Investigation into the circumstances surrounding the death of a prisoner at a hospital in Bridgend, while a prisoner at HMP Parc in February 2007

Report by the Prisons and Probation Ombudsman for England and Wales

January 2009

This is the report of an investigation into the circumstances surrounding the death of a man on 18 February 2007 at a local hospital in Bridgend. The man had been transferred from HMP Usk to HMP Parc on 12 February and was in poor health when he arrived. The following day he was admitted to hospital. The man suffered with rheumatoid arthritis and died after contracting pneumonia. He was 68 years old.

The loss of any family member is distressing, but especially so whilst they are in custody. I offer my sincere condolences to the man's family and friends.

The investigation was undertaken by one of my investigators who has since left my office. Another of my colleagues continued the investigation after my investigator's departure. We would like to thank the Governor of HMP Usk and the Director of HMP Parc and their staff for their co-operation. We would also like to thank the personal assistant to the Governor of HMP Usk, for facilitating a number of follow up enquiries between the draft and final stages of this report.

The Health Inspectorate for Wales (HIW), carried out a clinical review into the care and treatment the man received whilst at both Usk and Parc. I am grateful to the Inspectorate for completing the review.

The man had developed signs of rheumatoid arthritis prior to coming into prison. This is a debilitating illness, characterised by a swelling of joints, pain to inflamed areas, stiffness in movement and fatigue. Were it not for his imprisonment in 2001, the man would have seen a rheumatologist in both September and December of that year. Once in custody, his condition steadily worsened and by February 2007 he could no longer walk or take care of himself due to the deformity in his hands.

This was the eighth death in custody at Parc since I took over responsibility for all such investigations in April 2004. The man's circumstances were predominantly clinical, and I have relied heavily on the findings of the clinical reviewer for this report. The man was mainly cared for by healthcare staff at Usk, and the focus of my investigation, in agreement with the clinical reviewer, was extended to include his time at this establishment.

My investigation has highlighted the importance of maintaining good communication between prisons and within an establishment, both verbally and through good record keeping. More positively, it has revealed how the difficult balance between protecting the public and safeguarding a prisoner's dignity whilst in hospital can be struck.

My report makes six recommendations. I apologise for the delay in making it available.

Stephen Shaw CBE
Prisons and Probation Ombudsman **January 2009**

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SUMMARY

When the man was sentenced to ten years imprisonment in May 2001, he went straight to HMP Parc. Whilst in the community, the man had presented with symptoms of rheumatoid arthritis, but at no point during the two years he spent at the prison was the condition mentioned in his medical records.

The man was transferred to HMP Usk on 1 April 2003 to begin a number of offending behaviour programmes. On arrival, his condition was mis-recorded as another form of arthritis. For the next year, the man took in-possession medication to reduce the inflammation in his hands and was prescribed painkillers.

In March 2005, the man burnt his left hand whilst trying to use a kettle in his cell. He was treated for the burn in healthcare, but was not followed up with an assessment as to his ability to handle objects. A few weeks later, the man had an appointment at the chronic disease management clinic. The doctor reduced his medication and, at a follow up session, discussed arthritis care at length with the man.

Between June and October 2005, the man missed two appointments to see a rheumatoid specialist. He had been reluctant to attend but agreed when his condition worsened. There was no indication why the man did not keep the first appointment. A re-arranged appointment was also missed in September. This time, the man was not considered well enough to attend. Another appointment was made in October and the man was eventually seen by a consultant rheumatologist. The consultant felt that the man's arthritis had left him incapacitated. The man was prescribed an anti-inflammatory drug to stabilise his condition. The consultant ordered healthcare staff at Usk to take regular blood tests to monitor the man's response to the drug.

Throughout 2006, the management of the man's condition did not change. His blood was regularly monitored but not always recorded in the appropriate files. The man was persuaded to attend a review of his arthritis at the specialist clinic and his prescription was increased. This was the last time he attended an external appointment.

The man's hands became deformed and his disability increased as his arthritis worsened. By January 2007, he could no longer look after himself. After a prisoner alerted staff to the man falling in his cell, staff discovered that his cell mate had been helping him to live as independently as possible. It is not known how long this arrangement had been in place.

A few weeks later, on 12 February 2007, the man became bedridden. The doctor on duty was called to his cell and found him in pain and unable to get out of bed unaided. As Usk did not have an inpatient facility, the doctor felt it was no longer appropriate for the man to remain in his cell and arranged for a transfer to the healthcare centre at HMP Parc.

The man was transferred later that day. Within 24 hours of his arrival at Parc, he was admitted to outside hospital for more intensive nursing care. His restraints were removed the day after he was admitted, and his security level was reduced to one

officer. The man deteriorated and developed other complications including respiratory and renal failure. He was visited by his family and made as comfortable as possible for the last few days of his life.

The man died at 2.40pm on 18 February 2007. After his death, the appropriate procedures were followed in notifying his family and the prison. Representatives from Usk attended his funeral service.

THE INVESTIGATION PROCESS

1. The investigation was opened by one of my investigators in March 2007. My investigator requested all prison and medical files. She began to identify the key issues and the staff who interacted with the man during his brief time at HMP Parc. My investigator interviewed healthcare and operational staff on 28 June. My investigator also asked both Usk and Parc for further documentation, namely the man's core prison record and wing history. Unfortunately, neither prison could locate the documentation. At the draft report stage, the man's family asked if these were ever found. Neither of my investigators had sight of his wing history, and I cannot comment further on what happened to the documentation.

