses to allow continuity of care. Why does this not happen as standard?

- He had a heart problem and had been in hospital on two or three occasions prior to going into custody. My report refers to the man asking for his medication. His family questioned whether he was referring to his heart medication and felt that, if the prison had made more of an effort to obtain medical notes, they would have been aware of this.
- The man's solicitor told his family that all medical records should have been transferred to Cardiff on his arrival. The solicitor had not contacted the prison to inform staff how seriously ill the man was when he first went into custody, although his family first thought the solicitor had. The solicitor said that it was the responsibility of Cardiff to gather information on him and request GP records as required.

These concerns have been addressed in the appropriate sections of this report. I hope my investigation has been helpful to the man's family in understanding the events leading up to his death.

HMP CARDIFF

6. Built in 1827 as a county gaol, HMP Cardiff is a category B local and training prison located in the city centre. The prison holds adult male remand, unsentenced, and sentenced prisoners from South East Wales. The prison has an operational capacity (maximum crowded capacity) of 754 following extension of three new wings in 1996.

7. In addition to the modern wings, Cardiff has refurbished the original Victorian parts of the jail. A and B wings now hold convicted prisoners with D wing specifically for convicted prisoners with enhanced status. C wing is used as a detoxification unit, E wing holds life sentenced prisoners, and F wing is reserved for trial and remand prisoners. F wing also has a first night in custody (FNC) unit on the ground floor and a segregation and therapeutic unit on A wing.

8. The Healthcare Centre at Cardiff provides 24 hour primary care and has 16 in-patient beds. Clinical care is provided by doctors and nurses employed by the Prison Service. The latest staffing profile described a team comprising two general practitioners, a senior nurse, practice manager, three supervisory grade nurse/senior healthcare officers and 16 healthcare staff (nurses and healthcare officers). Cardiff and Vale NHS Trust provides the mental health in-reach team (MHIRT) specialist mental health services.

9. HM Inspectorate of Prisons last inspected Cardiff in February 2005 on a short unannounced inspection. The Inspectors found that the good healthcare observed on their previous full inspection in 2003 had been maintained. However, they were very disappointed that a new build healthcare centre promised in 2004 had not materialised. (It is due for completion towards the end of 2007.) Inspectors were also disappointed that their previous recommendation that ‘a primary care-compatible’ information technology system should be installed had not been achieved. While praising the work of the MHIRT, they found that the team was small and lacked the capacity to meet the needs of the prisoners at Cardiff.

Elderly prison population

10. Prison is not principally designed for the elderly, and it is difficult for an individual establishment to accommodate an increasingly aged prison population. A thematic review by HM Inspectorate of Prisons in 2003 found that, although older prisoners make up a small percentage of the overall prison population, the number of elderly prisoners had trebled between 1992 and 2002 and was continuing to grow. The study also found that there was no overall strategy throughout the prison estate for assessing and delivering a regime that addressed the needs of older prisoners.

11. The thematic review found that some elderly prisoners will inevitably spend the rest of their lives in prison, and will be housed and managed in the same way as the general prison population. Early release from prison on medical grounds for severely or terminally ill prisoners is subject to restrictive criteria,

and the thematic stressed that the prison environment must be geared towards meeting the specific needs of its ageing population.

12. With the exception of a small number of establishments, prisons do not provide a separate regime for elderly prisoners. At Cardiff, the man was located on A wing in the Victorian part of the prison. He was allocated a cell on the ground floor, in recognition of his poor health, but did not take part in any purposeful activity on the wing.

KEY FINDINGS

13. When the man arrived in reception at Cardiff on 22 December 2005, he was assessed as low risk for sharing a cell. The officer completing the first part of his Cell Sharing Risk Assessment form (CSRA) noted that he had expressed a preference for a single cell due to his breathing difficulties, but had no concerns about sharing. Section 3 of the CSRA, completed by a member of the healthcare team, said "fit for normal location".

14. He was then health screened as part of the reception process. A brief medical history of heart disease, asthma, and his current medication was recorded by the nurse. The nurse also noted that he had no psychiatric history but presented as "quite frail in appearance". He was referred to the prison doctor for physical health reasons.

15. He was located on the first night in custody wing (FNC). An entry in his wing history book (F2052A) recorded that he was "a bit weak at the knees" and needed to be located on the lower floor due to his breathing difficulties. The man was placed in a cell on A1, A wing's ground floor landing.

