Investigation into the circumstances surrounding the death of a man whilst in the custody of HMP & YOI Parc

Report by the Prisons and Probation Ombudsman for England and Wales

March 2011

This is the final report of an investigation into the death of a prisoner at HMP & YOI Parc, who died on 2 December 2009 in hospital. The man was 63 years old. He had been admitted to hospital on 12 November, and was diagnosed shortly afterwards with widespread cancer. The man remained in hospital until his death on 2 December.

I would like to add my personal condolences to those already expressed to the man's family on behalf of this office by one of the Ombudsman's Family Liaison Officers.

The investigation was undertaken by one of my investigators. I am grateful for the assistance they received from staff at HMP & YOI Parc and would ask the Director to pass on those sentiments. I would also like to thank the Prison Health Care Policy Co-ordinator for the Scottish Prison Service for his assistance. A member of staff from Healthcare Inspectorate Wales (HIW) was asked to undertake a review of the man's clinical care and I also appreciate her assistance. I must apologise for the delay in issuing this report which was caused by the late receipt of the clinical review.

The clinical review carried out by HIW concludes that the man's clinical care was not comparable to that expected in the community. I have noted the issues highlighted by the clinical reviewer and I endorse the eight recommendations in the clinical review. The recommendations concern the referral of prisoners to secondary care and a review of the healthcare systems at Parc.

I make no separate recommendations of my own.

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

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and detainees involved in my investigation.

Thea Walton
Deputy Prisons and Probation Ombudsman **March 2011**

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SUMMARY

The man was born in 1946 and was 63 years old when he died on 2 December 2009 at a hospital in South Wales. The man died of natural causes as a consequence of widespread cancer.

On 23 February 2007 at Crown Court, the man was sentenced to an indeterminate prison sentence for public protection (IPP) and was given a tariff of 30 months. He arrived at HMP Swansea on the same day. The man transferred to HMP & YOI Parc on the following day, 24 February.

During the man's first reception health screening interviews, it was recorded that he was asthmatic and had a past history of emphysema. It was also recorded that he had previously had a history of alcohol and drugs dependence.

The man transferred from Parc to HMP Aberdeen on 18 February 2009, to answer charges against him in Scotland. Only quite basic records exist of the man's time in Scotland. I am also unable to comment on the man's treatment whilst he was in custody in Scotland as this is outside my remit as Ombudsman for England and Wales. The man returned to Parc on 8 July.

On 12 November, after he was seen by a prison doctor, the man was taken to the Accident and Emergency (A&E) department at a local hospital. He was admitted to the hospital later that same day. On 17 November, the man was told by a hospital consultant that he had a tumour on his lung which had spread to his liver, ribs and bones.

Whilst the man was in hospital, his health continued to deteriorate. The initial risk assessment was that restraints were to be used and two officers should remain on duty at his bedside ('bedwatch'). The risk assessment was later revised, on 18 November, and restraints were removed and not re-applied.

The man died at 3.15am in his sleep on 2 December. One of his sisters was at his bedside.

After the man died, the prison activated its death in custody contingency plan. The police visited the hospital and found no suspicious circumstances. The man's body was therefore released to the undertakers. The coroner's officer told the Head of Safer Custody and Violence Reduction at Parc, who was managing the prison's response following the man's death, that he had died from natural causes.

The clinical review carried out by a member of staff from Healthcare Inspectorate Wales (HIW) considered the care provided for the man. In the clinical reviewer's view, the quality of care given to the man was not equivalent to that he would have received in the community. The reviewer makes eight recommendations for service improvement. I understand that the prison health partnership is considering the findings from the review and is developing an action plan to address them.

I make no additional recommendations of my own.

THE INVESTIGATION PROCESS

1. The investigation was opened on 2 December 2009 by one of the Ombudsman's investigators. He issued notices announcing the investigation to staff and to prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known. In the event no one came forward.

2. The investigator studied all the relevant prison records relating to the man. They included his main prison record and his medical records.

3. The Healthcare Inspectorate Wales (HIW) commissioned a member of their staff to carry out a review of the man's clinical care. I am grateful to the clinical reviewer for undertaking such a thorough review which was received on 6 October 2010.

4. The investigator visited HMP & YOI Parc on 26 January 2010. He discussed aspects of the man's treatment with staff and met with the Director of Parc, a member of the Independent Monitoring Board and the Deputy Controller. The investigator returned to Parc on 15 and 16 March. He carried out joint interviews with the clinical reviewer and they interviewed two nurses. The investigator also interviewed the man's personal officer and the manager of the houseblock where the man was housed.

