Investigation into the circumstances surrounding the death of the man in January 2011 at hospital, while in the custody of HMP Cardiff

Report by the Prisons and Probation Ombudsman for England and Wales

March 2012

This is the report of an investigation into the death of a man at hospital, while in the custody of HMP Cardiff, in January 2011. He was 83 years of age. His cause of death was recorded by the coroner as bilateral pulmonary thrombo-emboli (blood clots in the lungs), hypertensive heart disease (heart disease caused by chronic high blood pressure) and pulmonary abscess (a collection of pus in the lung) following a spleenectomy (removal of the spleen).

I extend my condolences and those of my colleagues to those affected by the man's death. I would also like to apologise for the delay in publishing this report.

The investigation into the man's death was undertaken by one of my investigators. In addition, a clinical review was conducted by the local PCT. I am grateful to the Governor and staff of HMP Cardiff for their co-operation.

The man was an elderly man with complex health problems. He was a wheelchair user and was diagnosed with severe heart failure in August 2010, which in turn caused both liver and kidney failure. Due to the poor quality of discharge notes and entries in his prison medical record, staff were not aware of the severity of his condition. The clinical reviewer highlights a number of problems in the healthcare provided to him which should act as a trigger for a significant event review within the healthcare setting at HMP Cardiff.

Perhaps of even greater concern are the conditions in which the man spent his last few months. His offence and his disability posed inevitable problems for the prison in locating him. Nevertheless, he was kept in a shared cell in which he was unable to use the toilet. Insufficient reasonable adjustments were made for him and he had to use urine bottles at night, when he could not be given access to the disabled toilet on the wing. He also suffered periods of incontinence and confusion. This arrangement was demeaning for both him and his cellmate. Indeed, it is hard to accept that in the twenty-first century an elderly, disabled and seriously ill man such as he, should have been kept for long in conditions which many might regard as degrading.

The report makes a number of recommendations to improve healthcare and the treatment of vulnerable prisoners such as the man. These include ensuring compliance with The Disability Discrimination Act, occupational and physiotherapy assessments and improving the standard of entries into medical notes.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **March 2012**

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SUMMARY

1. The man was remanded into HMP Cardiff from Magistrates' Court on 26 March 2010 charged with serious offences. He was later sentenced to 2 years and 3 months on 14 June that year.

2. He had a complex medical history. He was a wheelchair user (after his right leg was amputated as a result of a blood clot), and had had his spleen removed. After arriving at Cardiff, he was accommodated in the healthcare centre. Under Cardiff's disability policy, a disability questionnaire, a reasonable adjustments log and a personal evacuation plan should have been completed for him because of his mobility issues. These were not completed.

3. Whilst in healthcare, the man shared a cell. Although his cell was big enough to enable him to manoeuvre in his wheelchair, he could not use his in-cell toilet. Instead, he had to use a disabled toilet on the wing during the day and a urine bottle at night when his cell door was locked.

4. In August 2010, the man was diagnosed with severe heart failure, resulting in liver and kidney failure. Discharge notes following hospital appointments and entries within his medical record were poor and, as a result, healthcare and prison staff were not aware of the severity of his condition.

5. As the man's health deteriorated he became incontinent of urine and faeces. However, although he was sharing a cell, no action was taken to provide him with the privacy or appropriate facilities he required at this time. This would have been degrading for both him and his roommate.

6. As a result of the deterioration of his condition, he became frequently confused and would often refuse to take his medication. Staff encouraged him to take his medication in the knowledge that his health would decline further if he continued to refuse to do so.

7. On 16 January 2011, the man complained that he felt unwell, and that someone was kicking him from inside his body. After he became breathless the next morning, he was taken by emergency ambulance to hospital. His condition steadily declined and he died a few days later.

8. We make seven recommendations as a result of this investigation. These include ensuring compliance with Cardiff's Diversity and Equality policy, assessing the suitability of sharing cells and improving the standard of entries into medical notes

THE INVESTIGATION PROCESS

9. The investigation was opened on 3 February 2011, when the investigator issued notices announcing the investigation to staff and prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to the investigator. No-one came forward.

10. During the opening visit, the investigator collected copies of the man's prison files, including his medical records. She visited the healthcare unit, viewed his cell, and introduced herself to the staff on the wing. She returned to Cardiff on 29 March and 1 July, to conduct interviews with six members of staff.

11. During the investigation the investigator liaised with the Governor, providing written feedback detailing her preliminary findings and highlighting issues that she would be investigating further.

12. An independent clinical review was undertaken by the local PCT. The review was received on 7 November. Because of the unavailability of the clinical reviewer and some staff members at Cardiff, some interviews proved difficult to arrange. There was also a delay in the production of the clinical review. This delay, in turn, led to the investigation report being delayed, for which we would like to apologise.

13. One of the Ombudsman's family liaison officers attempted to contact the man's next of kin shortly after his death. She sent a letter explaining the investigation process and offered them the opportunity to raise any concerns or questions they would like addressed as part of the investigation. The family raised no issues of concern at the outset of the investigation. They were also offered an opportunity to receive and comment on the draft version of the report, however, to date, have chosen not to do so. I hope that the findings of my investigation answer any questions they may have, should they receive the report in the future.

14. This report was forwarded to the coroner to assist in their enquiries.

HMP CARDIFF

15. HMP Cardiff is a local prison with a maximum population of 784 adult men. It is located very close to the city centre and was originally built in 1827. The prison receives most of its population from the courts of South East Wales. The prison healthcare has 24 hour nursing cover and 16 inpatient beds. Rule 45 prisoners (Rule 45 allows for the segregation of certain prisoners for the good order of the prison or for their own protection – it is usually used in the case of convicted sex offenders) on healthcare are unlocked at different times to "normal" prisoners on healthcare, and they are kept apart at all times.

HM Inspectorate of Prisons report

16. HM Chief Inspector of Prisons (HMCIP) completed an unannounced follow up inspection of Cardiff in June 2010. In the report of the inspection, it was noted that four prisoners using wheelchairs were located in the health care centre, as it was the only available accommodation that met their needs. (One of these would have been the man.) Inspectors recommended that there should be adapted accommodation available on normal location.

17. HMCIP also made a recommendation to say that a database should be maintained of all prisoners with disabilities, ensuring that care plans were raised and regularly reviewed for all such prisoners. Formal support arrangements for prisoners with disabilities should also be introduced and action points arising from disability focus groups should be followed up until completed. The Deputy Chief Inspector concluded in his foreword:

> "This is a generally positive report which demonstrates that Cardiff has sustained much of the progress that we identified on our last visit, although we identify a number of areas for further improvement.
>
> "The new healthcare centre is a much improved environment … At the time of inspection; there were nine prisoners on Rule 45 including four with disabilities who were located there only because they could not be located appropriately on residential wings".

Independent Monitoring Board Reports

18. Each prison in England and Wales has an Independent Monitoring Board responsible for monitoring day-to-day life in the prison and to ensure that proper standards of care and decency are maintained. In their annual report for September 2009 to August 2010, the Independent Monitoring Board (IMB) for Cardiff stated that:

> "The Board has recognised, and is concerned about an increase in the number of complaints made to the board relating to healthcare, and treatments. This has been discussed at Board level and the Senior Management team of HMP Cardiff have undertaken a review of healthcare provision at the Prison."

19. Since the Ombudsman started investigating deaths in custody in April 2004, there have been 21 deaths in custody at HMP Cardiff, 10 of which have been due to natural causes, including that of the man. There were three deaths at Cardiff in January 2011, and we refer to the findings of the other two investigations in the relevant parts of the issues section.