2. The Healthcare Inspectorate for Wales (HIW) was asked to complete a clinical review into the care the man received at both prisons. A specialist rheumatological opinion was also sought by HIW. The clinical reviewer carried out joint interviews with my investigator and healthcare staff at Usk. Both the clinical review and the specialist report, including recommendations, are attached as an annex to this report.

3. One of my Family Liaison Officers contacted the man's next of kin shortly after the investigation was opened. My family liaison officer explained her role and that of my office and provided information about the investigation process. My family liaison officer also offered the man's family the opportunity to meet to discuss any issues or concerns.

4. On 12 April 2007, My family liaison officer and my investigator met the family at the home of the man's sister. During the visit, the man's family raised several concerns and asked for further information about certain events. These were as follows:

    - How often was the man seen by healthcare staff at Usk and when was the last time staff saw him before his transfer to Parc?

    - Is there a procedure at Usk for contacting families when their loved ones develop health concerns? If so, what is the procedure and why did the prison fail to contact the man's family following the deterioration in his health?

    - The man could not look after himself on the wing whilst imprisoned at Usk. Was there a single member of staff designated to monitor his disability?

    - What standard of treatment did the man receive for his rheumatoid arthritis whilst in prison?

5. I addressed these issues in the appropriate sections of the draft report, which was sent to both the Office for National Commissioning and the man's family. The Office for National Commissioning accepted my recommendations and their response can be found on page 23 of this report. The man's family

raised a number of other issues and provided additional comment on the care and treatment he received at Usk. I have attempted to answer as many questions as possible, and these, along with the man's family's comments can be found in the appropriate sections of this report.

HMP USK AND HMP PARC

HMP Usk

10. HMP Usk is a category C male training prison. Usk opened in 1844 and throughout its 164 years the prison has operated in several roles. Usk was originally a house of correction and became the county gaol for Monmouthshire in 1870. It closed in 1922, but reopened 19 years later as a borstal. In 1964, it became a detention centre. During the 1980s, Usk was a youth custody centre and young offender institution. It was re-roled to its current function in May 1990.

11. Usk consists of three wings (A, B and C), comprising 46 cells and two dormitories. The Ray Comber Unit, or D wing, is a relatively new 18-bed ground floor unit and is specifically for older prisoners. Most of the ground floor areas are accessible for wheelchair users. Usk has a certified normal accommodation of 150 and an operational capacity of 250 prisoners.

12. HM Chief Inspector of Prisons, Ms Anne Owers, has reported on Usk twice in the last six years. After the most recent inspection (April 2005), Ms Owers wrote that Usk continued to be an extremely well-run prison, and that prisoner- staff relations were good. However, some things did need attention – including a better focus on the needs of older prisoners. That aside, the consolidation of performance from the previous inspection in 2002 meant that there was pride in the prison.

Healthcare

13. The healthcare unit at Usk is situated at the end of B wing and comprises the healthcare office, a dental surgery and a doctor's room. The Head of Healthcare manages provision for both Usk and its neighbouring and linked establishment, Prescoed. All other clinical staff (one G grade nurse and four F grade nurses) work across both prisons, and one nurse provides on-call cover to both sites from 4.30pm daily when healthcare closes.

14. The commissioning of healthcare provision by Monmouthshire Local Health Board (LHB) took place in 2006. The LHB provides primary healthcare, akin to the services you would find in a local General Practitioner (GP) surgery. There is no inpatient facility. On arrival, prisoners are screened in reception and there is an opportunity to see a doctor, usually within 24 hours, or another health professional by appointment. Prisoners with ongoing medical conditions are asked by nursing staff for their consent to obtain a medical history from their GP in the community.

15. In 2005, HM Chief Inspector found that medical facilities for older prisoners were reasonable and that prisoners with long-standing medical conditions were monitored and well managed. However, her report did highlight the absence of good links with occupational therapy and recommended that Usk engage with and seek expert medical advice from a therapist to advise on the care of older prisoners.

16. Ms Owers' report also commented that healthcare staff were adept at referring prisoners to attend external healthcare appointments and generally had a good relationship with NHS Trust services. Prisoners needing emergency referrals were sent to the Neville Hall Hospital.

HMP Parc

17. HMP Parc is a category B local male and young offender establishment that holds both remand and sentenced prisoners. Parc is relatively new (opened in 1997) and is privately managed by G4S. It has a certified normal accommodation of 839 prisoners and a capacity of 1,039. Parc has a full primary and secondary healthcare facility.

18. HM Chief Inspector inspected Parc in 2002 and 2006. The second inspection found that Parc had not managed to consolidate its performance since the earlier one and found slippage in many key areas of work. Ms Owers voiced concern that both the contractor and the Office for Contracted Prisons had not taken the opportunity to address the slippage in service at the earliest opportunity. However, the 2006 report found that healthcare was not one of the areas that had lapsed.

Healthcare

19. Healthcare services are run by Primecare and staffed by one healthcare manager, three senior nurses (Grade G), 13 F Grade nurses and five healthcare assistants. Ms Owers was impressed with the healthcare unit at Parc. Her 2006 report found a varied range of healthcare services available, including 17 nurse-led clinics covering anything from well man clinics to pain management. The inpatient facility is large with 19 beds and one room converted to accommodate older and disabled prisoners.

20. When prisoners arrive at Parc, they are given a detailed health assessment by a Registered Mental Nurse (RMN). There is a dedicated room in admission for nursing staff to examine both newly arrived and discharged prisoners. Ms Owers found in 2006 that new prisoners with specific physical health needs were referred to appropriate clinics for follow up care, and all prisoners were triaged before seeing a GP.