5. The investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion, this report will be sent to the Coroner to assist in enquiries into the man's death. The investigator also contacted the Scottish Prison Service who supplied a copy of the man's medical records.

6. One of the Ombudsman's Family Liaison Officers contacted the man's family. They were able to discuss the purpose of the investigation and raise any concerns or questions that they wanted to be addressed. The family were concerned about the medical care the man received whilst he was in custody. They spoke very positively about the help and support they received from prison staff. The family will have the opportunity to receive my report and comment on the findings. I hope my report helps them better understand the events leading to the man's death.

HMP & YOI PARC

7. Parc is a category B local prison and Young Offender Institution (YOI) which opened in 1997 on the outskirts of Bridgend, South Wales. It is operated by Group 4 Securicor (G4S Justice Services) on behalf of the National Offender Management Service (NOMS). It is the only privately run prison in Wales. The prison holds up to 1,126 sentenced male adults and sentenced and remand young offenders. In addition, the prison also holds young people (those under 18 years of age.)

8. There are four houseblocks (A, B, C and D) and all cells are equipped with in-cell sanitation. All wings are equipped with showers, laundry facilities and large association area. Plans are well advanced for the construction of a new 332 cell wing on the east side of the prison.

9. Healthcare for Parc is contracted out to Primecare Forensic Medical Services Ltd, who employ three doctors and 25 nurses. The healthcare centre has 24-hour primary care and 13 in-patient beds. All prisoners needing to see a doctor following admission are able to do so within 24 hours. In addition to this all prisoners are seen by a nurse on admission to the prison and prior to their transfer to their houseblock. This is to identify medical problems at the earliest possible opportunity.

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

11. The risk assessment will consider the following:

    i. The prisoner's medical condition. When there is doubt, the prison's medical officer will be asked to advice on any medical objections to the use of restraints.
    ii. Behaviour in prison.
    iii. Home circumstances.
    iv. The nature of the offence, the risk to the public and hospital staff, including the risk of hostage taking.
    v. The prisoner's motivation to escape, likelihood of outside assistance and their conduct whilst in custody.
    vi. The physical security of the hospital.
    vii. Assessment of visits restrictions.

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

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

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

13. The investigator reviewed the Ombudsman's reports into earlier deaths from natural causes at Parc. He found that the quality of the information recorded in healthcare records has been raised in previous reports into deaths at Parc.

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Multi-Agency Public Protection Arrangements

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

15. There are three levels of MAPPA:

    - Level three - Anyone subject to level three is considered as being the highest risk case, where more than one agency will take responsibility for the management of the person concerned.
    - Level two - As with level three, anyone who has been identified as falling into the level two heading would be managed by more than one agency, very often limited to probation and the police. However, it is possible to involve more agencies if the circumstances warrant it.
    - Level one - An offender on level one MAPPA is normally managed by a single agency. This is the lowest monitoring procedure available under the MAPPA system.

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

Performance Rating

16. Prisons in England and Wales are assessed for performance by NOMS who use a Prison Rating System which assesses prisons by looking at performance in 34 indicators. Each establishment is then given a rating between one and

four (one being “serious concerns” and four “exceptional performance”). For the last three quarters, HMP & YOI Parc has been given a rating of three (or “good performance”).

Independent Monitoring Board Report

17. Each prison has an Independent Monitoring Board (IMB). IMB members are independent and unpaid. They monitor day-to-day life in their prison and ensure that proper standards of care and decency are maintained. The most recent annual report published by the IMB at Parc covers the period from March 2008 to February 2009.

18. The IMB report said:

> “During the current reporting period, HMP & YOI Parc has again made conspicuous ongoing efforts to ensure that all prisoners felt safe and were treated humanely, with dignity and fairness by all those charged with their care”.

19. Additionally the report said:

> “The Healthcare team have continued to provide excellent treatment and support to prisoners suffering from terminal illnesses, and such prisoners have been treated in a caring and appropriate manner during their final days”.

Her Majesty’s Chief Inspector of Prisons

20. The former HM Chief Inspector of Prisons, Dame Anne Owers, completed an inspection of Parc in July 2008. (There has been another inspection at Parc since the man’s death, but the report of that inspection has not yet been published.) She commented that:

> “The previous inspection also found that relationships between staff and prisoners were poor, and that work on race relations was underdeveloped, in spite of a very critical report by the Commission for Race Equality. While both these areas had had considerable management attention and had improved somewhat, neither was yet good. Staff were affable with prisoners, but lacked the training or confidence to engage positively with them and to challenge inappropriate behaviour.”

