

**Investigation into the circumstances surrounding the
death of a man in April 2012 at hospital,
while in the custody of HMP & YOI Parc**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

April 2013

This is the report of the investigation into the death of a man, a prisoner at HMP Parc. He died at hospital in April 2012. A post-mortem records his cause of death as cancer, specifically of the lung, and chronic bronchitis and emphysema. He was 71 years old. I extend my condolences to those affected by his death.

The investigation was carried out by an investigator. The local PCT commissioned a clinical reviewer to conduct a review of the clinical care the man received at Parc. Staff at Parc cooperated fully with the investigation.

In January 2012, the man was remanded to Parc to await a trial. He was an older prisoner with serious health problems, which he exacerbated by continuing to smoke. As his health deteriorated he was frequently admitted to hospital.

The investigation has identified some areas for improvement in procedures at Parc. When the man first arrived at the prison no efforts were made to obtain his community GP records, despite his significant long-standing health problems. Communication between the prison and hospitals was not always good and there were some deficiencies in clinical record keeping at the prison, which we have found before. We also identify the need for risk assessments for hospital escorts to take fully into account a prisoner's health condition when deciding whether restraints are necessary. However, it is unlikely that any of these issues would have altered the outcome for him. He was well cared for at Parc and we agree with the local PCT that overall, he received a level of clinical care at the prison equivalent to that in the community.

The Services' response to the recommendations is included in 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 prisoners involved in my investigation.

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Prisons and Probation Ombudsman

April 2013

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SUMMARY

1. The man was remanded to HMP Parc on 11 January 2012, and was due to be sentenced in April 2012. He did not have good health and during his time at Parc, he had extensive contact with health services both in the prison and the community.
2. When he arrived at Parc a reception healthscreen was carried out and it was recorded that he had chronic obstructive pulmonary disease (COPD) and emphysema. He had also been diagnosed with infective exacerbation of COPD. He smoked 20 cigarettes per day.
3. Between 21 January and 31 March the man was admitted to hospital five times with worsening of his COPD. He was admitted to another hospital on the 11 April 2012.
4. When admitted on 21 January, a chest X-ray was completed. It was reported on 27 January that there was fluid at the bottom of the lung, and a further chest X-ray should be completed to rule out any abnormalities. This second X-ray was not followed up. On each subsequent admission a chest X-ray was carried out, however none made reference to the findings of 27 January. On 27 March a clinical decision was made by a respiratory physician at the hospital that no further intervention should be taken.
5. The man was admitted to hospital on 4 February and was seen by a consultant who added a diagnosis of "cor pulmonale", (heart failure caused by a lung condition). Healthcare staff at Parc were not informed of this information and continued to treat him on the basis of a diagnosis of COPD and emphysema.
6. As the man's health deteriorated, his accommodation was reviewed and he moved to a residential unit adjacent to healthcare. Later, his cell remained permanently unlocked so that healthcare staff had ready access to him.
7. The man was worried about being admitted to hospital, but on 12 April, he agreed to go to hospital, where the admitting doctor gave a working diagnosis of "exacerbation of COPD". The following day a chest X-ray gave a diagnosis of right basal pneumonia (in the lower part of the right lung) and he was treated with antibiotics, steroids, oxygen and nebulised medication (medication inhaled in a mist) with intravenous fluids.
8. While his condition appeared to improve the man suddenly became ill and unresponsive several days later. The doctor said that he did not appear to have taken sufficient fluid in the previous 24 hours and that this had caused the sudden deterioration. This was in addition to the known problems of COPD, heart failure and chest infection. His condition continued to deteriorate and he died at 9.25pm. He did not have contact with his family, but his close friends were present at his bedside.