21. One Registered General Nurse (RGN) had sole responsibility for the care of older prisoners. In 2006, the inspectorate team found that the nurse talked to newly arrived disabled prisoners to ascertain their specific needs and ensure they would be met. Ms Owers commented that this dedicated staff initiative was in direct response to her 2004 thematic review of older prisoners, and the 2006 inspectorate report identified Parc's response as an example of good practice. I provide an overview of the thematic review below.

Older Prisoners

22. Prisons are not principally designed for the elderly and it is difficult for an individual establishment to accommodate an aged population. A thematic review by HM Chief Inspector of Prisons in 2003 found that, although older prisoners (60 years and over) 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 said that there was no overall strategy throughout the prison estate for assessing and delivering a regime that addressed the needs of older prisoners.

23. Since the review, the elderly male prisoner population has seen a year on year increase. The most recent figures, taken from the Ministry of Justice Offender Management Caseload Statistics, show that in the four years 2002-2006 the population has increased by another 26 per cent from 1,365 to 1,725.

24. The Chief Inspector's thematic review concluded that some elderly prisoners would inevitably spend the rest of their lives in prison. Early release from prison on medical grounds for severely or terminally ill prisoners is subject to restrictive criteria, and the thematic review stressed that the prison environment must be geared towards meeting the specific needs of its ageing population.

25. A report, Growing Old in Prison, published by the Prison Reform Trust in 2003 quoted a Department of Health study that also focussed on older prisoners. The study said that out of 203 prisoners aged 60 and over, 85 per cent had one or more major illnesses reported in their medical records. The most common illnesses were psychiatric, cardiovascular, musculoskeletal and respiratory.

KEY FINDINGS

26. The man was sentenced to a period of long term imprisonment at Cardiff Crown Court on 25 May 2001. Prior to his sentence, the man had spent a short period of time in the healthcare unit at Parc as a remand prisoner whilst he awaited the outcome of his trial. The medical officer who saw him on 14 May 2001 noticed a slight weakness to the left side of his body but arthritis was not mentioned at any point during his time at Parc. In the community, the man had been taking a number of prescription medications (painkillers and anti-inflammatory tablets) and he continued to have 'in possession' medication in prison. The man was also due to see a specialist rheumatologist in 2001, but due to his imprisonment he missed the appointment.

27. The man was declared fit for transfer on 30 March 2003, having spent just under two years at Parc. He was transferred to Usk on 1 April 2003 to begin a number of offending programmes. In reception, the man's arthritis was mis-recorded as osteoarthritis instead of the rheumatoid condition.

28. Between April 2003 and January 2004, the man's anti-inflammatory prescriptions were changed several times. He was also prescribed a different painkiller (co-proxamol) for pain in his hands. On 20 January 2004, the man complained of joint pains and was prescribed prednisolone, a common treatment for arthritis.

29. Two days later, the man's blood was taken by nursing staff and the results confirmed that he was suffering from rheumatoid arthritis. In March 2004, he suffered a burn to his left hand attempting to use a kettle and was treated in the healthcare unit. The man continued to take prednisolone for a number of months but, following a chronic disease management clinic appointment in April 2005, the doctor running the clinic reduced the man's dosage.

30. The doctor discussed the man's arthritis with him on 15 June 2005. At that time, the man refused to see a specialist. However, just over one month later (on 25 July), the man' symptoms increased and he agreed to be referred. The prednisolone was increased to 10mg and the doctor also prescribed medication for the prevention of osteoporosis and a bone protection drug. The man's appointment for the specialist clinic at the local Hospital was for 21 August but he did not attend. His medical record does not clearly state why the appointment was postponed.

31. The man was not considered well enough to attend his re-arranged appointment on 14 September. A month later, on 12 October 2005, the man saw the consultant rheumatologist at the local hospital, and was examined. The clinical reviewer, Healthcare Inspectorate for Wales, notes of the man's care that the consultant rheumatologist's letter to the prison doctor described a steady progression in the man's arthritis. Following blood tests and x-rays, the consultant rheumatologist's overall assessment was that the man was quite incapacitated, and his arthritis was particularly bad in his hands. The consultant prescribed methotrexate, a disease modifying drug with anti-

inflammatory components. The consultant rheumatologist stressed that regular blood tests would need to be carried out whilst the man was taking this prescription, and that he should visit the clinic again in three months time.

32. The man saw a clinical nurse specialist in rheumatology on 16 November 2005, and they discussed his treatment. Nursing staff at Usk continued to repeat his blood tests regularly as required, but in January 2006 this appeared to become less frequent. The clinical reviewer mentions in her review that there is no clear reason for this in the man's medical records.

33. There was no significant change in the management of the man's arthritis throughout the early part of 2006. On 10 April 2006, a note in the man's medical record said that the prison doctor had persuaded the man to go for a hospital review. In her clinical review, the clinical reviewer says, "this suggests that perhaps the man was not keen on keeping his [hospital] appointments".

34. The man attended the clinic on the same day (10 April 2006) and saw the consultant rheumatologist again. His prescription was increased to 12.5mg. A letter from the consultant, addressed to a doctor and copied to the prison doctor, stressed the need for healthcare staff to take the man's blood every month. The man was due to attend the clinic again on 7 August. From his records, it does not appear that he kept the appointment.

35. The man's arthritis deteriorated further. On 12 October 2006, an entry in his medical record said that his left hand 'is bad with secondary rheumatoid disease'. Unfortunately, the man would not go back to the rheumatoid clinic.