KEY EVENTS

21. The man was born in 1946 in South Wales. After he left school, the man joined the Royal Navy and achieved the rank of radio/electronic engineer. He received an honourable discharge from the navy at the age of 27 and went to live abroad. The man remained there for eight years and was employed as a radio communication engineer. He returned to Wales in 1979 and was then employed as an electrical engineer until his use of illicit drugs made it difficult for him to find employment.

22. Prior to his arrival in custody, the man was in receipt of state benefits as he was unable to work due to ill health. He was also a voluntary helper with Narcotics Anonymous and Alcoholics Anonymous.

23. The man was remanded into custody at HMP Swansea on 23 February 2007 by a local Crown Court after being charged with sexual offences. He transferred to HMP & YOI Parc on the following day, 24 February. This was his first time in prison. On his arrival at Parc, it was decided that the man should be given vulnerable prisoner status because of his age, the nature of his offence and the publicity surrounding his case. This meant that he was not located within the general population of the prison.

24. During the man's first reception health screening interviews, it was recorded that he had a history of emphysema (a long term progressive disease of the lung) and asthma (a respiratory disorder). It was also recorded that he had a history of alcohol and drugs dependence.

25. The man had reviews for his asthma and emphysema on 5 June 2007 and 4 November 2008 (his peak flow, a test which measures obstruction in the airways, was recorded as 400l/min and 300l/m which was quite low). There is no record any further review taking place. Additionally, there is no record of smoking cessation advice being given despite the fact that it had been recorded that the man had smoked 20 cigarettes a day for over 40 years.

26. The man was sentenced to an indeterminate sentence prison sentence for public protection (IPP) and was give a tariff of 30 months. An indeterminate sentence is a life sentence, where a minimum tariff is given, but the prisoner must satisfy the Parole Board that he is fit for release and does not pose any threat to the community. A prisoner's risk factors are identified by psychological assessments and they are required to complete prison courses that might help to reduce their risk and improve their chances of being considered for parole.

27. The man was categorised as a category B prisoner. All adult male prisoners are classified on reception into prison and put into one of four security categories based on the likelihood of escape and the risk to the public if they did escape. The categories are: Category A: prisoners who would be highly dangerous to the public, police or national security if they were to escape. Category B: prisoners for whom the highest security conditions are not necessary, but for whom escape needs to be made very difficult. Category C:

prisoners who cannot be trusted in open conditions but who are unlikely to make a determined escape attempt; and Category D: open conditions, prisoners who can be trusted not to try and escape.

28. On 23 January 2009, the Cross Border Transfer Section, part of the Offender Safety, Rights & Responsibilities Group of the Ministry of Justice, wrote to Parc about a warrant to transfer the man to Scotland so that he could appear at the Aberdeen Sheriff's Court.

29. The man transferred from Parc to HMP Aberdeen on 19 February 2009. A nursing assessment was undertaken when he arrived in Scotland. The assessment recorded the man's previous health issues but in addition that his big toe needed dressing. On 6 March, the man was seen by healthcare staff as he was complaining of low mood, poor appetite and lack of sleep. A diagnosis of depression was considered and an anti-depressant, citalopram, was prescribed. Three days later, on 9 March, the man had a bout of diarrhoea. He was thirsty and passing a lot of urine. The man was checked for diabetes and he was found to be clear.

30. Just under three weeks later, on 25 March, the man still felt physically unwell. He was seen by a prison doctor who conducted blood tests. The result of the tests showed that the man was mildly anaemic (his haemoglobin level was recorded as 126, when the normal range is 140-180). The blood tests were repeated and further discussed on 6 May, and he was again found to be suffering from mild anaemia. It was decided to opt for treatment for high cholesterol and a cholesterol lowering medication, Simvastatin, was prescribed.

31. On 18 March, the man appeared in court in Aberdeen. Just over two months later, on 20 May, the Procurator Fiscal Office wrote to HMP Aberdeen to inform them that Crown Counsel had instructed that the man was now allowed to move back to Wales. On 13 June, the man was offered nicotine replacement to assist him to stop smoking. He chose not to take up this offer and continued to smoke.