THE INVESTIGATION PROCESS

9. This office was informed of the man's death on 19 April 2012. The investigator issued notices to staff and prisoners inviting anyone with information to contact her. No one came forward.
10. The investigator visited Parc on 26 April and met the deputy Director, the Head of Healthcare, the prison family liaison officer and the prison liaison officer. She obtained copies of the man's prison records.
11. The investigator contacted Her Majesty's Coroner to inform her of the investigation and request a copy of the post mortem report. A copy of this investigation report will be sent to the Coroner to assist with her enquires.
12. In July 2012 the investigator returned to Parc to interview relevant staff. Following the interviews, written feedback was given to the Director.
13. A review of the man's clinical care was completed by a clinical reviewer on behalf of the local PCT. The investigator and clinical reviewer carried out joint interviews with healthcare staff.
14. When he arrived at Parc, the man said that he had two separate neighbours who were his close friends, and nominated one of them to be his next of kin. However, both remained involved in his care. One of our family liaison officers (FLO) contacted his nominated next of kin, and his other friend, to explain the purpose of the investigation and invited them to ask any questions or raise any issues for consideration. His friends said that communication between them and the prison's family liaison officer had been very good. However, they were concerned that the level of restraint that he was placed under when he was taken to hospital in January 2012 was inappropriate and caused him unnecessary stress.
15. His friends also asked why his diagnosis of pneumonia was not found earlier. We discussed this with the PCT and were informed that the man continually had a chest infection and was treated for this. They explained that a severe chest infection is given the name pneumonia, so as his condition worsened, this diagnosis was made. The pneumonia was a continuation and worsening of his existing chest infection.

HMP PARC

16. HMP & YOI Parc, which opened in 1997, is run by G4S. It holds up to 1474 convicted male adult prisoners, those on remand for sexual offences and young adults on remand or who are convicted.
17. Since October 2010, G4S has provided 24 hour primary general and mental healthcare services at Parc. The healthcare centre has two units each accommodating 16 elderly prisoners and those with increased health needs (known as U1 where the man was moved to in February 2012). Each house block has its own treatment room. General practice sessions are provided by a local surgery. The doctors offer 14 sessions per week, as well as out of hours cover.

HM Inspectorate of Prisons (HMIP)

18. HMIP last inspected Parc in September 2010. The Inspectorate found that prisoners were mostly positive about their relationships with staff. However, support for prisoners with disabilities was weak, with no clear assessment of individual needs or care plans. The Inspectorate identified little work specifically targeting older prisoners.
19. The Inspectorate reported that, at the time, healthcare services were not delivered to an acceptable standard, with inadequate staffing levels, chaotic appointment systems and poor management of chronic conditions. G4S had recently cancelled the contract with the healthcare provider and were about to take over the provision of healthcare services when the inspection occurred. The prison has not been re-inspected since then.

Independent Monitoring Board (IMB)

20. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community, which monitors all aspects of prison life to help ensure that proper care and decency are maintained. The most recent IMB annual report for Parc covers March 2010 to February 2011. The IMB noted that the prison had recently gone through an expansion programme, including the building of a new healthcare centre.

Previous deaths at Parc

21. The man is the fifteenth prisoner to die of natural causes at Parc since 2004, when the Ombudsman began investigating deaths in prisons in England and Wales. Previous reports have made recommendations about healthcare record keeping, and it is therefore disappointing to find this is still a problem. We have also recently identified in another report, a need for better risk assessments for prisoners going to hospital.