36. In early January 2007, the man's ability to look after himself took another downward turn. A request was made for him to have Velcro footwear as he found it difficult to do up his own shoes. Later that month, on 11 January 2007, a prisoner who shared a cell with the man contacted the healthcare unit to report that the man had fallen in his room the night before. He had bruised his elbow in the fall. An officer went to see him with another member of staff and his personal care was discussed. They discovered that the prisoner sharing his cell had been helping the man to live as independently as possible by collecting his meals. The man was also using a higher chair in his cell but had little room to move around.

37. As the man was a Listener (Listeners are trained by Samaritans to provide confidential emotional support to fellow prisoners in distress), he occupied a cell with three beds. This allowed him to accommodate other prisoners who wished to speak to him confidentially. A member of nursing staff, described to my investigator the close proximity of the man's cell to the healthcare unit. However, the nurse was critical of the space in the man's cell due to the number of beds in it. The nurse said that having three beds screwed to the floor left little room to get in and out of the cell and "was not conducive to nursing care".

38. In the absence of the man's wing history, it is not clear how he managed to care for himself in his cell over the next month. It is also unclear precisely how much, and what type, of help he received from his cell mate. On 12 February 2007, an entry in his medical record described the man as immobile and unable to get out of bed. A visiting GP at Usk, recalled going to see the man in his cell. When interviewed, the GP said that the man had hip and knee pain. Although he was aware that the man wanted to stay at Usk, as a medical practitioner the GP had to weigh up whether it was better for him to remain on the wing or move to the 24 hour inpatient facility at Parc.

At the draft report stage, the man's family were concerned that he did not have access to a doctor in the days leading up to 12 February. His family questioned why the man was not urgently referred for a doctor's appointment.

39. The GP also suggested that the man may have created an artificial picture of how he was managing to look after himself. At interview, the GP told my investigator that he sensed other prisoners were helping the man with his daily living needs and that the man presented him with "a veneer of coping". In the GP's opinion, the man could no longer collect his food or attend to his personal hygiene and therefore could not remain at Usk.

40. The man was prescribed a Kenalog injection (to suppress his inflamed joints) but this was not administered. Instead, the nurse contacted Parc and gave an overview of his condition. An agreement was made between the two healthcare units to transfer the man to Parc the same day.

At the draft report stage, the man's family were concerned about the telephone conversation between the nurse and a member of the healthcare team at Parc. In particular, his family questioned whether there was an adequate assessment of the man's needs and capabilities, and said that he was clearly grateful to be transferred.

41. The man transferred to Parc by taxi with two escorting officers from Usk. His transfer was slightly delayed due to the unsuitability of the first vehicle (ordered by the nurse via discipline staff) to accommodate the man in a wheelchair. On arrival at Parc, the man told staff that he could wash, dress, feed himself, and take himself to the toilet but it took a long time. This contrasted with the entry in his medical notes which said that the man was wheelchair bound, unable to stand and needed the help of someone to transfer him (presumably to and from the toilet). His extensive list of medication transferred with him.

42. The man's care plan at Parc started as soon as he arrived in healthcare. The plan included a description of the man's condition on arrival and said that he was unkempt, in a wheelchair, fed with the help of someone else and had approximately three months worth of medication with him. That evening, the man was shaved, given a bath, and placed into bed. He was given a snack and a cup of tea but did not eat anything.

43. The man's care plan was continuously reviewed and clearly stated that his main physical problem was arthritis. The plan was updated on 13 February 2007 to include incontinence of urine, immobility, and the man's inability to look after his own hygiene and to feed himself. The plan also said he was at risk of dehydration and malnutrition.

44. At midday on 13 February, the man was sick and his blood pressure dropped to 90/60 according to the nursing care records. A GP at Parc, went to see the man a couple of hours later. He arranged for the man to be admitted to hospital and updated his medical records. The entry described the man's hands as deformed due to secondary arthritis. The GP also said that the man had appeared short of breath.

45. The man was transferred by ambulance to the local Hospital. He was escorted by two prison custody officers (PCOs) and was placed in restraints (an escort chain) as instructed by his escort risk assessment. When he arrived at the hospital, the man was admitted via the Accident and Emergency Department, and from there he was placed in the Resuscitation Department. At approximately 2.55pm, one of the man's escorting officers recorded on his Prisoner Escort Record (PER) that the man underwent an x-ray. At about 4.40pm, the man moved to a medical assessment unit and began treatment.

46. The man's condition was described as stable during his first night in hospital. Healthcare staff at Parc kept in regular contact with the hospital and recorded the man's deteriorating health in his medical record. The hospital consultant, explained that the man had developed severe pneumonia, renal failure and type 2 respiratory failure. The consultant said this was likely to have happened as a result of "immunosuppression".

47. On 14 February, the hospital considered moving the man to a high dependency unit but decided the respiratory ward was more suitable and the man was made comfortable there. At 11.05am, a member of Parc's chaplaincy team, visited the man at his bedside. On her return to Parc, the member of the chaplaincy contacted the man's next of kin, his daughter, and informed her that he was in hospital. The member of chaplaincy also told one of the man's sisters that he had been admitted.

48. At around 3.15pm, two bedwatch duty officers received a revised risk assessment for the management of the man's hospital stay. The risk assessment reduced the man's security to low risk and a singleton officer. It also ordered the removal of the man's restraints. One officer stayed with the man and ensured his restraints were removed and returned to the prison. The officer also facilitated a visit from the man's family.