32. The man returned to Parc on 8 July (after leaving Aberdeen in late June). There is only very basic clinical information for the time the man spent in Scotland. The man also alleged that he was assaulted whilst he was in custody at Aberdeen for which there is no record. The transfer-in checklist, completed on 8 July, recorded that he had an injury to his sternum. There was also no record of the alleged assault in the medical records received from the Scottish Prison Service. I am unable to comment on the man's treatment whilst he was in Scotland due to the limited records of his time there and as this is outside my remit as Ombudsman for England and Wales.

33. On 30 July, the man saw the prison doctor and he again referred to being assaulted whilst in Aberdeen. He complained of increasing and on-going pain in his lower chest. The doctor found the man to be tender over the lower part of the sternum and requested a chest x-ray. This was undertaken on 11 August.

34. The man saw the prison doctor three days later, on 14 August, as he was complaining of pain from his chest injury. The doctor recorded that the man was experiencing continuing pain in his ribs which worsened when he coughed. The doctor saw him again four days later, on 18 August, and increased his pain relief medication.

35. On 19 August, the man became an enhanced prisoner. The Incentives and Earned Privileged Scheme (IEPS) is a scheme that is designed to encourage and reward good behaviour in prisons. There are three tiers – Basic, Standard and Enhanced. Incentives include access to in-cell televisions, more private cash to spend, being allowed to wear personal clothes, more time out of cell and community visits.

36. On 25 August, the man's personal officer (each prisoner is allocated a personal officer, who is the first point of contact for them), wrote in his record:

> "The man is set to start RSTOP (Rolling Sexual Treatment Offender Programme) next month and has a cell move to the RSTOP cells in preparation. After speaking to the man it has become apparent that there has been a dramatic change in behaviour and attitude, much more optimistic and approachable."

37. The man saw the prison doctor on 28 August who recorded symptoms of a chest infection and a perianal abscess (a shallow collection of pus under the skin surrounding the anus). The doctor also felt that there were signs of reduced air entry into the man's lungs. A chest x-ray was requested and a strong anti-biotic, co-amoxiclav, was prescribed. The results of the x-ray were received on 1 September and stated: "cardiac and media stinal contours normal. The lungs are clear". (The mediastinum is the part of the chest that lies between the sternum and the spinal column, and between the lungs. It contains the oesophagus, trachea, heart, and other important structures.) The man went to the medication hatch on the same day and complained that he did not feel well. He requested to be let off work for that day (the man was employed in the circuit board and car parts assembly workshop).

38. Four days later, on 5 September, the man was seen by healthcare staff on the houseblock as he was having chest pain. He was seen by the prison doctor on the following day. The doctor noted the normal chest x-ray and advised the man to continue with taking his asthma medication.

39. The Parole Board concluded on 11 September that the man's risk of offending remained too high for a direction for release or a recommendation for his transfer to an open prison. In their letter to him they wrote:

> "This is the man's first Parole Board review. He has no previous convictions and been well behaved in prison. He is willing to engage in work to reduce his risk of sexual re-offending. However he has so far not had the opportunity. His offences were very serious … He still minimises the seriousness of his offences and his responsibility. Further sexual offences were investigated in Scotland. In order to

> reduce his risk the man needs to accept greater responsibility for his offending, gain insight into contributory factors and develop robust relapse preventions strategies. In the absence of any SOTP [Sexual Offenders Treatment Programme) work completed it is clear that the man's risk to children has not reduced sufficiently for him to be released or transferred to open conditions."

40. Just over a week later, on 19 September, the man was seen by the prison doctor after complaining of chest pains. The doctor noted that the man still had a cough. A further review was undertaken by the doctor three days later, on 22 September, and it was recorded that the man's chest sounded clear.

41. On 21 September, the personal officer wrote: "the man is now on a healthcare mission feeling he is being discriminated against as he cannot get an appointment". The personal officer confirmed when interviewed by the investigator that she felt this statement was an accurate reflection of the man's feelings at the time.

42. The man complained to healthcare staff on 5 October that he had not seen a doctor for his "muscular chest pain". He saw a prison doctor on the following day who recorded that a referral to a chest physician should be made (the letter to the chest physician was not sent as it was mislaid). The man was also weighed on 6 October, and his weight recorded as 76.8kg; his weight had been recorded as 88kg seven months earlier, in February 2009. The man was prescribed stronger pain relief medication, tramadol, on the following day.

43. On 18 October, the man complained of chest pain to healthcare staff and an appointment was made for him to see the prison doctor. The man was unable to attend the appointment, on 22 October, as he was in a meeting. Another appointment was made for the following day, 23 October. The man missed this appointment because there were no staff available to escort him to healthcare. When he did arrive at healthcare the prison doctor left saying that his clinic had ended.