16. The following morning, whilst on the FNC, he was inducted into the prison using an induction passport booklet. He answered a series of questions which informed officers that he was retired and in receipt of a state pension and disability allowance. He also said that he had been in custody several times but approximately 25 years previously. My investigator found that whole sections of the induction passport had not been completed, including Section 9 entitled 'Attitudes and Behaviour', and the last section which asks prisoners to sign that they have received induction information on a number of issues. There was a note in his history sheet stating that he declined to take part in the full induction programme.

17. Over the Christmas period, the man tried to settle into prison life. Staff commented in his wing history book that he was quiet and a bit confused, probably due to his age. An entry by an Officer read, "needs looking after by staff".

18. On 10 January 2006, he was seen in triage at the healthcare centre. He was examined and it was noted in his medical record that he was breathing rapidly. The man was scheduled to see the prison doctor the next day and had been asked to bring his inhaler but forgot to do so. An entry by a Nurse in his medical record said that the man was due to have his medication reviewed and that staff would ensure he was using his inhaler properly.

19. He saw the doctor on 11 January and said that he had suffered with a chest infection prior to coming into prison. As a smoker, he was advised to stop. He was told about the 'quit smoking' clinic but declined to attend. He did not have a medication review and went back to his cell on A1.

20. Throughout the remainder of January and February, the man's mood fluctuated between being quiet and polite to abusive and anxious. Several entries in his wing history book reflected that he had become worried about the possibility of having to share a cell with a new prisoner. Another entry noted that he did not say much, but would be abusive when he did. Healthcare staff informed my investigator that he was reviewed by a Doctor on 27 January.

21. On the morning of 21 March, an entry in the man's core prison record said that he had been sent for trial at Cardiff Crown Court. The Prisoner Escort Record form (PER), to risk assess and record his transfer to and from court, said that he was remanded in custody again and arrived back in reception at 12.10pm the same day.

22. On 16 April, he showed signs of anger and frustration at an officer and accused him of deliberately opening and shutting his cell door and playing 'head games' with him. His wing history book recorded that he had become abusive and aggressive towards the officer.

23. Approximately one week later, on 22 April, He was back in court. He returned to A wing that evening and settled quickly. The PER form recording his transfer to court and return to Cardiff did not detail the outcome of the court appearance or when he arrived back in reception.

24. On 20 May, a nurse went to see the man on A1 at his request. The nurse found that he presented with cold-like symptoms and made an entry in his medical record following her visit. The entry said, "I feel this man should be reviewed by the doctor at the earliest opportunity." The doctor saw him in his cell later that day and prescribed antibiotics for a chest infection. The doctor wrote "…..cough, chest relatively clear but in view of PH of IHD for AB, Amoxicillin 500 tds."

25. He began to show further signs of anger and anxiety on 31 May. An extensive entry in his wing history book stated that he pressed his cell bell just before 6.00pm. When a wing officer responded, he shouted at him and told him to get his medication. The officer phoned the treatment room and was told a member of staff would pick them up from the healthcare centre. The man pressed his cell bell again and, when the officer arrived, the man told him he would smash his cell up if he did not get his medication. A senior officer (SO) attended shortly after and was told the same. The man then threatened the wing officer. The officer recorded that the man had said he would "Do me and get me out of here, which I took to mean the cell." The man was later spoken to by a principal officer (PO) and told his behaviour was not acceptable.

26. The following day, it was noted in his security file that he used to be a contractor at Cardiff and knew the prison well. It was also recorded that he made threats to staff. My investigator could not establish who made the comments as the record was not signed. On 2 June, a security report was opened due to the man's abusive behaviour. Again, it was reiterated that he

knew the layout of the prison and should be placed on disciplinary report for his behaviour. An officer completed the report and further noted that the man should be transferred to another prison as soon as possible. A governor and the security manager completed their relevant sections also. My investigator checked with Cardiff what action followed this report and was told there was no evidence to suggest he was placed on report or that a transfer was arranged.

27. On 8 June, the man was told by a wing officer that he would be "two-ing up" later that evening. This meant that he would be sharing a cell. He did not take the news well and told the officer that he would not speak to his new cellmate. The officer reminded the man that he was not a single cell occupant and noted in his wing history book that he seemed to think he could do what he wanted. The man was given his evening meal by the landing cleaner. He threw it down the toilet in his cell.