48. The following day, a member of healthcare staff at Parc contacted the hospital and was told that the man had moved to Ward 2, where he was more stable. The hospital also said he was likely to remain there over the weekend. The man continued his antibiotic treatment and his family, a chaplain and a member of the Samaritans visited him over the next two days.

49. The man became restless during the early hours of 18 February and his condition deteriorated further. At approximately 1.53pm, the officer who was on bedwatch duty updated the bedwatch log to reflect that the man had been taken to x-ray and would undergo an ECG. Shortly afterwards, the man developed breathing difficulties, and at 2.20pm he was moved to a coronary care unit. About 15 minutes later, the officer was told that the man had moved again - this time to intensive care.

50. Sadly, at 2.40pm on 18 February 2007 the man died. Hospital staff informed his family of the news. The consultant told the officer promptly, and he in turn contacted communications staff at Parc. The appropriate death in custody procedures began and were carried out without any problems.

51. The man's funeral was arranged privately. The chaplaincy team at Parc sent a condolence card and two representatives from Usk attended the service.

ISSUES

52. The man was not in good health when he began his sentence in May 2001. For most of his time in prison, he struggled to cope with a debilitating condition but rarely complained. The man gave the impression that he was coping well, and was known to be a reluctant patient, often resistant to both internal and external healthcare intervention. The man was a Listener and respected for the support he provided. He settled well at Usk and resisted a transfer to Parc, but it is clear that the deterioration in his arthritis dictated his move to the inpatient unit at Parc, and later to hospital.

53. I mention in my introduction to this report that the main focus of my investigation has been how Parc managed the last few days of the man's life in an outside medical environment. I deal with the issues raised by my investigation below.

54. The man's story would not have been told in full had the focus of the investigation remained this narrow. I am grateful to the clinical reviewer for extending the remit to include the man's healthcare provision at both Usk and Parc prisons. In addition, and to explicitly comment on the specifics of the man's condition, a further review of his care was undertaken by a rheumatoid consultant. The main findings of both reviews can also be found below.

The man's arrival at Parc in May 2001

55. The first signs of the man's rheumatoid arthritis were in 1999 while he was still living in the community. When the man arrived at Parc on 14 May 2001, he was already suffering with the condition. The clinical reviewer comments that attempts to contact his GP should have been made at the outset. Obtaining the man's GP records at the earliest opportunity would have told healthcare staff how his arthritis had previously been managed and how to continue that management in custody. The clinical review makes the following recommendation (which I have reworded slightly):

    Healthcare staff must ensure that, when a new prisoner arrives and has ongoing healthcare needs, the prisoner's GP is contacted at the earliest opportunity in order to obtain a full past medical history.

Healthcare Screening

56. The man was transferred from Parc to Usk on 1 April 2003. He returned to Parc on 12 February 2007. His medical record included one first reception healthscreen document from Parc, but it is unclear whether this related to his first reception at the prison or his second as it was not fully completed or dated. The clinical reviewer comments that, if the healthscreen related to his transfer on 12 February, the care plan indicated that staff could not obtain a sufficient amount of medical information from the man. Healthcare screenings are a vital tool for establishing immediate physical and mental healthcare needs. Reception healthcare staff have a duty to carry out screenings and to complete the correct documentation when new arrivals or transferring

prisoners come through reception. As I have already mentioned, it is not clear which reception date the man's screening relates to. Furthermore, and in the absence of documents recording subsequent screenings, it is unclear how much the receiving prison(s) knew about the man's condition. What is clear is that the prison doctor and nurse arranged the healthcare transfer between Usk and Parc on 12 February 2007. The nurse told my investigator that she spoke to the healthcare unit at Parc about the man's condition and his mobility problems. The clinical review makes the following recommendation. I have tailored this slightly:

Healthscreens must be completed on admission to prison, on transfer between prisons and on admission to healthcare, to determine prisoners' immediate healthcare needs and to note any deterioration in health, in order for appropriate treatment and care to be given in a timely manner.

At the draft report stage, the man's family commented that it was unclear who made the final decision to transfer him Parc. With regard to admissions to hospital, or transfers to 24 hour healthcare at other prison establishments, authorisation lies with doctors. When the doctor saw him in his cell on the day of his transfer to Parc, the nurse advised the doctor that Usk was no longer equipped to care for the man fully. In her transcript, the nurse said that she also discussed the man's risk factors with the doctor and told him that she felt strongly that he needed to be transferred. The doctor told the nurse that the man did not need acute 24 hour care in a hospital setting and so the nurse began procedures for transferring him to Parc's healthcare centre.

The man' 'in cell' care at Usk

57. Evidently, the man was not a man to complain. Despite being in acute pain and unable to fully take care of himself, he preferred to manage as best he could in his cell. When he fell in his cell and another prisoner alerted staff, the level of his incapacity came to light. A month later, the man presented the doctor with a "veneer of coping" and it was not until the doctor was called to his cell on 12 February 2007 that his deterioration and increased disability fully presented itself. This led the doctor to transfer the man to inpatient care at Parc. Whilst I accept that the man's choice was to stay on his wing, and his personal daily needs were met by his cell mate, this was not a desirable and appropriate arrangement.