KEY EVENTS

22. The man was born in Cardiff in 1940. On 11 January 2012, he appeared at Magistrates Court and was committed to Crown Court for trial in April 2012. He was remanded to HMP Parc.
23. During his time at the prison, the man had extensive contact with health services in the prison and was also admitted to hospital on a number of occasions. He had a medical history of chronic coronary disease (blocking of the arteries to the heart) and emphysema (a long-term, progressive disease of the lungs that primarily causes shortness of breath). He had also been diagnosed with infective exacerbation of chronic obstructive pulmonary disease (COPD - when the airflow to the lungs is restricted/obstructed). COPD is usually caused by smoking.
24. When he arrived at Parc a reception healthscreen was undertaken by a nurse and she recorded that he had COPD and emphysema, smoked 20 cigarettes per day and appeared breathless when walking. He was offered smoking cessation advice. He was in possession of various drugs including a nebuliser machine, salamol (nebuliser solution), seretide (for treating COPD), spiriva (used to assist with shortness of breath), prednisolone (for treating COPD), amoxicillin (antibiotic), clarithromycin (antibiotic), terbinafine (used for fungal infections), bendroflumethiazede (a diuretic), ramipril, (for high blood pressure) omeprazole (for the reduction of stomach acid) and mucodyne (for the loosening of mucus).
25. The nurse discussed with a prison doctor which medications the man should be allowed to keep and which should be removed and re-prescribed the following day if necessary. He was left with his nebuliser inhalers and antibiotics. The records show that his medications and medical history were to be obtained from his community doctor and he was to see the doctor the following day. However, his medical history was not checked with his community doctor.
26. The records do not show whether the man saw a doctor on 12 January. On 14 January, a prison doctor saw him and noted that he appeared breathless. He said he was concerned that he was running out of his medication. The doctor prescribed the medications he had previously received and also a course of steroids (short courses of high dose steroids are used to help open up the airways in those diagnosed with COPD).
27. The doctor saw the man again on 16 January, when he said that he felt much better after taking steroids over the weekend. His oxygen saturation was recorded at 90%. (Oxygen saturation is a measure of how much oxygen carried in the blood. Normal oxygen saturation should be above 95%.) The doctor recorded that he was to be kept under close observation.
28. On 18 January the man was seen by a nurse practitioner during her round of the wing. He complained of coughing up blood. He was assessed and an

urgent appointment was made for him to see a doctor that afternoon. He did not attend this appointment, but the reason is not recorded.

29. On 21 January, at 12.27am, the man asked to speak to a nurse and a nurse went to see him. He told her that he felt he was dying, and that he wanted to be moved to a different wing. It was recorded that this was to be discussed with other nursing staff that morning. At 6.23am healthcare staff were called to see him as he was having trouble breathing. His oxygen saturation was only 80%. An ambulance was called and he was taken to hospital for further tests. He was assessed and given a diagnosis of COPD with chest pain secondary to chest infection. The PCT examined his records from his admissions to both hospitals. During this admission he had a chest X-ray, although as this information was not given to Parc, it is not recorded in his prison medical records. The X-ray showed right shadowing and small effusion of the lung. (Abnormal areas within the lung that are more dense will stand out. An effusion is a collection of fluid next to the lung). A diagnosis of pneumonia of the right lower lobe of lung was made and it was noted by hospital staff that a follow up chest X-ray was advised. Healthcare staff at Parc were not informed of this information and the hospital did not follow this up.
30. On 22 January, healthcare staff at Parc contacted the hospital and were told that the man remained on oxygen and intravenous antibiotics. He was to be seen the following day by a doctor. During his time at the hospital he was escorted by two officers and restrained by an escort chain (a 1.8 metre chain with a handcuff at each end attached to an officer and the prisoner).
31. On 23 January, the man was discharged at his own request and returned to Parc. No discharge notes were sent with him. The PCT comments that the transfer care was simply a medication chart. There were no details of the investigations undertaken or any plans for his future care.
32. On his return the man was seen by a prison doctor. He found that he had widespread "inspiratory and expiratory wheezes" (associated with airway obstruction) and his oxygen saturation was also low. A care plan was opened. (A care plan records the needs of the prisoner so that they are accessible for both medical and wing staff.) Case conferences were held regularly to ensure that all staff involved with his care were aware of his needs. Senior managers, healthcare, probation and wing staff attended. The purpose was to ensure that a care plan was put in place as it would be in the community. The care plan contained information about the need for increased observations and the circumstances when a doctor should be informed for the purpose of conducting further investigations.
33. On 30 January, the man told a nurse practitioner that he was having trouble sleeping. He was advised to sleep in a more upright position and to request more pillows from the wing staff. He was also referred to the disability nurse, although the records do not show whether this was followed up.