KEY EVENTS

20. The man was born in February 1927. He was remanded into HMP Cardiff from Magistrates' Court on 26 March 2010 charged with serious sexual offences. He was sentenced to two years and three months imprisonment on 16 June that year.

21. The man had a complex medical history. He had his spleen removed following an accident, and used penicillin as a result to help fight any possible infections. He suffered a pulmonary embolism (a blockage of the pulmonary artery) in 1994 and suffered a clot in his right leg in 2001, which resulted in him having his leg amputated. He took warfarin to thin his blood to help reduce the risk of further clots developing.

22. On arrival at HMP Cardiff on 26 March, a nurse noted during the reception health screen that they were unable to record his height and weight. He was a Rule 45 prisoner (and as a result was kept apart from the general prison population for his own safety) and had to be seen in a separate room away from the main reception area. Healthcare staff were concerned that, because he only had one leg, he might fall and injure himself if he tried to use the ordinary weighing scales they had in the prison. His weight was first recorded some nine months after he first arrived at Cardiff.

23. During the reception health screen, the nurse recorded that the man had a heart murmur, sinus problems and that he was a wheelchair user. She listed the medications he had been prescribed and referred him to see the doctor regarding his physical health. Despite this referral, a secondary reception health screen was not completed as required.

24. As a result of his disability and complex health needs, the man was allocated a cell in the healthcare centre. On 5 April, after making friends with another Rule 45 prisoner (in healthcare) of a similar age, he was relocated to a shared cell.

25. On arrival into prison, all new prisoners are asked to disclose if they have any form of disability. According to the disability policy in place at Cardiff at the time, a disability questionnaire should have been completed because the man was a wheelchair user, and had mobility issues. The chaplain, who was the former manager of the disability liaison officer (DLO), confirmed at interview that that the prison had a system whereby every new prisoner was screened on arrival. If anyone disclosed a disability on reception, the information would be passed to the DLO and any relevant department, such as resettlement. He also confirmed that, once a disability had been disclosed, the DLO had regular meetings with the prisoners on their list to assist with any disability related problems.

26. The chaplain explained that it was the responsibility of the senior officer (SO) on duty in reception to decide where the most appropriate accommodation would be for someone on arrival. The healthcare

manager said at interview that she thought it was the responsibility of the DLO to complete the questionnaire with disabled prisoners, whereas the chaplain thought that as the man was living in healthcare, they would have used their own policies and procedures and thus needed little input from the DLO. However, from reviewing his records and interviewing staff it does not appear that a disability questionnaire was completed and there was no communication to establish if one had been done.

27. PSO (Prison Service Order) 2855 'Prisoners with Disabilities' says that

> "All prisons will normally have in place contingency plans for dealing with fires that take account of persons with individual/special needs. The PEEP [Personal Emergency Evacuation Plan] should be drawn up for every prisoner who may need assistance in the event of an evacuation".

28. The position of the current Diversity Officer now includes the responsibilities formerly held by the DLO. He and the chaplain said that it would have been the responsibility of the healthcare manager to complete the man's PEEP. There is no evidence to show anyone from healthcare completed a PEEP for him.

29. On 28 March 2010, a healthcare assistant made a note in the man's medical record to say that he needed minimal assistance with his bath chair (a chair that sits in the bath/ shower providing someone with mobility problems postural support whilst ensuring the individual is safe and secure during bathing and hand rail (which is fixed to the wall to provide extra support), and he was eating well and interacting appropriately with staff. The same day, he complained that he was suffering from a rash. The healthcare assistant issued him with some calamine lotion and advised him to speak with the doctor at his appointment the following week. A further entry the following day states that he was occupying himself by writing poetry and had become friends with another prisoner on the wing. It was noted that he was largely looking after himself and did not present any concerns.

30. The man slipped in the toilet area of his cell on 30 March. It was noted on an injury report form that he did not have any injuries as a result of the fall. Despite this fall, there does not appear to have been any formal risk assessment completed to establish if any further action needed to be taken, or whether appropriate equipment should be added to prevent a further fall happening in the future.

31. The following day, the man attended a doctor's appointment. The doctor noted in his medical record that he suffered from high blood pressure and had been diagnosed with a heart murmur the previous year. The doctor also noted that he was complaining of a pain in his chest just under his left nipple, and that his heart murmur had now disappeared. As a result of this appointment, the prison doctor made a request that his community GP

records should be requested. Contact was made with the man's surgery and his records were received the following day.

32. On 5 April, an entry was made in the man's wing notes to say that he was in good spirits and that he had been moved to a shared cell with another prisoner. However, he raised concerns with a healthcare assistant that he was worried that he may fall in his cell while attempting to use the toilet. He explained that he found it difficult to transfer from his wheelchair to the toilet, not being able to use the riser (a raised toilet seat on legs used to improve the accessibility of toilets to older people or those with disabilities) located in healthcare as it was too wide to fit into the toilet space. As a result of this conversation he was given a portable emergency alarm to use in case he fell.

33. On 17 April, a note was made in his wing record to say that he was still unhappy with the toilet in his cell finding it difficult to transfer from his wheelchair. Even though he shared a cell, as a solution he was asked to use the disabled toilet on the main healthcare wing during the day and given urine bottles for use during the night.

34. The man was assessed by the prison doctor on 24 April, as he was still presenting with left sided chest pain. A note in his medical record says that he had a tender, swollen lump over his lower rib area. He mentioned the fall he had in his cell the previous month and it was thought that the injury might be related to this.

35. The man was next seen by the prison doctor on 28 April after he complained of two small lesions (a lesion is a skin abnormality) on both of his legs. The lesions were examined and a note was made in his records to say "two lesions on leg – superficial flaky growth – BCC [basal cell carcinoma (cancer)]?" The doctor referred him to a dermatologist the following week and an appointment was scheduled for 26 May.

36. On 12 May, the man presented to healthcare staff with further chest pain. He said that he had felt dizzy the previous day, had vomited and had loose bowels. The doctor examined him and found his blood pressure to be slightly raised, and his heart rate to be erratic, but not fast. It was also noted that his abdomen was soft and that he was slightly dehydrated. He was advised to drink plenty of fluids and prescribed antibiotics and domperidone (anti-sickness tablets).

37. The man attended an appointment with the dermatologist on 26 May. A letter summarising the consultation stated that he had psoriasis (a skin condition causing the person to have itchy and sometimes painful flaky skin) on his right leg and given cream to be used for the next six weeks. The lesion on his left leg was thought to be early basal cell carcinoma (a common form of skin cancer) or Bowen's disease (a skin disease that can turn into skin cancer). It was suggested that it was too early to tell if it was either condition, but that he would be reviewed in three months time when the dermatologist visited HMP Cardiff. There is no evidence

within his medical records to show if he was reviewed by the dermatologist or if a treatment regime was devised. During interview with the investigator, the doctor said that the dermatologists were an independent external service and made their own notes. They then follow up by writing a letter and sending it to the healthcare centre. She said that she had not seen a second follow-up letter and therefore could not say if he had been reviewed or not.