28. The next day, the man appeared in court. The PER form for this transfer said that he was received back in Cardiff's custody at 1.35pm. On his return, he was admitted to the healthcare centre for respite care. He was seen by a doctor on 7 June and diagnosed with acute exacerbation of COPD. Antibiotics were prescribed, and he stayed in the healthcare centre for just over two weeks, returning to his normal accommodation on 24 June. During his respite, nursing staff made regular entries in his medical record saying that he presented no problems throughout that period. The man did not participate in any meaningful regime whilst an inpatient and remained reclusive. He took a diet with encouragement from healthcare staff and was discharged when an urgent admission arose and a bed was needed.

29. The man returned to his previous cell, cell 15 on A1, unhappy with the discharge. Wing officers monitored him for the next few days. When his new cellmate arrived, an officer noted that he had made it through the night and appeared to be "getting on well".

30. The man went back to court on 7 July. His Prisoner Escort Record form said that he presented no risk. He arrived at Cardiff Crown Court at 8.36am and appeared in court No 2 at 10.05am. His appearance lasted approximately 30 minutes and he was sentenced to three years imprisonment. He arrived back at Cardiff at 3.10pm. He was located back on A wing, this time into cell 16, with no problems.

31. The man only left his cell occasionally for the rest of July. He was seen by the doctor on 14 July after again complaining of a cough. He was examined and prescribed Amoxycillin, an antibiotic, to treat a chest infection.

32. On 6 August, an officer wrote in his wing history book, "[he] seems to develop a medical problem most days and appears to enjoy the fuss". The following day, the man presented as unwell again and was prescribed a different antibiotic to treat a chest infection.

33. He saw the doctor again on 1 September and complained that he was coughing blood. However, he refused further examination and was again, prescribed an antibiotic for infection. The doctor made a note that, if his symptoms persisted, He would need to be referred for exploratory tests. Healthcare staff told my investigator that the man also refused any referral to hospital for further exploration into his physical health. This was despite being advised that his 'red flag' symptoms needed a second option and a chest x-ray.

34. Just over two weeks later, on 18 September, he was again seen by a doctor. He presented as breathless and the doctor noticed that he had lost his voice. A PER form showed that he was transferred to University Hospital Wales at 11.40am under escort. On arrival, the man went straight into x-ray and returned to Cardiff in a taxi at 12.50pm. It is not clear whether restraints were used to escort him to hospital, and there was no corresponding entry in his medical record to date and note the referral.

35. On 26 September, the man's x-ray results were explained to him by a member of the healthcare team. He was told that the results were not good news, but in order to determine an exact diagnosis he needed a CT scan urgently. His medical record noted that he was not in pain and had no breathing difficulties, but had lost his appetite. Healthcare staff took the decision not to tell him that his diagnosis from the x-ray revealed a central obstructing neoplasm (cancer) until a CT scan could confirm the illness.

36. On the same day, a doctor referred him to the Rapid Access Clinic at Llandough Hospital in writing. In her letter, the doctor explained that the man required an urgent referral for suspected lung cancer and had presented himself in healthcare on 1 September with a cough, haemoptysis and a hoarse voice which he had had for weeks. The letter also explained that he had initially refused an x-ray but had agreed to one on 18 September. The doctor asked the hospital to send the out-patient appointment to healthcare direct, in order for an escort to be arranged. The letter was faxed the same day.

37. On the morning of 30 September, an A wing officer contacted the healthcare centre and asked for a nurse to visit the man in his cell. The officer made the request following an allegation the man had made that the officer had been victimising him. His medical record said that he claimed the officer was trying to kill him with paint fumes. The Community Psychiatric Nurse (CPN) who made the entry wrote that there were no obvious signs of mental illness. This was the first time the man had seen a member of the mental health in-reach team.

38. The following day, a B wing officer, asked for the man to be relocated in the healthcare centre due to the condition of his chest and the allegations made against the A wing officer. The officer from B wing recorded that, following an assessment (presumably by the CPN), the man had been refused admittance to healthcare because he was not "mentally ill".

39. It was not clear when the man went for his CT scan as this part of his medical record was missing from the documentation my investigator reviewed. A scan result form sent by the hospital suggested the scan was carried out on 6 October.