34. Later that day the man requested an appointment to see a doctor, which was booked for 2 February. When he saw the doctor he asked for a different mattress and a foot board to help prevent him sliding down his bed. The doctor agreed that this would help him sleep more upright and therefore be beneficial. He also complained of blurry vision, which the doctor said could be associated with the steroids he was taking. He recorded that he would refer him to the optician for assessment. There is no record that a referral or assessment took place.
35. On 3 February, healthcare staff discussed the man being moved to a more appropriate location to accommodate his health needs. He was then moved to a unit which was readily accessible to healthcare. Here he was provided with the equipment he had requested to assist his sleeping.
36. On 4 February, a nurse practitioner examined the man and found him weak, grey in colour and with severe shortness of breath. She contacted a doctor who advised her that he should be sent to hospital for investigation. An ambulance was called and a letter containing his medical history was written for hospital staff. He was again restrained with an escort chain and escorted by two officers.
37. During this period in hospital, where the man was taken, the man had an X-ray and the diagnosis was “non-infective exacerbation of COPD”. No mention was made anywhere in the hospital clinical records of the previous chest X-ray report dated 27 January 2012, which questioned a problem at the right base of the lung. He was also seen by a consultant who added a diagnosis of “cor pulmonale” (heart failure caused by a lung condition). Healthcare staff at Parc were not informed of this information.
38. On 6 February, 2012, while still in hospital, the man has an echocardiogram of the heart (which shows how well the heart is functioning). The conclusion was that his heart condition had deteriorated and as a result changes were made to his medication.
39. The man returned to Parc on 7 February, and there is a transfer of care form of that date. The plan was to repeat blood tests in three days to test his liver function. There are no entries in his records to indicate that these tests were carried out, and it does not appear that Parc was informed of any of the investigations undertaken or of their outcome during this stay at hospital. The PCT comment that healthcare staff at Parc assumed that during this hospital stay it was the worsening of his COPD that had been treated.
40. On 8 February, a nurse practitioner recorded that the man had not been seen by a prison doctor since his discharge. A doctor saw him later that day and recorded that his mobility was deteriorating and that he might require a wheelchair. Although he had been strongly advised to stop smoking he continued to smoke twenty cigarettes a day. He agreed to take part in a smoking cessation programme, though two doctors said that he never stopped smoking.

41. A nurse noted that due to the man's physical deterioration, he needed assistance with getting his meals and drinks, but he was reluctant to ask staff for help. She recorded that this was to be discussed at his care plan review later that day.
42. On the evening of 8 February, officers reported that they were concerned that the man was not taking his medication. When asked, he could not say whether he had. Most of the medication that he was prescribed when he was at hospital appeared untouched. This was recorded and was to be discussed at his care plan review. A doctor told us that it was decided not to leave his medication in his possession, and for it to be administered when needed.
43. The care plan review on 8 February, recorded that the man appeared too exhausted and lethargic to help himself, and that he was unable to manage his own medications. It was also noted that he was reluctant to get help from staff. It was agreed that his condition would be assessed daily and assistance was to be offered as necessary, especially with hot meals and drinks.
55. Between 20 and 29 February, healthcare staff were called to the man's cell 25 times. Each time they assessed his oxygen saturation levels, and when necessary administered oxygen. On 29 February, he was reviewed on the wing by a doctor and was diagnosed with respiratory failure. He agreed to be admitted to hospital and an ambulance was called to take him to hospital. A doctor wrote a referral letter.
56. During this admission, healthcare staff at Parc remained in contact with the hospital. An X-ray was carried out and the report indicated that the lung fields were hyperinflated (over expanded) and that "non-specific changes are demonstrated at the lung bases. Some of these have progressed into a serious infection". When he was discharged from hospital this information was not passed to healthcare at Parc.
57. On 2 March, the man was seen by a cardiologist at the hospital, who confirmed the diagnosis of "exacerbation of COPD, pulmonary hypertension, cor pulmonale and congestive cardiac failure (heart failure)". The cardiologist made some alterations to his medication and treatment. He was discharged back to Parc on 7 March. There was a discharge letter in the hospital records which said that he had needed intermittent oxygen treatment and he had been referred to the Respiratory Nurse for a long-term oxygen therapy assessment. An appointment had been booked for 17 April. The discharge note also said that he would need an ECHO stress test (special lung and heart scan done during exercise) as an out-patient. Finally, it mentioned that he had not been physically able in hospital and had been referred for a physiotherapy assessment. There is no mention of the chest X-rays or any results.
58. On 13 March the man informed a doctor that he wanted his friends, one of whom was his nominated next of kin, to be contacted should anything happen to him.