38. An entry was made in the man's wing notes on 31 May by a healthcare assistant. He was said to have declined his lunch and that a wing cleaner (a prisoner working in healthcare) had told them that they had noticed that he hadn't eaten much over the past few weeks. A further entry on 10 June, states that he declined lunch and evening meal. It was noted that he appeared to have lost weight. However, healthcare staff were unable to confirm this as the only weighing scales available to them were not suitable for wheelchair or disabled users. He commented that he had little appetite and that before he came into prison he did not eat much. It was noted that his mood was pleasant and he was chatty, although he mentioned that he was stressed about his upcoming sentencing and was dealing with the situation as best as he could.

39. On 29 June, a note was made to say that an officer was still trying to obtain a rail to enable the man to use his in-cell toilet, as this continued to be a problem for him. It is not clear from his prison or medical records why, despite him falling three months prior to this, this problem had not been resolved.

40. The man told healthcare staff on 7 July, that he had been feeling uncomfortable after eating his meals. A fasting blood test (a test to show blood sugar levels with the sugar from food affecting the results) was arranged the following day. He complained of further symptoms on 9 July, to say that he felt "flushed" after eating. He was examined by the doctor on 14 July. It was recorded in his medical record that he was obese, had some bloating and was anaemic (low levels of iron in the blood). She referred him to a gastroenterology department (gastroenterology is the study of the digestive system) at hospital. The referral letter stated that he:

> "had an episode of nausea and abdominal pain/loose bowels several weeks back. He was prescribed domperidone [a drug used to suppress nausea] for a while, but on stopping the nausea has returned with postprandial [frequent] retching."

41. On 21 July, the man saw the doctor, where she informed him that the blood test taken on 8 July had returned as abnormal. She recorded in his medical record that she noticed that he was also short of breath and complained of abdominal pain. He was subsequently sent to hospital for further investigation.

42. After further tests, the man was discharged from hospital on 27 July, six days later. The discharge letter from the hospital stated that a scan of his abdomen had showed that he was suffering from gallstones, and that blood tests had highlighted that his liver function was slightly abnormal. As a result of the findings, a referral was made for the man to attend an outpatient's appointment at the Upper Gastroenterology department.

43. The man was seen by the prison doctor on 28 July. Although he was only discharged from hospital the previous day, there is no mention of his recent hospital admission or note in his prison medical records to give an indication of the direction of care. It is unclear which prison doctor examined him as the signature is illegible. It was noted by the clinical reviewer that hospital records show that his liver tests were so abnormal at this time that, it was their view, he must have been jaundiced. However, there was no record of jaundice made within his prison medical record until some weeks later.

44. In the days following the man's discharge from hospital, entries were made in his wing notes that he was still eating very little and was generally unwell. He was examined by the prison doctor on 6 August. He had swelling in his left leg and was short of breath. The doctor requested a full set of blood tests to be taken and for him to have an echocardiogram (a procedure that allows a doctor to view the heart without the need for surgery). He was prescribed furosemide (to treat excessive fluid retention and swelling) and dioxin (used in the treatment of heart failure and shortness of breath).

45. A healthcare assistant made a note on 8 August, to say that as the man needed a lot of care he "continues to very demanding on staff time". He had become incontinent of urine and was supplied with incontinence pads and advised to speak with the doctor the following Monday. The following day, he had a sample of blood taken for testing and, as he was unwell, he spent most of the day in bed. He declined to shower or associate with his peers on the landing. A letter from the gastroenterology service arrived later that day, stating that he was now on the waiting list for an appointment.

46. When the man was unlocked on the morning of 10 August, he was said to have appeared a little disorientated and confused. He had also been incontinent of urine during the night. He was moved cells to enable staff to clean him and his cell appropriately and his in possession medication was taken away as a precaution. That evening, he became increasingly unsettled, becoming agitated and possibly hallucinating. He became increasingly confused the following day and a doctor reviewed him in healthcare. He was thought to be dehydrated and was sent to hospital.

47. An entry was made in the man's medical record on 15 August to say that he was still in hospital. He was currently being treated for a urinary tract infection and it was reported that he was no longer confused. It was noted however that he was still suffering from atrial fibrillation

(irregular heartbeat) and it agreed with healthcare that he would remain an inpatient for the foreseeable future for further investigation.

48. On 16 August, the healthcare manager called the hospital and spoke to the nurse in charge. She enquired about the man's condition and asked whether the prison should explore compassionate release. The hospital advised that at present compassionate release would not be necessary as his condition had improved.

49. A member of healthcare staff spoke with a nurse at the hospital on 20 August. They recorded in the man's medical record that he was stable and was not displaying any signs of confusion.

50. Prison records show that the man was discharged from hospital on 26 August. His discharge letter showed that he had been diagnosed with heart failure and sepsis (infection of the blood), although the cause of sepsis was unknown. It was advised that the man was not to lay flat on his back due to his heart condition, and that he was to have his INR (International Normalised Ratio, a measure of how quickly the blood clots) checked daily. He was to be reviewed in outpatients in four weeks time.

51. The discharge letter detailed above did not include details of the echocardiogram and other investigations undertaken at hospital. Therefore it is unclear whether staff at Cardiff were fully aware of the man's heart condition.

52. Following his return to Cardiff, it was noted that healthcare staff were concerned that the man may have been discharged too early as he did not look well. His legs and the lower half of his torso were oedematous (swollen from fluid retention) and he was not fully orientated. It was noted that due to his current presentation he would need assistance with the majority of his daily care needs. He was confused throughout the evening and continued to be incontinent of urine. His condition did not improve over the following days and he began to be unsettled throughout the night, often shouting out names.

53. On 28 August, staff contacted the hospital to ask if the man required a hospital bed as he had been advised to not lay flat on his back. An occupational therapy assessment was arranged. A member of staff at the hospital telephoned back and confirmed that he did not need a hospital bed; and that he could just be propped up with lots of pillows.

54. He continued to be confused and disorientated. An entry in his wing record the same day said that his behaviour had been demanding with continual inappropriate use of his call bell. He had become incontinent of both urine and faeces through the night and he needed considerable prompting for him to take his medication and to eat and drink. Healthcare staff found that he had become un-cooperative, and because

of this staff were unable to check his pressure sore areas. It was noted that he was eating very little and looked generally unwell.

55. On the evening of 28 August, the man refused to get into bed and due to his continued confusion told staff that he was "off to the pub". He refused to take his medication and finding him to be unsteady staff assisted him into bed. The same evening he was observed by a nurse getting in and out of bed, and into his wheelchair to go to the toilet. The nurse commented in his medical record the next morning that "this man is obviously not as confused or as incapable as he is allowing us to believe". It is not clear which nurse made this entry as the signature is illegible. On the morning of 29 August, another entry made by another member of staff to say that he remained "apparently" disorientated, although he was able to attend to some of his needs. It is unclear who made these comments as the signatures are illegible.

56. By 31 August, the man's behaviour had deteriorated, and it was noted that he had on occasion become aggressive. He used his cell bell incessantly and had been persistently turning his light switch on and off throwing water around in his cell that night. He was said to have been throwing water over any member of staff that tried to open the observation panel on his cell door, trying to flood his cell.

57. The prison doctor assessed him on 1 September. The doctor made an entry in his medical record that he was orientated in place and person, but not orientated to time. She noted that he was dehydrated and recorded his general observations. He was started on a fluid chart, and she asked that he have between 2 and 2.5 litres of fluid per day.

58. The following day the man was reported to be more lucid. He ate small amounts of food, and his diet and fluid intake were recorded. He continued to be assisted with his care needs by staff and associated with his Rule 45 peers.

59. The man's confusion started to return on 7 September. He kept saying that he was a 'free man' and that he should be let out. It was noted that during that evening he was banging on his cell door constantly, demanding to see his son next door. When staff came to try and calm the situation he became verbally abusive.