58. My investigator's attempts to obtain the man's wing history were not successful, and this has hindered my ability to tell the man's story in full. Given his immobility and inability to look after himself, it is perhaps surprising that officers did not notice or alert healthcare staff to his debilitation sooner. The man was a Listener, and as such would have come to the attention of officers more frequently. At the draft report stage, the man's family asked my investigator to clarify how many Listeners there were at Usk. My investigator liaised with Governor's secretary who passed their concern on to the relevant Head of Service. My investigator received confirmation that for the year 2006, there were up to 14 Listeners at the prison. For the year 2007, the maximum

number was 13, and currently, the prison has 11 trained listeners. My investigator also asked whether Usk aims to maintain a regular number of Listeners and received the following information:

> "Yes, seven will be trained in September (2008) [sic], and the only rule is that there will be no more than 12 at any one time as this can sometimes cause in group arguing. Although we will have up to 19 trained next month, this is so that if we get any discharged or transferred prisoners [sic] to another prison, we have a list of those already trained and waiting to fill the gap".

The man's family expressed concern that during his interview, a Governor could not remember when the man's last attended a Listener's meeting. I do not criticise the Governor for not knowing this information off the top of his head, as he could not have foreseen that these specific details would be asked of him. That said, my investigator requested the dates of the Listener's meeting minutes for 2006/07. These clarified that the last minuted meeting that the man attended was on 1 November 2006. It is worth pointing out that Listeners meetings are held each week with The Samaritans, but they are not minuted. An additional Listeners group meeting is held once a month and these meetings are minuted. The man's family also stressed they felt it inappropriate for the man to rely on other prisoners for day care. I can only assume that the man's wing history, if recovered, could fill in some of these gaps. That said, the use of prisoners as carers for others, in the absence of follow up assessments and care plans, is not an appropriate and sustainable arrangement.

The man family were critical of the lack of basic equipment in the healthcare unit at Usk. Having read the transcript from the nurse, they questioned why, when he could not go to the toilet on his own, a nurse would have to search for another receptacle for him, instead of a urine bottle. My investigator asked the Governor what basic equipment the healthcare unit had. In response, the governor provided the following information:

> "The surgery is set up as per any surgery in the community and specimen bottles are available"

59. In one of my recent investigation reports into the death of an older prisoner following a stroke, I quoted the clinical reviewer's comments in that case about the level of personal care given by another prisoner who shared the cell. I can draw parallels between that report and the circumstances that the man found himself in. I repeat the recommendation made in that earlier report (again, I have slightly tailored the exact wording).

The Head of Healthcare at Usk should review how social care is provided to prisoners who clearly demonstrate an inability to carry out basic care needs such as washing and dressing for themselves.

The man's treatment and medication for rheumatoid arthritis

60. In March 2005, a wing officer noticed that the man had sustained a burn to his left thumb and index finger. When the man went to healthcare for treatment, he told staff that he had burnt himself lifting a kettle. An F213 form (Report of Injury to Inmate) was completed, but staff did not carry out a risk assessment following the accident. The clinical reviewer highlights gaps in the man's follow up care. The man's medication was extensive, but given the debilitation in his hands due to arthritis there was no clear evidence that he was reassessed to determine how he managed to take his medication (e.g. opening bottles and blister packs). The man did have an initial assessment at Usk. When jointly interviewed by my investigator and the clinical reviewer, the nurse said that healthcare staff relied on prisoners to inform them of any significant changes.

At the draft report stage, the man's family were concerned that he could not self medicate due to the disability in his hands. They also expressed concern that when the man was later transferred to Parc, he took with him a substantial amount of medication, and asked how often cells were searched. The man's family stressed that if regular cell checks were carried out, then the quantity of medication that he had in his possession, could have been discovered sooner.

The National Security Framework guidelines, covering cell searches, states that Governors, in conjunction with their Area Managers, should agree a cell search cycle of either once every three or every six months. Once agreed, it is then the responsibility of local wing managers to ensure that the cell search cycle is adhered to. At Usk, the agreed cycle is once every three months. My investigator asked the relevant functional head what action officers should take, if following a search, an unusual quantity of in-possession medication is found. In addition, my investigator asked whether Usk could provide documentary evidence that the man's cell was searched between September 2006 and February 2007.

Usk provided the following responses:

> "[following a cell search], any excess [medication] is removed and returned to healthcare who will place the patient before the GP, if they are failing to comply with their medication….the prisoner could also face disciplinary action".

Unfortunately, I cannot comment further on whether his cell was searched during his last six months and if so, whether officers found anything that concerned them. There is no evidence that medication was returned to the healthcare centre and that the man was referred to the prison doctor. Usk confirmed that, despite a trawl of their archive records, no documentation for cell searches was found.

61. The clinical reviewer judges that the man's condition deteriorated to a point where he was quite disabled. He was not reassessed as part of chronic disease management and it is unclear whether any referral was made for the man to see a disability liaison officer whilst at Usk. As I mention on page 7 of

this report, HM Chief Inspector of Prisons found in 2005 that medical facilities for older prisoners were reasonable and that prisoners with long-standing medical conditions were monitored and well managed. However, the inspection report recommended that Usk engage with and seek expert medical advice from an occupational therapist (OT) to advise on the care of older prisoners. The nurse told my investigator that the man had been referred to an OT.

At the draft report stage, the man's family questioned the thoroughness of his needs assessment to determine his level of disability. In response to the report, his family said that they had formed the impression that he had been disabled for some time, but that the staff at Usk only acted when he could no longer get out of bed. Usk have since confirmed to my investigator that elderly and disability needs assessments were introduced in April 2005, and that the prison does have a dedicated Disability Liaison Officer.

My investigator approached the relevant function head at Usk and asked whether copies of the man's disability and elderly care assessments, in addition to any follow up assessments or care plans, could be forwarded to my office. In response, the Governor said that all of the man's healthcare records were transferred with him to Parc, and copies were not kept locally at Usk. However, I have not seen evidence of these documents in his medical record or any other records considered as part of my investigation. It is unfortunate that I cannot comment further on the man's follow up care, given his level of disability.