59. Between his discharge from hospital on 7 March, and his next admission to hospital on 22 March, the man was again seen numerous times by healthcare and administered oxygen when his saturation levels were low. A doctor told us that he saw him on the wing on 22 March. They discussed his poor prognosis and he said he did not want to be treated palliatively. He wanted to be actively resuscitated in the event of a cardiac arrest and he wanted to be actively treated any time he got a chest infection or any time he got short of breath. This was noted in his medical records.
60. Later on 22 March, he was admitted to hospital due to oxygen saturation deterioration. He returned to Parc on 26 March, and was again admitted soon after, on 29 March. He was discharged from hospital on 6 April. In the transfer of care there were no indications that any investigations occurred while he was at hospital.
61. It was noted that the man was breathless when he returned to Parc, but he still refused to stop smoking. Between 8 and 10 April, he was seen seven times by healthcare staff, and oxygen was administered where necessary. On 11 April, it was agreed that his cell would remain open at all times so that staff could easily assist with his healthcare needs at any time.
62. A doctor spoke to the man several times about his deteriorating health and that he should be admitted to hospital. He initially refused as he was afraid. However, he eventually agreed and was taken to hospital on 12 April 2012.
63. An escort risk assessment was completed to determine the level of security needed, including whether restraints should be used. It was recorded that because of the man's medical conditions, poor mobility and that he was on an oxygen cylinder no restraints were to be applied. He was accompanied by two officers when he was transferred, and this was to be reviewed once he arrived at the hospital. On 13 April, the escort log notes that a nurse had perceived that he had been sexually inappropriate towards her, but the log does not record in what way. It was decided that female nurses should not be left alone with him, including when he was being examined.
64. On 13 April, doctors confirmed that the man would need to remain in the hospital for the foreseeable future. The prison was informed and the prison chaplain visited him. He was also visited by two friends, one of whom was his nominated next of kin.
65. The man's health deteriorated. The PCT note that all staff were surprised by his unexpected deterioration and doctors believed that a contributory factor, in addition to the known problems of COPD, heart failure and chest infection, was that he had not drunk enough fluids over the previous 24 hours. Escort officers at the hospital contacted the chaplain who, in turn, contacted the man's next of kin at 5.10 pm and let the officers know that his friends intended to visit that evening.

66. The man was reviewed again by doctors at 7.00pm when a marginal improvement was noted. However his condition subsequently deteriorated and he died at 9.25pm. His friends were with him at the time.

Contact with the man's friends

67. When his health deteriorated liaison staff at Parc contacted the man's friends, and kept them informed of any changes in his condition. As noted above, his friends were able to be with him when he died. After his death, the chaplain, who was also the prison's family liaison officer, met the man's friends at the hospital. He kept in contact and the prison assisted with funeral arrangements and expenses.

Informing staff and prisoners

68. Staff and prisoners were informed of the man's death by a notice from the director, and support was offered if needed.
69. Escort and healthcare staff involved in the care of the man were appropriately debriefed and supported where required.

Results of the post mortem

70. The post mortem confirmed that the man had a long standing severe lung disease in the form of chronic bronchitis and emphysema, and that more recently had developed a carcinoma of the right lung (cancer) with evidence of tumour spread to the adjacent lymph nodes and his liver. The post mortem concludes that he died of the following:

1a Left lower lobe pneumonia and metastatic carcinoma of right lung.