40. He was given an appointment to see a lung cancer specialist at Llandough Hospital for 9 October. An escort and hospital risk assessment was carried out on 6 October in preparation for the transfer. Under 'specific factors of concern', he was assessed as presenting a medium risk to the public due to his offence. He was also assessed as medium risk of escape and hostage taking but no known history of either was recorded. Two escort officers were instructed to use 'double cuffs and an escort chain' to transfer him from Cardiff to the hospital. They were also told that restraints could be removed for emergencies and medical treatment, but that they could only be removed with the prior knowledge of the duty governor.

41. At 9.30am on 9 October, He arrived at the Llandough Hospital for an out-patient appointment in the lung cancer clinic. He was diagnosed with stage four lung cancer, which denotes an advanced stage of the illness, and was informed of his condition by the hospital doctor. At 11.50am, the same doctor decided to admit him as an inpatient. The man became depressed by the news of his illness and returned to the out-patients department to wait for a bed. An escort officer rang Cardiff at 12.10pm and told the control room that the man was likely to stay in hospital for the foreseeable future. The officer rang again at 1.50pm to confirm his new location in the hospital, which would be ward West 6.

42. A letter from the Llandough Hospital told the prison doctor that the man's prognosis was probably weeks. The letter also explained that the hospital would explore whether he could be admitted for palliation (terminal illness care) and would contact Cardiff in due course with regard to setting up a long term care plan for him. At 3.50pm on 9 October, he was admitted to ward West 6 and was escorted by two officers. This was the last entry recorded on his PER form. My investigator could not determine from the man's records when his family were told of his stay in hospital and who informed them.

43. A bedwatch log commenced for the man at 9.10 pm that evening. Two officers were assigned escort duty for that first night in hospital. The log said that restraints were attached to him and that he was 'cuffed' to one of the officers. The log check list showed that the officers had seen the current risk assessment and instructions for removing and reapplying restraints.

44. The man had a relatively quiet night in hospital. He took fluids and slept for long periods. The bedwatch log recorded two periods of restlessness at 2.30am and again at 7.45am. The morning entry noted that he had "attempted on many occasions to try and slip his hands from the cuffs" and that the "security cuffs" had been checked every hour throughout the night.

45. At 11.00am on 10 October, he began his chemotherapy treatment which was scheduled to take two or three hours. The bedwatch log recorded that the

man was cuffed to an officer using an escort chain at the time of his treatment. An entry by another officer at 11.50am said:

> "Seen by doctor. Moaning about being cuffed. Doctor asked if they could be removed. Informed her that someone would be visiting from the prison later today [10 October] and a decision would then be made as to when, or if cuffs could be removed."

46. The bedwatch pack issued to staff includes local guidance which details escort officer duties, when and what to expect from management checks, and what to do in the event of change in a prisoner's condition. On the use of restraints, the local guidance states that escort officers must remove restraints immediately where a doctor requests removal for emergency treatment or where restraints impede immediate or ongoing treatment. Where this is necessary, officers are required to contact the duty governor at Cardiff to notify them of the changes in security and health.

47. At 1.15pm, the man's chemotherapy finished. Approximately 15 minutes later, escort officers opened the emergency escort bag. The bedwatch log recorded that the bag was opened because he was still in prison clothing. He was given pyjamas to wear but no slippers were found in the bag.

48. At 2.00pm, an officer contacted Cardiff and reported that there were no changes to his condition. My investigator found no record of a conversation to reflect the doctor's request for removal of restraints and no record that the officer spoke to the duty governor about that issue. My investigator spoke to a governor by telephone and was told that, if no record existed, it was probably safe to assume no conversation took place.

49. An SO carried out a management check at 3.00pm and confirmed that the log was up to date. The SO also ticked to confirm that the man was in suitable bed wear and that a risk assessment, signed by a governor, was in place. The SO's management check made no mention of the doctor's request for removal of restraints during treatment. My investigator did find evidence of a conversation about restraints between a member of healthcare staff and the hospital in a significant events form. Unfortunately, the form was not signed.

50. The man had another quiet night. He remained cuffed to an officer, who had relieved another officer of bedwatch duties that evening. The man slept throughout the night until staff went off duty at 8.00am on 11 October. At 1.50pm, a governor carried out a management check in accordance with the local guidelines. The checklist was completed at 2.10pm and recorded that all was correct. His family visited his bedside at 2.45pm and this was recorded on the bedwatch log. The governor amended his risk assessment with the following entry:

> "11/10/06 – Risk assessment amended – restraints to be removed. Restraints can be used if escort staff deem it necessary. Duty governor to be informed if this happens."