44. In his letter of complaint dated 23 October, the man states: "I have lost 13kg in weight. I'm not sleeping or eating – I need direct care as soon as possible". The response he received on 27 October did not answer his complaint or address his clear concerns about the level of care he was receiving.

45. The man was reviewed by the prison doctor on 24 October. It was recorded that his chest was clear and that both his blood pressure and pulse were normal. An electrocardiogram (ECG, a graphical recording of the electrical activity of the heart) was requested to rule out angina. Three days later, on 27 October, blood tests were carried out which showed a significantly raised level of alkaline phosphate. (This can be found when liver disease, metabolic bone disease and/or tumours are present.)

46. The results of the blood tests were received by the prison doctor on 4 November, and a physical examination was arranged for the following day. No abnormalities were found but the man's weight had fallen again and was

recorded as being 74kgs. Following the consultation the prison doctor submitted a request for an ultrasound. Two days later, on 7 November, a Saturday, healthcare staff were asked to see the man by staff on the houseblock. They were concerned about the man's deteriorating health and his weight loss. It was recorded that the man was very unhappy about the medical care he had received.

47. On 8 November, the personal officer wrote:

> "Since returning from a week of training the man appears to have deteriorated rapidly with his health. The man has lost weight and appears frail and weak and a little shaky – concerns have been passed to healthcare."

48. On the following day, 9 November, an appointment was made for the man to see the prison doctor on 10 November. The record of the review stated that the man's pulse was raised but that examination of his cardiovascular system, chest and abdomen were unrevealing. A probable malignancy (cancer) was noted. The man's weight was recorded as 71kgs. A letter was sent to the local hospital on 11 November requesting that the man's appointment be brought forward.

49. On 12 November, a prison doctor saw the man and decided that he should go to hospital. The man was taken to the Accident and Emergency (A&E) department at the local hospital. After he was assessed the man was admitted to the hospital.

50. Five days later, on 17 November, the man was told by a hospital consultant that he had a tumour on his lung which had spread to his liver, ribs and bones. The following day, the Delta Wing House Block Manager sent an e-mail to the Offender Management Administration Manager. The Block Manager wrote:

> "The man is a Delta Block prisoner who was admitted to hospital last week, yesterday afternoon he was diagnosed with terminal cancer, would you be able to look into compassionate parole for him on the grounds he has been informed that there is no cure for him and the hospital will only be looking at palliative care."

51. Whilst the man was in hospital his health continued to deteriorate. The initial risk assessment was that restraints (an escort chain – a set of handcuffs linked by a chain) were to be used and two officers should remain on duty at his bedside ('bedwatch'). This was later revised on 18 November and restraints were removed and not re-applied.

52. The prison doctor visited the man in hospital on 20 November. After being informed that the man's life expectancy was between three and six months, the prison doctor made a request for early release from prison. Later that same day, the prison doctor revised his decision saying that the man appeared to improve physically and therefore could be a risk so the probability of early release should not be pursued. (However, the hospital had informed Parc on

same day that the man's pain relief had been increased and that a liver biopsy was being considered.) Three days later, on 23 November, the hospital wrote to Parc confirming that a Computerised Tomography (CT) scan had shown that the man had: "liver/pulmonary/bony metastases (cancer throughout his body) with no clear primary".

53. On 28 November, the man's condition deteriorated further and it was recorded that he had pneumonia complicated by pulmonary oedema (a condition in which fluid collects in the lung). He was transferred to the palliative care unit.

54. A log of activities was maintained by the officers on bedwatch duty and this was checked on a regular basis by a visiting duty governor. According to the bedwatch log, the man passed away at 3.15am and one of his sisters was at his bedside.

55. Prisoners were informed about the man's death when they were unlocked the following morning. They were also asked whether they required anything or wanted to speak to a Listener. (Listeners are prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners in distress.) All prisoners who were thought to be at risk of suicide or self-harm were reviewed.

56. A chaplain was appointed as Parc's family liaison officer before the man passed away. On 3 December, the chaplain, the Director of Parc and the Block Manager met with the man's sisters at the prison. At the meeting it was agreed that Parc would cover the costs and make all the necessary arrangements for the man's funeral. The man's funeral took place on 16 December 2009 and the service was conducted by the chaplain.