2 Chronic bronchitis and emphysema.

ISSUES

Clinical care

71. The PCT noted that the man received a high level of care and attention from healthcare staff at Parc. After he moved at the beginning of February, he was adjacent to healthcare and was seen almost daily. The PCT comment that if he had been in the community he would not have had the frequency of visits or attention. They concluded that his access to primary health care services was equitable with that he could have expected to receive in the community.
72. The PCT note that throughout his time at Parc, the man was given all possible treatment for his known conditions. He was prescribed the correct pain relief, and his request for active treatment was taken into account. He frequently did not take his prescribed medications and Parc managed this by ensuring a staff member gave it to him daily.
73. We discussed with the PCT that hospital doctors believed that the man might not have taken sufficient fluids on 19 April, and that this had contributed to his sudden deterioration. They consider that as he was mobile and appeared much better at that time, it would have been his responsibility to drink and make sure he was hydrated. However, we are surprised that the hospital did not manage the fluid intake for a man who was very unwell.

The post mortem diagnosis of lung cancer

74. The PCT say that a diagnosis of lung cancer is typically made when a doctor orders a chest X-ray after a patient complains of chest problems. Once carried out, if a consultant radiologist (an expert in X-rays and their interpretation) suspects a problem, then a report is produced and a referral is made to the chest clinic. In the man's case, a chest X-ray was carried out on each admission to hospital. On each of these occasions an admitting doctor wrote their interpretation of the X-rays in his hospital notes, and the radiologists reports followed on much later. The PCT note that the only occasion where the possibility of a more serious diagnosis was made, was following an X-ray report on 27 January. The doctor recorded 'follow up chest X-ray advised post treatment to check for resolution and exclusion of any abnormality'. Follow up X-rays were carried out and reviewed. On 27 March, an entry was made in his hospital records, which notes that a respiratory physician was content that no further intervention was required at that time.
75. The PCT conclude that while sometimes a chest X-ray cannot truly reflect what is actually happening, there were some inexplicable delays between X-rays being taken and the reports being completed. Treatment in hospital is outside the PPO's remit, and the PCT is addressing this issue separately.

Obtaining medical records

76. Prison Service Order 3050, entitled Continuity of Healthcare for Prisoners, notes that when a new clinical record is created “efforts should be made to retrieve any information required from the prisoner’s GP or other relevant services he/she has been in contact with”. The man had a complex medical history which was immediately apparent from the amount of prescribed medication he arrived with. At his reception health screen it was noted that his medical history and medication needed to be checked with his community doctor. This was not done. As a result healthcare staff at Parc were not aware of a previous admission to hospital and that he had an outstanding chest X-ray appointment. During interviews, Parc staff said that obtaining community GP records is a perpetual problem as when they do request them, they are often not received. However, in his case no attempt was made. The PCT suggest that if clear processes were in place, there should be no problems in obtaining community medical records. We make the following recommendation:

The Head of Healthcare should ensure that there is a clear process to request and obtain medical records from community doctors for newly arrived prisoners.

Communication between hospital and prison

77. The PCT comment that communication between healthcare at Parc and both hospitals was poor. In the man’s case he was sometimes admitted to hospital without full details being provided to the hospital. When he was discharged from hospital, the diagnosis made, the results of investigations and future plans were not always provided to Parc to ensure continuity of care.
78. The PCT comment that “GPs work under the assumption that if an issue is important the hospital will tell the GP”. In the absence of any noteworthy information, the GPs (Parc) made the assumption that the man was seen and an exacerbation of COPD had been treated.
79. The PCT note that an echocardiogram was carried out on 6 February. This showed that the man had severe heart failure, yet staff at Parc were not made aware of this significant diagnosis. Fortunately, in his case, both doctors interviewed at Parc were satisfied that even without the knowledge of this diagnosis, he was on the correct medication. The only detailed letter that came to Parc followed his discharge on 5 March.
80. We consider that, in order to ensure appropriate continuity of care, information sharing between the prison and hospitals needs to improve.