60. The following day the doctor met with the man to assess his general health. She advised continuation of the fluid chart to ensure he was drinking plenty and he was to have further blood and urine tests. She said that she would meet with the healthcare manager, as she felt that the prison environment was not the appropriate environment for him at that time. It is unclear if or when this was discussed as there is no note in his medical record of this discussion taking place.

61. The man was assisted to bed on 9 September. He was said to be delusional and confused, not orientated to time or place. For his safety,

after he had been put to bed, his wheelchair was taken out of his cell. However, he was disgruntled by this and managed to get out of bed and slept on the floor, where he remained through the night. It is not clear from his medical records whether, on noticing that he was sleeping on the floor, if anyone tried to assist him back into bed or not.

62. On 11 September, the man was said to still be in a confused state. His medical record mentions an injury to his left hand; although there is no mention as to how the injury occurred, apart from detailing that the skin had come away, leaving the area sore. A doctor examined, cleaned and dressed the mans hand later that day.

63. The man continued to be confused and aggressive towards staff. On 15 September, he demanded to be let out of his cell, and became abusive when his demands were denied by staff. A nurse made a note to say that "[he]recalled in graphic detail his crime stating that he was innocent and that if he was not released he would cut our throats".

64. The man was awaiting appointments to see a vascular surgeon and a gastroenterologist. Blood test results from 8 September were returned as being normal, apart from his erythrocyte sedimentation rate (a marker for inflammation) and gamma-glutamyl transferase (liver) levels, which were high. It was noted that he should have another blood test a week later.

65. On 17 September, it was recorded that the man's injury to his hand was not healing properly. The dressing was appropriately changed regularly and a wound care plan was completed requesting the assistance of a tissue viability nurse. He remained disorientated and generally unwell.

66. An entry in his wing record, on 21 September, mentioned that the man now needed full nursing care and said it was difficult for him to comply with the prison environment. Despite the issues raised in relation to the accessibility of the mans in-cell toilet some six months earlier, it was noted in his medical record that he still currently had to use the disabled toilet in the main healthcare wing. However, because of the prison regime he could not be unlocked at night to use this toilet and continued to use a bottle at night.

67. On 28 September, the man had to wait to be unlocked due to his Rule 45 status as other prisoners were out of their cells. He became argumentative and stated to staff "you people are making life hard for me". Despite a fluid chart being introduced, he was still dehydrated and staff were reminded to encourage him to drink and fill out his fluid chart.

68. The man attended an appointment at the gastroenterology clinic on 1 October. He was told that his health problems were secondary to his heart failure and it was recommended that his diuretic medication be increased, and that his renal function should be monitored monthly.

69. On 4 October, the man displayed odd behaviour throughout the night. He was observed by healthcare staff sticking his hands down the toilet, trying to clean it. When a member of staff attempted to try and speak with him he became aggressive. He was said to have spent the night in his wheelchair, with a blanket around him and no underwear. Despite staff offering to help him into bed, he spent the next two nights sleeping in his wheelchair.

70. The man was examined by a doctor on 8 October. His pressure sore areas were deteriorating and he kept pulling the dressing pads off and "interfering with the area". He was sent to the accident and emergency department at hospital to have his pressure sores examined. He was diagnosed with cellulitis (skin infection) of the groin area and was admitted to hospital. He was provided with a special pressure relieving mattress, was prescribed antibiotics to treat the infection and had a catheter fitted to help prevent future infection from urine. The man was discharged back to Cardiff prison on 12 October.

71. On discharge, when the man became incontinent of faeces, staff helped to wash and re-dress him and met his care needs. He continued to be intermittently confused, along with periods of lucidity. An entry in his wing record suggested "a nursing home would be a more appropriate care setting for this gentleman". The healthcare manager said during interview that comments such as these were made by staff who may have had anxieties regarding his complex medical and care needs. She said that these were personal views and that the appropriateness of his environment would have been determined by risk assessments, occupational therapy assessments and his offending history.

72. On 15 October, the man had an assessment with a nurse. His waterflow score was measured. A waterflow score shows a person's estimated risk of developing pressure sores. He was assessed as having a high risk of developing pressure sores. The mans catheter was leaking around the outside and his bag was not being kept in place. He said that he was finding the catheter very uncomfortable and it was removed. His pressure sores were re-dressed and it was noted that he needed reviewing daily.

73. A letter was received from the hospital on 19 October. The letter stated that hospital staff had inserted a long term catheter and started the man on antibiotics. At the time of discharge, the mans cellulitis was said to have improved dramatically and that he would need his catheter changed in three weeks time. There was no further entry in his medical record to suggest that, on receipt of this letter, another catheter was inserted. During interview, a doctor said that the catheter was not re-inserted. She spoke to the nurses about this and was told that he did not want a catheter and would thus just remove it. On that basis they decided to see how they could manage without re-inserting the catheter.

74. A doctor reviewed the man the following day and a physical and occupational therapy referral was made for a full assessment of his needs. The doctor also asked that contact be made with the local hospital to see if a hospital bed could be obtained. HMP Parc were asked to assess him (the assessment was booked for 1 November) to see if he could be transferred to their older persons unit (the unit was due to open in January 2011). As a result of this consultation, the doctor advised the healthcare manager that compassionate release procedures should be started. The duty governor was informed.

75. A case conference was held on 22 October, regarding the man's future management and appropriate location. The case conference was attended by the healthcare manager, prison GP, a senior nurse and a senior healthcare officer. The doctor commented during the meeting that the man needed a lot of care in regard to his personal needs, hygiene and incontinence. She felt that, if he had not been in prison, he would have been risk assessed by the district nurse and an appropriate care plan to suit his needs would be in place. She said that "due to the restricted regime especially during the night this could not be achieved". As a result of the case conference it was decided that an occupational therapy application should be made to obtain a new care plan regarding his pressure sores, and for compassionate release to be explored.

76. The man developed pitted oedema (fluid retention) in his mid thigh and complained of pain. He was examined by a doctor on 23 October, who prescribed antibiotics and advised him to rest on his bed with his leg elevated. He was given paracetemol for pain relief and encouraged to stay in bed. A couple of days later, he developed an ulcer on his big toe and it was noted that the outer area of his heel had broken down. The areas were cleaned and he was advised to keep his leg elevated as much as possible.

77. An occupational therapy assessment was completed by the senior healthcare officer on 25 October. The aim of the assessment was to help improve the man's level of independence. The officer concluded that the man needed significant nursing input, which was difficult as he spent much of his time in his cell.

78. On 26 October, staff contacted two companies to try to obtain a hospital bed and mattress for the man. A tissue viability nurse was also contacted for advice on the care for his leg. She said that she was not able to suggest anything more than staff were already doing, advising that she was aware that, due to hospital ward closures, the hospital might have a spare hospital bed that they could use.

79. The man continued to remove the dressing from his leg during the night. It was re-dressed the following morning. It was noted that his leg was improving, but he still remained irritable, lethargic and confused. A doctor examined him and requested he be sent to hospital for further assessment. On 28 October, he had a cardiac assessment and was

then discharged the following day as test results were normal. A hospital bed arrived for him shortly after his arrival back on healthcare. However, it was discovered that the bed would not fit through the healthcare doors and was immediately returned. He continued to use a prison bed until an alternative hospital bed arrived on 2 November.