In his continuous medical record, an entry made on 11 January 2007 by another nurse, said that the man would need an 'OT' assessment. A referral to the OT Department at a local Hospital was made by the doctor on 15 January. Unfortunately, I have not been able establish whether the man received, and attended an appointment before he was transferred to Parc.

The clinical reviewer makes the following recommendation (again, I have reworded this slightly):

The Head of Healthcare at Usk should ensure that regular assessments are completed for all prisoners diagnosed with chronic and disabling diseases.

62. I have already mentioned that the remit of the clinical review into the man's healthcare extended to a further review of the specific treatment and medication he received for his arthritis. A consultant rheumatologist, conducted a review based on the same evidence made available to the clinical reviewer. The consultant rheumatologist explains the man's condition in lay terms and says that, in addition to the inflammatory characteristics, rheumatoid arthritis also has:

> "… an auto immune aetiology. That is to say, the body's immune system employed to ward off infection … turns in on itself and begins to attack a patient's joint tissue."

63. The consultant rheumatologist has quantified the risk of death for patients with the condition as approximately double that of the general population. Within the general population, men have the poorest prognosis and the man had the most severe form of the disease.

64. In terms of the treatment he received, the consultant rheumatologist concludes that prescribing prednisolone and methotrexate was a typical combination. Both the consultant rheumatologist, and the clinical reviewer stress the necessity of regular blood monitoring when a patient is taking methotrexate. The consultant rheumatologist is satisfied that the man was regularly monitored, and comments that his results showed no evidence of increased toxicity (a side effect of the drug).

65. The consultant rheumatologist carried out his review in the absence of the man's post mortem results. He stresses that this limited his comments to general findings about the man's condition and the treatment he received. In short, the consultant rheumatologist, assesses that the prescribing and monitoring of the man's medication was carried out to a high and acceptable standard. The consultant rheumatologist does question why the man was not transferred straight to hospital once he was assessed as too ill to remain at Usk. However, he judges that the decision to move the man to inpatient facilities at Parc was not inappropriate.

66. It is worth pointing out that the National Institute for Clinical Excellence (NICE) Guidelines on the treatment of arthritis are currently in development and will be published in February 2009. This will give clear direction to healthcare units across the Prison Service as to the expected care and treatment of prisoners with arthritic conditions. It is also worth noting that Usk now carries out an older prisoner healthcare review - a direct response to the thematic review published by HM Chief Inspector of Prisons in 2004. Although I have not been able to establish when the older prisoner healthcare review was introduced, and therefore cannot determine whether this is something the man should have had, I am pleased to see that Usk has implemented a specific healthcare tool for a small, but growing, elderly prison population.

Record keeping

67. I have already mentioned the absence of the man's wing history at Usk and how, despite the efforts of my investigator to retrieve them, these documents were not recovered. This is most unfortunate. The importance of accurate and consistent record keeping and retention is something I comment on frequently in my reports, and this one is no exception. I make no formal recommendation but ask the Governor of Usk and Director of Parc to remind staff of the importance of securely sending and receiving records when prisoners transfer.

68. Additionally, the clinical reviewer has found that the man's medical records were difficult to decipher and lacking in continuity. In her report, the clinical reviewer says that some entries were illegible, undated, unsigned and not

always chronological. Furthermore, the clinical reviewer writes that it was not clear why a Kenalog injection, ordered by the doctor on 12 February 2007, was not administered to the man. The clinical reviewer makes the following recommendation, which I endorse:

The Head of Healthcare should ensure that, if a medication is not administered as prescribed, then a reason and explanation is given. Healthcare staff must ensure that they adhere to standards of record keeping as outlined by the General Medical Council and the Nursing and Midwifery Council.

The man's transfer from Usk to Parc on 12 February 2007

69. When the man's family spoke to healthcare staff at Parc, the man's sister was told that he arrived in an "unkempt" state. When interviewed, the nurse described how both she and a second nurse prepared the man for his reluctant move to Parc. The nurse described in detail how the second nurse helped the man to wash, get dressed, and get settled into his wheelchair whilst he waited for a suitable vehicle to transfer him. The nurse contacted Parc direct for a verbal handover, and then rejoined the man in his wing. Once the wheelchair-compatible vehicle arrived, the nurse explained that discipline staff took over. The nurse stressed to my investigator that the last time she saw the man he was not unkempt and had not been incontinent in his bed that day. My investigator also sought the views of the Head of Healthcare at Usk. The head of healthcare echoed the recollections of the nurse. He also asked the second nurse what he could recall from that day and found no internal evidence to suggest that the man arrived at Parc in an unacceptable state.

At the draft report stage, the man's family asked how many members of staff were on duty when he was transferred. My investigator obtained a breakdown of staff numbers for that weekend. The numbers clarified that healthcare staff were not on duty over that weekend period, but did remain on call for that period. This is normal procedure. In addition, Usk confirmed that the head of healthcare, who was the duty governor when the man transferred, is also a qualified nurse.

The man's family also asked for further information in relation to the 'on call' arrangements for the doctor, as they found it unacceptable that access to the doctor was via an answering machine service. My investigator received confirmation from the head of healthcare that the 'on call' arrangements for the out of hours doctors service remained the same. The head of healthcare further explained that an 'on call' nurse is contacted initially, and will normally make an assessment before contacting the doctor.