ISSUES CONSIDERED

57. As noted, a review of the man's medical care was undertaken by a member staff from Healthcare Inspectorate Wales.

58. The review found that the man had received appropriate health assessments when he arrived in custody and when he moved locations. Although he had access to various healthcare professionals including podiatrists, opticians and physiotherapists, there were a number of areas where, according to the clinical reviewer, the care provided to the man was "questionable".

59. According to the man's medical record there was evidence of only two occasions when his respiratory condition was formally assessed and then only peak flow (a test which measures obstruction in the airways) was recorded. The first evidence of the man being offered help with smoking cessation was when he moved to Aberdeen nearly two years after he arrived in custody.

60. There is little evidence of the man's chronic conditions being regularly assessed and proactively managed. The Quality and Outcomes Framework used by general practitioners requires more regular assessments and a formal spirometry (the measuring of breath) to be recorded.

61. Whilst the man was in custody in Scotland, he was diagnosed with mild anaemia, although blood tests did not identify any other abnormalities. Symptoms of his final illness did not become apparent until his return to Parc. The reviewer feels that the actions taken by the prison doctor in July 2009 were reasonable as the symptoms were consistent with an injury sustained in an assault (as the man had alleged). The ordering of a precautionary x-ray was an appropriate response. However, the man's symptoms continued for a further two months and staff appeared to be reassured by the x-rays taken in August 2009. They seemed to attribute the symptoms to the alleged assault and no repeat x-rays were ordered.

62. By early October, the man had lost a substantial amount of weight and this should have alerted healthcare staff. However, according to the clinical reviewer there were "a number of errors and shortcomings that delayed the man receiving appropriate and timely care". These included:

    - When the man returned to Parc, there was no follow-up in relation to his anaemia and the results of his blood tests.

    - The letter prepared on 6 October for a referral to a chest physician was never sent as it was mislaid.

    - The delay of six days between the man asking to see a doctor on 18 October and him being seen. During this time two opportunities for review by the prison doctor were missed (on 22 October as the man was in a meeting and on 23 October as there were no staff initially able to escort him to healthcare). When the man did eventually arrive at healthcare on 23 October, the prison doctor left without seeing him, saying that his clinic

had ended. Given the concerns in relation to the man's condition, that cannot be considered as acceptable.

- According to the clinical reviewer, the man's complaint of 23 October about the prison doctor leaving without seeing him was not handled well. In his complaint, the man said: "I have lost 13kg of weight. I'm not sleeping or eating – I need direct care as soon as possible". If his concerns had been properly considered, shortfalls in his care may have been highlighted sooner.

- Blood samples taken on 27 October proved to be very abnormal and should have raised concerns in relation to liver disease. The results of the tests were received by the prison doctor on 4 November and a physical examination was arranged for the next day. The reviewer felt that this added an unnecessary delay. Referral letters were also sent for an urgent ultrasound and for an urgent consultant appointment.

- A further letter was sent on 11 November requesting that the man's appointment be brought forward. The reviewer was concerned that the prison doctor did not use a fast track referral process as the man's symptoms justified this approach being taken.

- On 12 November, despite the man being unwell, not eating and being tremulous with a waxy appearance, his appointment with the prison doctor was cancelled due to staffing issued on the houseblock. This was not acceptable given how unwell the man was.

- The man was admitted to hospital on 12 November via the A& E Department. The reviewer felt that it was unacceptable that someone as unwell as the man had to go through the distress of admission via A&E. In the community, GPs refer patients directly onto a particular ward or Medical Assessment Unit. It is unclear why the man was not admitted to hospital earlier for investigations, particularly when the results of his blood tests were know by the prison doctor on 4 November.

63. The late diagnosis of the man's advancing cancer afforded little opportunity for him to consider information about his illness and care options. It would appear that instead the man was left worried because he felt that his concerns and symptoms were not being addressed properly in a timely way. If the referral letter to a chest physician, which was supposedly drafted on 6 October, had been sent and properly directed, the man's illness might have been diagnosed around the middle of October. This would have been a month earlier that his actual diagnosis. The reviewer states that as the man had an aggressive cancer the outcome would not have changed. However, his care could have been more appropriate and his symptoms could have been better managed.

64. There was little evidence of care pathways and well thought out pain management arrangements for the man. The reviewer felt that Parc was, in the main, reactive with very little evidence of a proactive approach being in place. Neither the investigator nor the reviewer could find evidence of a pain

assessment tool being used. The reviewer felt that the man's discomfort could have been better monitored and managed.