80. A doctor assessed the man on 3 November. She said that he was happy in his hospital bed and his leg swelling had reduced. He was still having a problem with incontinence, but informed her that he did not want the catheter re-inserted.

81. On 9 November, the healthcare manager requested that staff were to physically check on the man every two hours overnight "as his skin has broken down – to prevent further breakdown and is incontinent of faeces and urine". However, there is a note in his medical records to say that the night orderly officer had spoken to the duty governor about this request, who had said that for security reasons, his cell should only be entered if medical intervention was required, such as discomfort from soiling. It was explained that the duty governor would discuss this issue with the healthcare manager further. Medical records show that visual checks were conducted every two hours, speaking to him when he was awake to check that he was comfortable.

82. The man had a physiotherapy assessment on 10 November. He was able to move well on his bed and was able to transfer into his wheelchair.

83. A second case conference was held on 10 November. The purpose of the case conference was to further discuss the issue of compassionate release, and the man's medical care during the night. It was mentioned that there were plans to move him to HMP Parc, but this could not be facilitated until January 2011. The doctor commented that his condition had improved after the appropriate equipment arrived, such as the hospital bed with leg gutter (an inflatable leg support). After discussion it was decided that compassionate release was no longer appropriate.

84. The doctor made an entry in the man's medical record on 17 November after completing a weekly review. She noted that he looked well, but there were "med problems". It is not clear if they were medical or medicine problems.

85. When staff took the man his evening meal on 21 November, they noticed that he appeared to be unconscious. He was unresponsive and appeared to have a facial droop. His blood pressure was taken, which was lower than normal, and paramedic assistance was requested. When the paramedics arrived he appeared to become more responsive. He was taken to hospital via emergency ambulance. Later that evening, healthcare staff contacted the hospital and were told that the doctor thought the problem may have been cardiac related.

86. The next morning, staff contacted the hospital for an update on the man's condition. They were told that he would be discharged later that morning. An ECG (electrocardiogram, a test to record the hearts electrical activity, to detect abnormal heart rhythms and to investigate the cause of chest pains) had shown normal results, and he had complained of no other physical problems. It was thought the symptoms had been caused by medication and the hospital advised healthcare staff at Cardiff to review his heart medication.

87. On 29 November, the man declined his morning medication. As a result of this he was assessed by a doctor and prison psychiatrist regarding his mental state. A note was made in his medical record to say that there was no clear mental illness; although there were apparent cognitive problems. He was seen by the psychiatrist and was unable to give a reason for refusing his medication apart from saying that he didn't need it. The psychiatrist made a note in his medical notes to say, "I do not believe he does have capacity to refuse oral medicine and will undoubtedly deteriorate physically if [he] continues to refuse".

88. The doctor and psychiatrist strongly advised and encouraged the man to take his medication and advised him of the consequences, but he refused. He also refused to have his INR (International Normalised Ratio, a measure of how quickly the blood clots) taken. He was referred for a further psychological assessment and to the cardiology department at hospital for advice. He continued to decline his medication, although, on 2 December, he agreed to take his warfarin.

89. Due to his medication refusal the man was observed daily by staff. Staff noted that, despite not taking his medication, he appeared to be well. They continued to encourage him to take his medication without success. He had a dementia test on 8 December, of which his score was six (which is deemed to be normal). He appeared lucid and was not confused during this assessment.

90. On 9 December, the healthcare manager asked that a mental capacity test be requested. A psychiatric hospital was contacted for advice and the Ward Manager agreed to send their policy over to see if that would assist. It was noted that Treasury Solicitors (who provide legal advice to government organisations) would also be contacted for advice and a Senior Nurse would again try and advise the man of the importance of taking his medications. The man needed a full capacity assessment and because of this it was thought that an advocate (who would help him understand his legal rights) might need to be involved.

91. Later that day a nurse from healthcare had a long conversation with the man to discuss his refusal to take his medication. Following this conversation, he agreed to take his medication. It was also noticed at this time that his left arm appeared to be swollen. The doctor examined him the following morning and diagnosed him as suffering from oedema.

She prescribed antibiotics and also sent a letter to the hospital asking for their advice on medication refusal.

92. Despite the man's discussion with the nurse (as detailed above) he only started to take his medication intermittently, only agreeing to take it on certain days. A mental health nurse commented at interview that

> "…he may take it from certain people on certain days. I mean sometimes you'd go in there and he'd be bright as a button, you know. You'd say here's your medication and he'd take it … Other days he wouldn't and maybe then a couple of hours later you'd say to somebody else can you go and have a chat with him and he may just react to them."

93. On 15 December, it was recorded in the man's medical notes that his intermittent confusion could be related to strokes. This was thought to be due to a possible transient ischemic attack (TIA), which is a form of a mini-stroke. A note was also made by the doctor in relation to his mental capacity. The doctor concluded that they could not force medication on the man, but he said he would contact the elder person's team at the hospital asking that someone come and assess him. In addition to this the doctor sent a referral letter to a stroke prevention specialist. The doctor asked if they could assess the man and give some advice as to his management.

94. The man presented as being very confused on 28 December. The man told prison staff that he had only been at Cardiff for two days and was a guest and not a prisoner. At this time the man was now refusing to take any of his medication. He attended an appointment at the TIA clinic at hospital the following day to meet with the specialist. During the consultation, the specialist explained the consequences of not taking his medication.

95. The specialist outlined his assessment of the man in a letter. He reported that his main problem was the diuretic as it caused him to urinate more frequently, and toileting proved difficult due to his poor mobility. The man felt that staff were not doing all they could to assist him. It was explained that he had agreed to take the diuretic if the issue of increased urination could be tackled. The specialist also explained that it would not be justifiable for staff to force the man to take his medication and treatment might have to be withheld until he became acutely unwell, when he may then be compliant. Once back at Cardiff, the man continued to be intermittently compliant with his medications.

96. Cardiff purchased specially adapted weighing scales, which meant they could weigh the man in his wheelchair. He was weighed on 30 December. His weight was recorded as 64.1kg, which meant he had lost 5.3kg in the three months since his weight was last recorded at the Gastroenterology Clinic in September. Build up drinks (high calorie

milkshake drinks) were considered but were deemed inappropriate because of his gallbladder issues.

97. On 5 January 2011, the man was examined in healthcare by a doctor. It was recorded that on examination that he was suffering from an inguinal hernia (when part of the bowel comes through the abdominal wall into the groin). He had mild pain and was having trouble opening his bowels. The doctor noted that she would refer him for an operation to correct the hernia.

98. During the night of 16 January, the man was unable to sleep as he said he felt like someone was kicking him. He was in and out of his bed continually pressing his cell bell demanding to see a doctor or a paramedic, or for someone to contact his family. When staff attempted to reason with him, he became verbally aggressive towards them and his cell mate. Despite his incontinence he was in a shared cell and it was noted that he was now also disturbing his cell mate who was not able to sleep due to his behaviour. A nurse commented that he felt that "sharing a cell does not seem to be a satisfactory arrangement at this time". Despite the nurse's concerns there is no evidence to show that a move to a single cell was considered.

99. The following morning, the man used the toilet and was assisted to the shower where he was able to wash himself. He was then assisted back to bed complaining to staff that he had a sore throat. The doctor was asked to come and assess him once she had finished her surgery that morning.

100. Later that morning, at 11.50am, the man became short of breath and his fingertips were said to be blue. The doctor was informed, and an emergency ambulance was called. Paramedics arrived at 12.05pm and he was taken to hospital. A risk assessment prior to him going to hospital advised that he was to have a two officer escort, but was not to be cuffed until after assessment at the hospital, dependent on his condition.