51. A hospital watch checklist and handover log for 11 October was made available to my investigator. The log was completed at 3.05pm by an officer who took over duties from an SO. The log suggested that the man was no longer cuffed to an escort officer. It also confirmed that a new bedwatch log had commenced for another officer's shift. My investigator discovered that the bedwatch log for this officer's shift, between 3.05pm and 8.00pm, was not completed.

52. Two escort officers took over bedwatch duty at 8.00pm and reported no problems throughout the night. Both officers went off duty at 8.00am on 12 October and were relieved by two other officers. The bedwatch log for their shift confirmed that the man had received visits from his family between 11.30am and 12.30pm. An hour later, one of the officers, contacted Cardiff to confirm that the man would be staying in hospital over the weekend. He slept for most of the day until his sister visited him in the early evening. He had a restless night due to developing breathing difficulties.

53. A prison doctor received a further letter from the hospital on 12 October. The letter was from the Lead Cliniciann, and explained that the man had been discussed at the lung cancer multi-disciplinary team. The team confirmed that numerous malignant cells had been found and that his disease was "extensive". The next day, his family visited him again.

54. On the afternoon of 15 October, He received another family visit. At 4.25pm, an officer on bedwatch duty made an entry in the log which said that one of the man's visitors objected to officers being present whilst visits took place. Both officers stepped outside the room and observed him through the window. He had a restful night with no problems.

55. At 3.30pm on 16 October, the man was placed on single officer bedwatch following a management check by a governor that morning. Hospital staff were also informed of the change in circumstances and his risk assessment was amended to reflect this. An officer remained at the hospital and made regular entries in the log describing the man as weak and sleeping most of the time. The following day, he was placed on a drip and seen by a physiotherapist because of his breathing problems. Nursing staff at Cardiff telephoned the hospital for updates on his condition and entered them into his medical record. The record showed that he deteriorated quickly over this period.

56. On 19 October, a nurse spoke to the Ward Sister at Llandough Hospital and was told that a case conference had been scheduled for the following Tuesday. The conference would discuss discharge planning for the man. The entries in his medical record were not signed.

57. Later that evening, he received a visit from friends and family. The officer on bedwatch duty, placed himself in the corridor away from the man's room because he had picked up an infection. The officer reported this to the duty governor. Throughout the evening, he took food and fluids but remained sleepy.

58. At 1.00am on 20 October, the bedwatch log recorded that the man got out of bed, fell, and was helped back into bed by the nurse attending. Approximately 20 minutes later, the same nurse told an officer that the man had passed away. The doctor pronounced death at 2.00am. An officer notified the night orderly officer at Cardiff, before returning to the prison at 2.35am by taxi.

Events following the man's death

59. At approximately 1.30am, a governor was told that the man had died and that an escort officer had remained at the hospital. The governor agreed to make his way to Cardiff to start contingency plans for a death in custody, and arrived within half an hour of receiving the phone call.

60. The governor completed all the relevant paperwork and followed Cardiff's local contingency plans. He also drafted a memo to the prison's governing governor . In the memo, the governor explained that he had experienced some difficulty contacting the man's named next of kin but had managed to get in touch with his niece and had passed on the news of his death. The governor asked the governing governor to pass on thanks to the officer on bedwatch duty, for his invaluable support. The governing governor was also made aware of the support the SO gave in carrying out the duties required following a death in custody.

61. At 7.20am on 20 October, the Head of Healthcare recorded in the man's medical record that he had died suddenly in the early hours of the morning. She also told the prison's Family Liaison Officer of his death. A notice to prisoners was circulated throughout the prison, informing them that the chaplain would deliver a service for the man and that all were welcome to attend.

62. The man's funeral took place on 31 October. The funeral was arranged by his family and the cost was met by Cardiff in accordance with the relevant Prison Service Order (PSO). Cardiff's chaplain arranged for a wreath to be sent to the service on behalf of the prison.