65. During the period from July to November 2009, the man was noted to have lost a significant amount of weight (his weight decreased from 88kgs in February to 71kgs in November). However, at no time were arrangements put in place to regularly monitor his weight. According to the reviewer, if the man's weight, along with his pain, had been properly monitored the seriousness of his condition might have been detected earlier.

66. The reviewer concludes that the man suffered from various health issues throughout his time in custody. Whilst he had access to various healthcare professionals (including podiatrists, opticians and physiotherapists), his care seemed to be reactive rather than proactive and the management of his chronic conditions was wanting. During the last months of the man's life there was clear evidence of declining health and symptoms of serious underlying problems. His loss of weight was significant and the level of pain he was experiencing must have been high. If appropriate arrangements had been put in place to monitor both of these issues the seriousness of his condition would have been highlighted earlier. When he complained about the care being provided to him, his complaint was not dealt with appropriately. His concerns were not properly investigated and he was not provided with a proper response.

67. While the outcome of the man's condition would not have been changed by an earlier diagnosis, the management of his care and pain would have been improved. The man could also have received counseling regarding his illness. It is the view of the reviewer that the man's care should have been discussed with secondary care colleagues at an earlier stage and he should have been admitted to hospital sooner.

68. The reviewer has made the following eight recommendations:

The Director of HMP & YOI Parc should further develop care pathways for the management of chronic conditions to ensure that care is provided in line with the Quality Outcomes Framework standards used by General Practitioners across Wales.

The Director of HMP & YOI Parc in liaison with the Health Board should develop appropriate referral pathways to ensure timely access to specialist services and second opinions. This should include the development of 'fast track' referral processes for those prisoners with suspected cancer/ terminal illness.

The Director of HMP &YOI Parc should put in place mechanisms for the timely follow-up and tracking of referrals to secondary care and specialist services should also be put in place.

The Director of HMP & YOI Parc should work with the Health Board to develop appropriate mechanisms for emergency admissions of prisoners

with deteriorating health into secondary care, negating the need for admission via Accident and Emergency Departments.

The Director of HMP & YOI Parc should ensure that care plans are put in place for those prisoners with long term health problems to ensure that 'holistic' care is provided. These plans should include tools for the monitoring of weight loss, pain and nutrition.

The Director of HMP & YOI Parc should put in place a mechanism for flagging those prisoners with serious and deteriorating health, so that priority is given to their attendance at clinics and healthcare related appointments.

The Director of HMP & YOI Parc should introduce multi-disciplinary meetings at which the care and treatment of those patients with on-going and serious health issues can be discussed and planned; where appropriate these should include members of the secondary care team. These should be supported by a unified health record.

The Director of HMP & YOI Parc should ensure that mechanisms are put in place for the independent investigation of complaints made in relation to healthcare. Appropriate quality assurance procedures should be put in place to ensure complaints are appropriately dealt with.

69. While the reviewer refrained from making a recommendation in relation to the quality of healthcare records it should be noted that those seen were often illegible, unsigned and brief. As mentioned earlier this issue has been raised in previous reports.

Use of restraints

70. I am pleased to report that the risk assessment for the man was regularly reviewed and revised during his time outside Parc. When the man was taken to hospital on 12 November 2009, the security risk assessment was that restraints should be used and two officers needed to be in attendance. The use of an escort chain (a set of handcuffs linked by a chain) enabled the nursing staff to have easy access to the man when they carried out their duties. The investigator found that restraints were removed when the man's condition deteriorated and he was then simply accompanied by two officers.

71. The investigator found that the bedwatch notes were concise with legible and appropriate entries. At interview, prison staff spoke perceptively and compassionately about their relationship with the man. This speaks well of the care offered to him during his time in custody and is a credit to the staff at Parc. The Director may wish to share my view with managers and staff.

CONCLUSION

72. The man returned to HMP & YOI Parc on 8 July 2009. Just over four months later, on 12 November, he was referred to hospital after experiencing significant weight loss. After being admitted to hospital he was later diagnosed with wide spread cancer. The man passed away in the early hours of 2 December.

73. From the bedwatch log, it was clear to my investigator that the staff involved in the man's care behaved with compassion and sensitivity. The security arrangements at the hospital were also in line with current policy and expectations.

74. In light of the findings of my investigation and the clinical review, I conclude that the care provided to the man was not appropriate. In the clinical reviewer's opinion action should have been taken earlier to identify the source of the man's illness. Systems did not appear to be in place to monitor the man's weight loss and pain management. Opportunities were also missed in relation to an earlier diagnosis of the man's terminal condition. The clinical reviewer has made eight recommendations concerning the shortcomings in relation to the care provided to the man which I endorse.