101. The man's Person Escort Record (PER is a form that accompanies prisoners on all journeys from and between prisons. It serves as a communication tool about risks a prisoner poses on escort or transfer. It also provides a chronological record of the escort,) showed an entry at 1.50pm to say that hospital staff thought he was suffering from a chest infection causing septicaemia (blood poisoning). The prison was advised that he was likely to be kept in hospital for a while. A further entry ten minutes later showed that after examination by the consultant in charge escort officers were informed that his prognosis was not good and there was a chance he could die. The consultant suggested to the bedwatch officers that his next of kin should be contacted. The prison was contacted and the Governor was updated on the situation. The Governor spoke to healthcare staff telling them that the man was very unwell and that next of kin should be contacted.

102. At 4.15pm, it was noted that the man had “perked up” slightly. Staff were waiting for a bed to become available so that he could be admitted to a ward. A short while later he was moved to a ward and the escort officers started a bedwatch log. He was said to be un-cuffed and compliant, although after he made some inappropriate comments, male staff took over his care.

103. An entry in his bedwatch log at 6.50pm showed that hospital staff were concerned that his blood pressure was so low. At this time, it was noted that he was suitable for resuscitation if his condition deteriorated and he required it. At 9.10pm, bedwatch officers contacted healthcare staff at Cardiff on behalf of the man’s consultant. The consultant spoke directly with a member of staff in healthcare and gave them a full update on his condition. He was visited by a member of his family later that evening. Due to a deterioration in his health, a note was made in the handover section of the bedwatch log to say that he was now deemed as not suitable for resuscitation should he require it.

104. The man was moved to a different ward the following morning. His condition was said to be weak, but he was compliant and his behaviour throughout the day caused no concerns.

105. On 19 January, the consultant visited the man at 11.55am. He was now unable to pass urine. Hospital staff explained that they wanted to check the condition of his kidneys, and had arranged for him to have a scan, which was facilitated later that afternoon. There were no further significant entries in his bedwatch record for the rest of the day.

106. The following morning, hospital staff were concerned that his kidneys were still not working properly. The scan had showed that there was no urinary retention in the bladder. However, it was noted that the renal tract showed chronic kidney disease with a large accumulation of excess fluid. Doctors discussed his condition and decided that renal replacement therapy (such as dialysis) would not improve his prognosis and supportive therapy (such as pain relief) was his only option.

107. The man did not eat his lunch and was constantly complaining of being in pain. Pain relief was administered intravenously (given directly into the vein). It was noted in his hospital record that due to increased pain, the man was noisy, shouting out “help me God” and bedwatch officers and nursing staff had to try and ask him to quieten down. He did not eat his evening meal and continued to be generally noisy. It was recorded that he had a restless night and appeared quite confused.

108. An entry was made in the bedwatch log that evening. It said that hospital staff had informed the bedwatch officers that the man’s heart was failing and his major organs were shutting down.

109. The man was examined by a doctor at 8.50am on 21 January. The doctor asked the bedwatch officers to speak to the prison, asking that the mans family be contacted. Later that day, due to increased pain, he was given morphine. The man settled to sleep, although his breathing was said to appear laboured.

110. At 1.55pm, an officer who was part of the bedwatch team noticed that the man appeared not to be breathing. He informed nursing staff who examined him, informing him that the man had died. The officer telephoned Cardiff and informed staff. Death in custody contingency plans were activated and a hospital doctor confirmed that he had died at 2.45pm. Prison staff returned to Cardiff and a debrief was held. Support was offered to all staff involved, and notices were put up around the prison informing prisoners and offering support. Following confirmation of the mans death the Governor contacted the man's family to inform them of the news and offer support. The Governor noted in their contact log that the family declined the offer of a home visit at this time.

111. The man's funeral was arranged for by HMP Cardiff and the costs were offered in accordance with the relevant prison service order. The funeral was held on 10 March and was conducted by a chaplain. Staff attended to represent Cardiff with the family's permission.

ISSUES

Reception health screen

112. During his reception health screen the man was examined by a nurse and referred to the prison doctor for a secondary health screen. He was not seen for a secondary health screen. The first time he was seen by the doctor was on 31 March, eight days later.

113. HM Chief Inspector of Prisons carried out an unannounced inspection in June 2010. In a previous inspection in 2008 they made a recommendation to say that "secondary screening should be mandatory unless specially refused". It was discovered in the follow up inspection that this had not been achieved. They were told during the inspection that secondary screening was offered to all prisoners. However, the inspectors noted that there were no designated clinics for secondary screening and the section in the reception screening template had not been completed in the records they reviewed.

114. Inspectors were also told that a GP attended reception and saw all prisoners on admission. However, there is no record in the man's medical notes or reception health screen to show that a doctor saw him on arrival. He had complex health needs and should have been seen for a secondary health screen. Because of this we make the following recommendation,

    The Head of Healthcare should ensure that secondary health screenings are completed for all prisoners with complex health needs or those identified by healthcare staff on arrival as requiring it.

The man's disability

115. The man arrived into Cardiff on 23 March 2010 presenting with a complex medical history. Prior to his time in prison he had had his spleen removed following an accident, had suffered from a pulmonary embolism (a blockage of the pulmonary artery), and had his right leg amputated. As a result of the above he was a long term warfarin and penicillin user (to prevent future infection or blood clotting) and required a wheelchair to get around.

116. As part of the reception process, all new prisoners are asked to disclose if they have any form of disability, whether it is physical, sensory or mental impairment. Cardiff's 'Disabled Prisoners Policy 2009' explains that a disability disclosure form/questionnaire will be completed on entry into Cardiff. The purpose of this questionnaire is inform prison staff of the exact nature of their disability, to explain what obstacles the prisoner will face, and what facilities or other support they need to carry out normal day to day activities.

117. The 2009 policy also explains that “it will be the responsibility of the senior officer in charge of reception to complete the disability disclosure form”. The orderly officer then collects the questionnaires and gives them to the DLO the following morning. However, this was not done and a questionnaire was not completed for the man.

118. In addition to the questionnaire, all prisoners who declare a disability should have a “reasonable adjustments log” completed. Cardiff policy says

> “When disabled prisoners are located in any residential unit or healthcare, then a cell or room appropriate to their needs must be provided. The DLO and healthcare staff should be consulted on assessing needs and recorded on the reasonable adjustment log and establishment disability action plan”

Despite the above, a reasonable adjustment log was not completed for the man.

119. Prison Service Order 3803 ‘Fire Safety’ explains that

> “Governing Governors must ensure that procedures are in place for the safe evacuation of staff and prisoners, who may, because of a disability, be unable to exit to a place of safety unaided”.

The consequence of this is that personal emergency evacuation plans (PEEPS) should be drawn up for all prisoners who may need assistance in the event of an evacuation. However, despite the man being a wheelchair user, a PEEP was not completed for him.

120. The chaplain, who was the DLO’s manager, explained during interview that he thought the reason the disability questionnaire and adjustment log had not completed was due to an ‘oversight’, and that

> “my guess would be that when he was received into the prison his condition was seen as so obvious… and [with] the blatantly obvious sometimes you don’t bother to actually do [this] because it is obvious to all those around”.

121. Further to this the chaplain explained that as the man was living in healthcare he was under the assumption that there would be a personal evacuation plan for the whole of healthcare. He would not therefore need an individual plan.