ISSUES

Family concerns

63. Why was the man not reviewed by a doctor as recommended by a nurse on 20 May 2006?

    He was seen by a doctor on 20 May 2006 and underwent a chest examination in his cell. He was prescribed antibiotics for his cough symptoms and was scheduled for an appointment at the chronic disease clinic.

64. He was a proud man and not one to make a fuss about his health. It would have taken a lot for him to admit to feeling unwell.

    A prison doctor told my investigator that she agreed that the man presented as someone who did not complain unduly. In her limited contact with him, the doctor said that he was reluctant to acknowledge the need for further investigations of his symptoms when this became necessary.

65. On 1 September 2006, he complained he was coughing blood. However, he was not referred for further tests until 18 September, over two weeks later. It was then another eight days before he received the results of his x-ray. This process took almost a month. Why were there such delays?

    The doctor saw him on 1 September 2006 after he had reported coughing up blood and having a hoarse voice over the last few days. The doctor examined him and advised that his symptoms were of some concern. Then doctor recommended a chest x-ray as soon as possible and asked the man to provide a sputum specimen to send for analysis. He was also told that he should be referred to see a specialist in hospital for further examination. The doctor told my investigator that the man declined all advice, despite being told that the underlying cause could be serious. He asked for antibiotics but did agree to return for a health review two weeks later and then agreed to have a chest x-ray which took place the same day. The chest x-ray results were sent to Cardiff a week later and were acted upon immediately. He was referred for an urgent CT scan on his chest and was also referred to a lung specialist. These interventions took place within the NHS cancer referral recommended guidelines of two weeks or less.

66. As well as physical symptoms, there were other signs of his deteriorating health, such as withdrawing from the regime, being reclusive and showing aggression towards staff. Why were these not picked up on?

    He was reviewed regularly during his custodial period at Cardiff. He had appointments for both the chronic disease management clinic, as instigated by healthcare staff, and attended appointments for acute infective exacerbations of his lung disease, as instigated by the man. Prior to 1 September 2006, no healthcare interventions found any significant deterioration in his physical or mental health. He was seen by a Registered Mental Nurse (RMN) in his cell after he displayed what an officer described as

allegatory behaviour. The nurse concluded that there were no obvious signs of mental health problems.

67. The clinical review states that standard healthcare checks, such as blood pressure checks, were not made on him during his respite care in the healthcare centre. Why were these not carried out given his age and recent poor health?

The man's respite care was initiated as a response to his 'challenging behaviour' on the therapeutic landing. It was not initiated as a result of any concerns over his physical health. The doctor said that no new symptoms were presented during his respite in June 2006, therefore no medical interventions followed. His stay in healthcare was undertaken to help alleviate the behavioural difficulties he experienced on the wing.

68. He presented as unwell from 20 May 2006, but did not receive any tangible medical examinations until 18 September. His family were concerned that he could have been suffering during this time and found this quality of care unacceptable.

The prison doctor confirmed that the man was reviewed on seven separate occasions during this period. Where he did not refuse medical interventions, He was treated appropriately for acute exacerbations of his pre-existing lung disease. As his heart condition presented as stable, on no occasion was it felt that he deteriorated significantly between May and September. The doctor said that his symptoms did give rise to medical concern on 1 September. He was advised appropriately, had a chest x-ray, but initially refused further medical intervention.

69. The first recommendation in the clinical review mentions that healthcare staff should always request and chase medical notes for prisoners who present with illnesses to allow continuity of care. Why does this not happen as standard?

It is not standard current practice for a prisoner's GP or hospital notes to be routinely forwarded to prison establishments when they are first taken into custody. Where there is doubt about a prisoner's condition or medication, previous notes can be requested with a prisoner's permission. The doctor said that, in the man's case, he was able to provide information about his medical history. Healthcare staff noted this and monitored his chronic conditions. His condition remained stable in prison up until 1 September 2006 when he presented with new symptoms.

70. He had a heart problem and had been in hospital on two or three occasions prior to going into custody. My report refers to the man asking for his medication. His family questioned whether he was referring to his heart medication and felt that, if the prison had made more of an effort to obtain medical notes, they would have been aware of this.

The prison doctor was unable to confirm which episode this concern referred to but said that the man was receiving medication for his chronic conditions. He did ask for his medication on the evening of 31 May 2006 and was told it would be picked up from healthcare and brought to the wing. This was at approximately 6.00pm, prior to the evening medication rounds. My investigator could not determine whether the man did or did not receive his medication that evening.