75. In response to the draft report the family said that the man was clearly in a lot of pain and was begging for help and pain relief to address his deteriorating health which was ignored. They thought blood tests could and should have been done earlier; this would have resulted in him receiving a diagnosis and pain relief sooner. It would also have allowed his family them to visit him when he was still able to talk to visitors and they could then have provided him some much needed comfort. The family also felt the man could have accessed counselling given more time to do so (although they acknowledged that the support provided by chaplaincy staff was very good).

RECOMMENDATIONS

1. The Director of HMP & YOI Parc should further develop care pathways for the management of chronic conditions to ensure that care is provided in line with the Quality Outcomes Framework standards used by General Practitioners across Wales.

   Recommendation accepted - Arrangements are in place for meetings with local Nurse Practitioner to advise and facilitate the set up of a chronic disease pathway, in line with the QOF in Wales. This joined up working with our GPs will ensure that the service developed will adhere to all current guidance.

2. The Director of HMP & YOI Parc in liaison with the Health Board should develop appropriate referral pathways to ensure timely access to specialist services and second opinions. This should include the development of 'fast track' referral processes for those prisoners with suspected cancer/ terminal illness.

   Recommendation accepted - This is to be tabled in the next Partnership Board Meeting and support will be requested with the Local Health Board. Links to be made with local providers to discuss the possibility for a "fast track" system in suspected cases as described aside. Structure is already in place to ensure that once a referral is made, Healthcare remains in communication for the first appointment date and we would expect to receive this within two weeks.

3. The Director of HMP &YOI Parc should put in place mechanisms for the timely follow-up and tracking of referrals to secondary care and specialist services should also be put in place.

   Recommendation accepted - A new spreadsheet will be implemented which will illustrate an audit trail from referral to discharge from secondary care providers. This may then be tracked and reviewed in line with our in house quality procedures.

4. The Director of HMP & YOI Parc should work with the Health Board to develop appropriate mechanisms for emergency admissions of prisoners with deteriorating health into secondary care, negating the need for admission via Accident and Emergency Departments.

   Recommendation accepted - This will be tabled at the Partnership Board, to consider the possibilities and benefits of developing a route of admission that best avoids delays and provides continuity of care. The process will be reviewed and advice taken

5. The Director of HMP & YOI Parc should ensure that care plans should be put in place for those prisoners with long term health problems to ensure that 'holistic' care is provided. These plans should include tools for the monitoring of weight loss, pain and nutrition.

   Recommendation accepted - Initial and Secondary Screening templates to be revised and include further information in relation to long-term health problems,

disabilities etc. Currently meeting with other local providers to develop an Older Prisoners pathway. Development of an Older Persons Unit is also underway. Better links are being developed with other departments to ensure a holistic approach to the care of our patients, including Gym provision. Designated nurses for Disability, Older Persons are already in place. Care plan will be developed for every newly admitted prisoner. New Health Promotion Group to continue to develop the care pathways for all identified persons.

6. The Director of HMP & YOI Parc should put in place a mechanism for flagging those prisoners with serious and deteriorating health, so that priority is given to their attendance at clinics and healthcare related appointments.

   Recommendation accepted - The introduction of System 1 will ensure that all flags are made. Currently being installed and plans are that this will be operational soon. Development of additional clinical activity and "out reach services" to ensure that all those that find accessibility an issue have the opportunity to use our services. Areas are being identified and plans are in place to go live with clinical rooms on normal locations in the prison.

7. The Director of HMP & YOI Parc should introduce multi-disciplinary meetings at which the care and treatment of those patients with on-going and serious health issues can be discussed and planned; where appropriate these should include members of the secondary care team. These should be supported by a unified health record.

   Recommendation accepted - Weekly practice meetings will be reintroduced to allow and encourage good information sharing and care planning. Governance Meetings, including the wider Prison Management and LHB, will be recommenced from November 2010.

8. The Director of HMP & YOI Parc should ensure that mechanisms are put in place for the independent investigation of complaints made in relation to healthcare. Appropriate quality assurance procedures should be put in place to ensure complaints are appropriately dealt with.

   Recommendation accepted - A new policy for complaints is already in place that details the pathway for escalating a complaint. The outcomes and figures are monitored monthly and in are presented to our Clinical Performance Manager and Clinical Director in quarterly reviews.