122. After speaking with the chaplain, there appears to be some confusion as to who should have completed the relevant paperwork. The healthcare manager explained that she was unaware that a disability questionnaire had not been completed, commenting that it would be in the man’s main prison file (and not his healthcare record) and that the responsibility for

completing the PEEP would have been with the DLO. This shows lack of knowledge of the disability policy in place at the time, and a lack of communication between healthcare and DLO staff. This is unacceptable.

123. The investigator met with the new diversity officer. He explained that Cardiff were due to introduce a new 'Diversity and Equality' policy. This new policy was introduced in July 2011. This policy incorporates aspects of the old disability policy and incorporating elements of the Equality Act 2010.

124. We are pleased to see that the disability policy has been updated. However, because aspects of the previous disability policy were not adhered to we make the following recommendation to ensure that this is addressed.

The Governor should ensure that the disability policy is robust and that all relevant prisoners are correctly identified in reception, with appropriate action being taken to ensure their needs are met.

125. The man arrived at Cardiff in March 2010. However, despite him having mobility problems and suffering a fall trying to use his in-cell toilet, an occupational therapy assessment was not requested until 28 August, when he returned from outside hospital. If this had been done earlier, it may have prompted healthcare staff to start a reasonable adjustments log to aid the use of facilities in his room (such as his toilet) more freely. The healthcare manager should ensure that all prisoners with disabilities have an occupational therapy assessment following admission to prison.

126. As a result of another death in custody at Cardiff in January 2011, issues were highlighted in relation to physiotherapy and occupational therapy assessments. As a result of this the following recommendation was made:

> "The Governor must ensure that steps are taken to make sure compliance with relevant legislation including the Disability and Equality Act 2010, in line with the Her Majesty's Chief Inspector of Prison's expectations."

127. This recommendation was accepted. The prison commented that the disability liaison officer would ensure that disability assessments are carried out on all disabled prisoners that they are located on normal location if appropriate and in particular those prisoners in wheelchairs would only be located in the healthcare when there was medical need. Because of this, we do not make a recommendation on this issue as a result of this investigation.

Recording of medical notes

128. At the time of investigation, SystmOne, an electronic medical record, had not been introduced into the prison and the man's medical record was a handwritten record. Entries by doctors and healthcare staff were often illegible, brief and hard to understand. They also included medical jargon and abbreviations. It was also not clear who had made the entries as signatures were hard to read, with some entries not signed at all. This is not in line with Nursing and Midwifery Council Guidelines. The guidelines state that:

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

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

- Handwriting should be legible
- All entries to records should be signed
- The person's name and job title should be printed alongside the first entry.
- Records should be accurate and recorded in such a way that the meaning is clear
- Entries should be factual and not include unnecessary abbreviations or jargon
- You should not use coded expressions of sarcasm or humorous abbreviations to describe the people in your care.

130. The clinical review notes that the medical records that were reviewed were often illegible, unsigned and brief. We agree with this.

131. In the third recent investigation into a death in custody at Cardiff in January 2011, issues were highlighted in relation to record keeping. A recommendation was made that:

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

132. This recommendation was accepted. The prison explained that a notice would be sent out reminding staff of the importance of making accurate records, and that monthly management checks would be completed by a Band 7 Senior Nurse. A target date for completion was October 2011. The investigator was also advised that the prison would be receiving SystmOne a clinical I.T. system in January 2012. We are pleased to see that the previous recommendation was accepted. However, because

the target date for receiving the computerised system is not until next year, and the installation date could change, we repeat the recommendation.

The Head of Healthcare should ensure that all entries in medical notes are completed in accordance with Nursing and Midwifery Council Guidelines.

133. HM Chief Inspector of Prisons inspected Cardiff in 2008. As a result of this inspection they made a recommendation that written entries into clinical records should be "legible and a method for identifying the writer and their designation introduced. Entries should be respectful". As a result of an unannounced inspection in 2010, it was recorded that this recommendation had not been achieved.

134. Despite this recommendation it was disappointing to see that some staff members had made inappropriate entries relating to the man. On 28 August 2010, a nurse made an entry in his notes to say that he was

> "later observed on more than one occasion easily getting on and off the bed into the chair to go to the toilet. This man is obviously not as confused or incapable as allowing us to believe".

On 29 August, an entry was made by another member of staff to say that he remained "apparently" disorientated. These comments are based on personal opinion and are inappropriate.

135. The investigator discussed these comments with the healthcare manager during her interview. It was explained to her that these comments were inappropriate, commenting that it was not good practice for staff to write personal opinions or assumptions in a person's records. She said that she thought the comments seemed inappropriate from the way they were written, but felt that it had not been meant in that way. She said she would speak to the member of staff who made the entry. As a result of this we make the following recommendation:

The Head of Healthcare should ensure that all entries in prisoners records are respectful and do not contain personal opinion.

The man's accommodation

136. On arrival into Cardiff, the man was taken to healthcare because of his mobility and health needs. He remained there for the duration of his stay. The man was unable to use his in-cell toilet as specialist equipment was too big for his toilet area. As a consequence, he had to use the disabled toilet outside of his room during the day and urination bottles at night. A reasonable adjustments log should have been started, and adjustments made (such as a support rail on the wall) to allow him to transfer safely from his chair to the toilet in his cell.

However, although this was mentioned in his medical record, this was never facilitated.

137. On 28 August, it was recorded that the man had become incontinent of both urine and faeces. Cardiff's 'Disabled Prisoners Policy 2009' says that "HMPS and HMP Cardiff will treat all disabled prisoners with decency and without discrimination". It was neither decent nor dignified for him (or for his room mate) to have to share a cell at this time.

138. The case of Price v United Kingdom (2001), heard before the European Court of Human Rights, discussed the rights of a severely disabled prisoner in prison accommodation. In section 30, the court considered that

> "to detain a severely disabled person in conditions where [s]he is dangerously cold, risks developing sores because her bed is too hard or unreachable, and is unable to go to the toilet or keep clean without the greatest of difficulty, constitutes degrading treatment contrary to Article 3 [of the European Charter on Human Rights]."

While not all of these circumstances apply to the man, he was clearly unable to go to the toilet without a great deal of difficulty. It is with this in mind that we come to the judgement in the following paragraph.

139. The clinical reviewer commented in his report, "In the 21st century, should a terminally ill prisoner with double incontinence be still in prison sharing with another vulnerable prisoner?" We agree. This is potentially degrading for both the prisoners involved, and it is not acceptable. It is clear that the healthcare unit at Cardiff has a difficult role, especially as it has to cater for both vulnerable and non-vulnerable prisoners in the same location. This will make the allocation of cells difficult. However, it is inappropriate for a prisoner with the man's needs to share a cell. We make the following recommendation:

The Governor and Head of Healthcare should ensure that cells in healthcare are, whenever possible, not shared and that when cell sharing is required a full assessment of the needs of each prisoner is undertaken to ensure that cell sharing is appropriate given their circumstances.

140. Cardiff disability policy (2009) also says that "experience demonstrates that anticipating hazardous situations before they actually arise is the best method of creating and maintaining a safe and healthy environment". However, no formal risk assessments were completed to ensure his future safety after a fall in his room in March 2010. It is essential that staff are sure that the accommodation provided for a prisoner remains suitable for them, and is safe. This is vital, in particular, for disabled prisoners. Because of this we make the following recommendation:

The Governor and the Head of Healthcare should ensure that proper risk assessments are completed when there might be a change in a disabled prisoner's circumstances or health.