71. The man's solicitor told his family that all medical records should have been transferred to Cardiff on his arrival. The solicitor had not contacted the prison to inform staff how seriously ill he was when he first went into custody, although his family first thought the solicitor had. The solicitor said that it was the responsibility of Cardiff to gather information on him and request GP records as required.

Then doctor confirmed she was not aware of any contact between the man's solicitor and Cardiff's healthcare with regard to his health. She added that, in any event, healthcare staff identified his chronic conditions on his initial first healthcare screening in reception. He was seen by a doctor the same day and appropriate arrangements were made for a follow up and further monitoring of his medical condition. He was identified as in need of extra support within a prison setting due to his age and chronic medical condition, and was located on the therapeutic landing. The doctor felt that having access to his medical history prior to custody, or being in receipt of a solicitor's letter at the time of his reception at Cardiff, was unlikely to have made a significant difference to the medical management he received.

72. The man was elderly man and came into Cardiff in poor health. He did not participate well in the prison regime prior to his diagnosis and found it hard to settle into prison life. It is clear from his core records that his poor health was taken into consideration when he was located. Meals were collected for him so that he did not have to negotiate any stairs. He was permanently placed on A wing's therapeutic unit and moved to B wing when the therapeutic unit was relocated there. Despite these considerations, and in the absence of a separate elderly prisoner regime, he was managed like any other prisoner on his wing and found this difficult.

73. He presented himself, and was also referred by wing staff, to the healthcare centre on many occasions. The symptoms of his physical condition were treated by the prison doctor, but during his two week 'respite' period in healthcare he did not undergo any further tests. Nor was he given any restricted or adapted regime by virtue of being an elderly healthcare patient. It is of little surprise that an urgent case and the need for his bed led to his return to A wing. Respite care is not a healthcare intervention and staff had no alternative but to return the man to his wing.

74. The balance between security and the compassionate management of a prisoner in poor health is a difficult one for any prison to strike. I have no doubt that, once the man was diagnosed with terminal cancer, healthcare staff did all they could within their means to refer him to hospital for treatment as

quickly as possible. Once in hospital, Cardiff's management of his condition was generally compassionate and dignified. This is reflected in both governors' decisions to remove restraints and reduce the bedwatch from two officers to one officer for the last few days of his life.

75. Although it must be stressed that there would have been no effect on the ultimate outcome for him, the investigation has highlighted a number of areas where practice could be improved. I deal with these below.

Clinical Review

76. The Healthcare Inspectorate for Wales carried out a review of the clinical care the man received whilst at HMP Cardiff. The review noted that he was in poor physical health when he was sent to prison, but commented that he was, in the main, sufficiently tested and monitored when he presented healthcare staff with his symptoms.

77**.** The clinical reviewer made the following recommendations:

The man's primary care medical notes were not requested from the NHS once he was in prison. Prison healthcare staff should always request and chase medical notes for prisoners who present with illnesses and requiring medication, to allow continuity of care.

There was no action taken to monitor the level of potassium in his blood. The primary care was, therefore, not adequate in this regard. The Medical Officer should have organised blood tests as a precaution for him, given the quantity of different medication he was taking.

We have noted … that at least one sheet is missing from the Medical Record, despite repeated requests for it to be found and sent to us. This may have been filed incorrectly in the Prisoner Medical Record. Prison healthcare staff must locate and keep medical records securely and in the correct file.

Use of Restraints

78. The man remained in restraints from 9 October until approximately 2.15pm on 11 October when a governor authorised their removal. It is clear from the bedwatch log that, when the man underwent chemotherapy treatment on 10 October, he was still attached to an escort officer despite a request from the doctor for restraints to be removed. He also complained about being restrained whilst undergoing treatment. Officers on bedwatch duty have a pack which provides them with information they need to manage a prisoner in an outside environment safely and effectively. Cardiff's local guidelines for escort staff are attached to each bedwatch log. The guidelines state that:

> "When restraints are in use, if a healthcare professional (e.g. doctor, nurse, ambulance officer, paramedic) asks for them to be removed because of an immediate risk to the health of a prisoner or because the

> restraints are impeding essential treatment, they must be removed. The escort staff must notify the Duty Manager immediately, in case additional security arrangements need to be made."