Maintaining family contact

70. When the man was transferred to Parc, his family received a telephone call from a member of staff at Usk who explained that this was for "specialist" treatment. When my FLO visited the man's sister at her home, she told my

FLO that she assumed the treatment was for his ongoing arthritis. The man's sister then telephoned Parc and discovered that he was being admitted to hospital. As I mention above, she was also told that the man looked as if he had been neglected at Usk, given his condition on arrival.

71. When the man's family visited him at the local Hospital, they learnt the full extent of his poor health. The man's sister raised the issue of keeping families informed when prisoners' healthcare needs change or they move between establishments or to outside environments. In a discussion with my FLO, The man's family questioned why, if staff at Usk knew his condition was serious enough for specialist care, they were not told about this sooner.

72. Prisons are under no obligation to contact families prior to transferring them to another establishment. I addressed this issue in another recent investigation report, where a man was moved to prison and then hospital without his family's knowledge. I commented that, whilst there is no expectation in local policy and procedure, it is good practice to inform families where a prisoner is not physically able to make contact himself. It is of course right and proper for the onus to be on prisoners to tell their families where they are, and it cannot be taken for granted that every prisoner would wish his or her family to know their movements or the condition of their health. I am pleased to see that a member of the healthcare team at Usk did contact the man's family when he was about to be transferred. I am also reassured that Parc's chaplaincy team maintained contact with the man's family once he was admitted to hospital.

Risk assessment and use of restraints

73. The man was known to staff at Usk, having been there since April 2003. He was not known by staff at Parc. On 12 February 2007, he was transferred from Usk to Parc in a taxi, accompanied by two escorting officers. The man was not placed in restraints. When he arrived at Parc, he was admitted as an inpatient and, within a few hours, was transferred to hospital. For this transfer, the man was escorted by two PCOs and was attached to one officer using an escort chain.

74. When the man transferred to the local Hospital, he was assessed as presenting a medium risk to the public and a standard level of security and restraint was authorised. A medical opinion was sought as to the use of restraints and the man's risk of escape. Section 2 of the risk assessment, entitled 'Medical assessment', was completed by a nurse. The nurse confirmed that there were no medical objections to restraints being used, but that the man's use of a wheelchair could provide him the ability to escape unaided.

75. Shortly after his arrival, the man underwent an x-ray procedure but it is not clear whether restraints were removed and, if so, how authorisation for their removal was sought. In yet another recent report, I commented on an arrangement used by another prison and its local hospital where officers are issued with a protective apron and prisoners remain attached to one officer during x-rays. The apron protects officers against radiation. I am not aware

of similar arrangements at the Hospital. If they do indeed exist, I would expect to see this recorded appropriately by the PCOs on duty. In the absence of further information, it remains highly improbable that the man was attached to a PCO during the x-ray. This would have increased the risk of harm to the officer. That said, escorting officers have a duty to record any changes in the level of security and restraints for hospital procedures. I make the following recommendation:

The Director should remind bedwatch officers of the importance of recording the temporary removal and re-application of restraints in the appropriate prison documentation.

76. Less than 24 hours after the man was admitted to hospital, his risk assessment was reviewed and reduced due to his declining health. Following the reduction in the man's security level, one officer sat with him for the remainder of his time and his restraints were permanently removed. The man's family said that they found the officers on bedwatch duty to have been compassionate and sensitive as they could be given the circumstances. The man' sister found this comforting. (The Director may wish to share those sentiments with the relevant staff.) His family were also appreciative of the Director's timely decision to remove the man's restraints shortly after his arrival at the hospital. I am pleased to report that Parc balanced the man's security risk with his deteriorating health very well. This ensured that his last few days in hospital were managed as benevolently as possible.

Conclusion

77. The man had the most severe form of rheumatoid arthritis, which was associated with an increased risk of mortality. He seemed to be a reluctant patient who was stoical about his condition and gave the appearance of coping. Although it is questionable whether he should have transferred directly to hospital rather than to Parc when his condition deteriorated, it is unlikely that his death would have been prevented. The investigation has found that, once diagnosed, the man's treatment was appropriate. However, the clinical reviewer has made several recommendations which I endorse. In addition, I have made a recommendation about documenting of the use of restraints.

RECOMMENDATIONS

To the Primary Care Trust

1. **Healthcare staff must ensure that, when a new prisoner arrives and has ongoing healthcare needs, the prisoner's GP is contacted at the earliest opportunity in order to obtain a full past medical history.**

2. **Healthscreens must be completed on admission to prison, on transfer between prisons and on admission to healthcare, to determine prisoners' immediate healthcare needs and to note any deterioration in health, in order for appropriate treatment and care to be given in a timely manner.**

3. **The Head of Healthcare at Usk should review how social care is provided to prisoners who clearly demonstrate an inability to carry out basic care needs such as washing and dressing for themselves.**

4. **The Head of Healthcare at Usk should ensure that regular assessments are completed for all prisoners diagnosed with chronic and disabling diseases.**

5. **The Head of Healthcare should ensure that, if a medication is not administered as prescribed, then a reason and explanation is given. Healthcare staff must ensure that they adhere to standards of record keeping as outlined by the General Medical Council and the Nursing and Midwifery Council.**

The Director at HMP Parc

6. **The Director should remind bedwatch officers of the importance of recording the temporary removal and re-application of restraints in the appropriate prison documentation.**

   The recommendation was accepted. In reply, the Office for National Commissioning said:

   The Director will ensure that all officers who perform bedwatch escorts and duties will be reminded of the requirement to record actions appropriately. A Director's notice to this effect was issued on 7 July 2008.