The man and the prison environment.

141. The man returned from outside hospital on 12 October, having had intravenous antibiotics for an infection. The clinical reviewer commented that at this point his condition had been fully diagnosed. A detailed letter from the gastroenterologist commented on the severity of the heart failure. The clinical reviewer explained in his report that, as per NICE guidelines, he had a 30-40% chance of dying in a year and should have been regarded as terminally ill. The reviewer believed at this stage the question should have been asked "is HMP Cardiff the best place to care for a terminally ill patient with severe heart failure?"

142. In the last two months of the man's life, the doctor referred him to two specialists, one at the stroke clinic at hospital and the other to a surgeon for a possible hernia repair. The clinical reviewer commented that he could understand the rationale behind the referral to the stroke adviser, but "the referral of a man in severe heart failure who is not taking his medication and has a gross infection in the region of his hernia is very odd indeed". Because of this, the reviewer felt that the doctor had not fully comprehended the severity of his illness.

143. Consideration was given to transferring the man to HMP Parc. Parc were due to open an elderly person's unit in January 2011. However, although he was diagnosed with congestive heart failure in August 2010, a request was not made until 20 October for him to be assessed to see if he was suitable for transfer.

144. On 22 October, a nurse commented in a case conference meeting that the man should not be in Cardiff as it was difficult to dedicate the time required to care for him. Compassionate release was explored during a case conference held on 10 November. However, the doctor commented,

> "from a diagnostic point of view the patient [the man] should not get early release as he is capable of taking care of himself and is attention seeking".

145. The doctor decided that his condition did not warrant compassionate release. However, compassionate release should have been explored at this point. He had been diagnosed with congestive heart failure, was incontinent and suffered from periods of confusion. Advice should have been sought about the suitability and availability of a transfer to a nursing home. Nursing staff who saw him on a daily basis commented on how hard it was to care for him in the prison environment. We make the following recommendation:

The Governor and Head of Healthcare should ensure the proper implementation of the compassionate release process at Cardiff and ensure that decisions about whether to pursue an application are recorded appropriately

Monitoring the man's weight

146. During the man's first reception health screen, his height and weight could not be taken. As he only had one leg, healthcare staff feared that he may fall if they used regular weighing scales. The mans weight was only recorded some nine months after first arriving at Cardiff. This is an unacceptable delay and would have prevented medical professionals from being able to monitor any weight loss (or gain) effectively.

147. The clinical review commented that "There were no objective assessments made about the loss of weight of the man because of lack of proper equipment".

148. The Healthcare Manager confirmed at interview that they had to ask the hospital to weigh him during his outpatient appointments. This was unacceptable. Cardiff healthcare have now been able to hire special scales adapted for wheelchair users. Because Cardiff has resolved this issue we do not make a recommendation.

The man's refusal to take medication

149. It is noted within the clinical review that there were problems in managing the man's refusal to take his medication. His consultant commented in a letter to healthcare at Cardiff that it is not unusual for patients with heart failure to refuse medication when they are also incontinent of urine due to the prescription of diuretic drugs. The review states that by stopping his medication and only taking it haphazardly, it should have been clear that his condition would deteriorate more quickly.

150. Prison and healthcare staff spoke to the man about his refusal to take his medication but this made little difference to his attitude. At this stage questions were being raised about his mental capacity and he was referred to a psychiatrist on 29 November, who stated "I do not believe he does have the capacity to refuse oral medication".

151. On 8 December, the man took a dementia test. It was reported in his medical notes that he was lucid and not confused that day, scoring a 'six' on the test which was deemed to be normal.

152. At the request of the doctor, the man was examined by a stroke prevention specialist from the stroke clinic at hospital on 29 December. The specialist explained in a letter to Cardiff healthcare that he felt that it would not be justifiable for staff to force him to take his medication and treatment may have to be held off until he became acutely unwell, when

he may then be compliant. Once back at Cardiff, he continued to be intermittently complaint with his medications.

CONCLUSION

153. The man was remanded into custody on 26 March 2010. On entry to Cardiff he was seen in reception and due to mobility and complex health issues he was allocated a cell in healthcare. Despite being in healthcare his disability was not managed appropriately or according to Cardiff's disability policy in place at the time.

154. In October, the man was diagnosed with severe heart failure and should have (according to NICE guidelines) been regarded as terminally ill. It appears that healthcare staff did not fully comprehend how sick he was. The clinical reviewer commented that his care from the point of diagnosis until his death in January 2011 was "reactive and not proactive".

155. It was recorded in case conference minutes in the October that nursing staff did not feel that the man should be in Cardiff as they found it difficult to dedicate the time and care he needed. The clinical reviewer commented in his report that,

> "… There were inadequate staff and facilities to provide the optimum care for him especially from October 2010 onwards. The healthcare set up in HMP Cardiff was not equipped to deal with his health needs…"

156. The clinical reviewer commented that it was apparent that the medical (doctors) aspect of the man's care and the nursing aspect of his care were running in parallel, and these vital staff groups at Cardiff were not working in unison. He said that there was no leadership, and no-one taking responsibility for making proactive decisions on his care.

157. This investigation has raised serious concerns about the care afforded to the man while he was in the healthcare unit in Cardiff. Locating him in a cell where he could not use the toilet meant that, at night, he had to use bottles. This is completely inappropriate and could be regarded as degrading treatment.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that secondary health screenings are completed for all prisoners with complex health needs or those identified by healthcare staff on arrival as requiring it.

   National Offender Management Service responded with,

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

2. The Governor should ensure that the disability policy is robust and that all relevant prisoners are correctly identified in reception, with appropriate action being taken to ensure their needs are met.

   National Offender Management Service responded with,

   Accepted - A dedicated equal opportunities team now exists with disability as part of their remit. They are an integral part of the reception, 1st Night and Induction team and are actually based on the 1st Night centre. The policy has been reviewed and prisoner's needs identified at reception, 1st Night, Induction or any other point a prisoner might wish to disclose a disability. An assessment is then completed and appropriate measures taken to meet the needs identified within the consideration of cost.

3. The Head of Healthcare should ensure that all entries in medical notes are completed in accordance with Nursing and Midwifery Council Guidelines.

   National Offender Management Service responded with,

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

4. The Head of Healthcare should remind all staff that entries in prisoners' records should be respectful and not contain personal opinion.

   National Offender Management Service responded with,

   Please see answer three for response.

5. The Governor and Head of Healthcare should ensure that cells in healthcare are, whenever possible, not shared and that when cell sharing is required a full assessment of the needs of each prisoner is undertaken to ensure that cell sharing is appropriate given their circumstances.

   National Offender Management Service responded with,

   Partially accepted - All prisoners at HMP Cardiff have a CSRA (Cell Sharing Risk Assessment) completed, if any changes in both physical and mental state are observed, then the CSRA is reviewed and the prisoner is located appropriately to his needs.

6. The Governor and the Head of Healthcare should ensure that proper risk assessments when there might be a change in a disabled prisoner's circumstances or health

   National Offender Management Service responded with,

   Accepted - Continual risk assessment is in place with daily handovers, weekly psychiatric and GP ward rounds.

7. The Governor and Head of Healthcare should review the compassionate release process at Cardiff and ensure that decisions about whether to pursue an application are recorded appropriately

   National Offender Management Service responded with,

   Accepted - With the introduction of SystmOne an entry would record the initiation for the compassionate release process also an entry would be made on the P-nomis system which would also record relevant details.