The local guidelines to staff also say:

> "Similarly, if a healthcare professional seeks the removal of restraints because, although immediate treatment is not required, they are impeding examination or treatment, the restraints should be removed unless there is a risk of the prisoner escaping."

79. The man's risk assessment was carried out on 6 October which was three days before his outpatient hospital appointment. Security staff at Cardiff were not aware, in advance, that he was to be admitted as an inpatient on the day he arrived at the hospital, and it is important to place the decisions made over the risk he posed within this context. However, as a governor confirmed, there was no evidence in the man's security file to support the 'medium' risk of escape and hostage taking he was considered to pose in the risk assessment completed on 6 October. Moreover, the focus on medium risk is clearly tempered by the inclusion of a measure at the back of the risk assessment which permits the removal of restraints 'for medical reasons' with the authority of a duty governor.

80. The man's restraints were removed during the afternoon of 11 October. This was more than 24 hours after his chemotherapy treatment had finished. The officer on escort duty on the day of his treatment, 9 October, told the doctor that the request would be raised with the member of staff responsible for carrying out a management check later that day. No record of any consideration or further risk assessment to remove restraints from him was recorded that day. His log simply said that HMP Cardiff had been contacted and there were no changes in circumstance. I have taken into consideration that escort officers may not be aware that, under the local guidance to staff above, they must remove restraints at the request of the medical profession under certain circumstances. However, the duty governor should have been made aware of the medical requests at some point that day.

81. The man was 76 years old and terminally ill. Had the duty governor, been contacted immediately in accordance with the risk assessment and local bedwatch guidelines, the man might have received his treatment without the need for restraints and such close supervision from escort officers. I make the following recommendation:

The Governor should ensure that officers on escort duty are familiar with risk assessment procedures and local guidelines to staff on bedwatch duty. In particular, escort officers must ensure they are fully aware of their responsibility to consider the requests of medical practitioners and to notify the duty governor immediately that a request or change in security arrangement is suggested.

Healthcare Records

82. Healthcare staff at Cardiff saw him regularly during the last months of his life. It was not always clear from the record who his primary carers were in the healthcare centre, and when he was transferred to the outside hospital and discharged. His medical records were often difficult to read and failed to record every relevant event. Some entries were not correctly initialled or signed.

The Healthcare Manager should remind staff that, in accordance with the Nursing and Midwifery Council's guidelines for records and record keeping, all medical records should be legible, up to date and in chronological order. In addition, audits of the quality and consistency of records should be undertaken in partnership with the PCT on a regular basis.

Housekeeping points

83. The man was transferred to hospital for exploratory procedures before being admitted to ward West 6 at Llandough Hospital on 9 October. Local security instructions were clearly followed with regard to escorts maintaining regular contact with the prison to update staff as to his condition. However, there are some gaps in reporting between 3.50pm and 9.10pm on 9 October and 3.05pm and 8.00pm on 11 October. Bedwatch logs are a valuable communication tool and, properly completed, allow for early detection of changes in an individual's condition and security risk. I draw this to the Governor's attention but make no formal recommendation.

84. He remained in prison issue clothing for approximately 24 hours after his admission to Llandough Hospital. When escort officers did open the emergency bag at lunchtime on 10 October, they found night clothes but no slippers for him to wear. Local guidelines to staff on bedwatch duty state that all prisoners must wear suitable night wear in hospital. I have not been able to establish why he remained in either prison or hospital issue clothing for this period. I must assume that officers were either unaware of the requirement or, due to his unforeseen admittance as an inpatient, did not receive the emergency bag until the afternoon of 10 October. I draw the Governor's attention to this issue but again make no formal recommendation.

RECOMMENDATIONS

1. **The Governor should ensure that officers on escort duty are familiar with risk assessment procedures and local guidelines to staff on bedwatch duty. In particular, escort officers must ensure they are fully aware of their responsibility to consider the requests of medical practitioners and to notify the duty governor immediately a request or change in security arrangement is suggested.**

   The Prison Service has accepted this recommendation.

2. **The Healthcare Manager should remind staff that, in accordance with the Nursing and Midwifery Council's guidelines for records and record keeping, all medical records should be legible, up to date and in chronological order. In addition, audits of the quality and consistency of records should be undertaken in partnership with the PCT on a regular basis.**

   The Prison Service has accepted this recommendation

Additional recommendations are made in the clinical review and are cited in the text above on page 21.