The Head of Healthcare should agree a protocol with local hospitals to ensure that necessary patient information is shared between the prison and hospital to allow appropriate continuity of care.

Record Keeping

81. The PCT concludes that there has been a considerable improvement in the medical records at HMP Parc since the introduction of SystmOne (a centralised clinical computer system). They comment that the records are now easy to read and that there is evidence of some good entries with management plans. However, they note that there are some omissions in the man's records, including aspects of care offered and names of staff involved.
82. A discharge plan from the hospital dated 7 February, requested that blood tests be repeated in three days. There were no entries in the man's records to indicate that these tests were requested or carried out. When interviewed, a doctor said that he had refused to have the tests. However, the blood test requests were not recorded and neither was the refusal to have them done. The PCT comment that this is a clinical governance issue and should have been recorded.
83. All healthcare staff, irrespective of grade, including agency staff, have a duty to ensure that accurate and comprehensive records are entered on the computerised system. Record keeping has been identified as a problem in previous investigation reports into deaths at Parc and it is regrettable that it is still an issue.

The Head of Healthcare should ensure that all healthcare staff comply fully with the requirements for accurate and contemporaneous record keeping in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.

Use of Restraints

84. On each occasion a prisoner is taken from prison to hospital a risk assessment should be carried out. The assessment should consider the risk to the public, risk of further offending, and likelihood of escape, taking into account the prisoner's health and mobility. The risk assessment should inform decisions about the number of officers who are needed to escort a prisoner, whether any restraints are needed and if so the type of restraint to be used.
85. When the man was admitted to hospital on 21 January, a risk assessment was completed and reviewed the next day. He was discharged on 23 January. It was decided that he had the ability to escape and he was restrained by an escort chain (a 1.8 metre long chain with a handcuff at either end, one end attached to the prisoner and one to an officer). He was accompanied by two officers. When reviewed on 22 January, it was again concluded that his ability to escape and the nature of his alleged offence meant that he was considered to pose a risk as he was on an open ward. The decision remained that he should be restrained by a single handcuff and escort chain. On 4 February, when he was admitted to hospital again, the risk assessment remained the same.

86. The man's friend told us that she felt his level of restraint was not appropriate and had caused him additional distress when he was admitted to hospital on these occasions.
87. On all subsequent admissions to hospital risk assessments were completed, and the man was not restrained as his health had clearly deteriorated. He was always escorted by two officers.
88. When a risk assessment is completed for a hospital escort the assessor should judge the risk of escape and of harm to the public taking into account the prisoner's current state of health. The use of restraints should be proportionate to the perceived security risks and be balanced by considerations of care and decency for the prisoner. In his case, when he was admitted to hospital in January, risk assessment documents were completed. Both record that there were no medical objections to the use of restraints, but how his health problems affected his risk was not considered and there is no evidence it was taken into account. He was an elderly, unwell man, who was being taken to hospital because of breathing difficulties. It is probable that the presence of two escorting officers would have been sufficient to manage the risk but it is not apparent from the risk assessment that this was considered. We make the following recommendation:

The Director should ensure that hospital escort risk assessments fully take into account and record the prisoner's state of health and how this impacts on his security risk at the time.

CONCLUSION

89. The man arrived at Parc in January 2012 already in very poor health. During his reception health screen it was recorded that he had COPD, emphysema and exacerbation of obstructive pulmonary disease. No medical records were obtained from his community doctor.
90. The man was admitted to hospital a number of times while at Parc, and on several occasions there were no discharge notes from the hospital so healthcare staff at Parc were not always fully aware of investigations, diagnoses and treatment given.
91. Healthcare and prison staff was worked well together to make the man more comfortable. He was moved him to a unit where he would have easy and regular access from healthcare staff as his condition got worse. Overall his care was of a standard equal to what he might have expected in the community.
92. However, we are concerned that the man's community medical records were not obtained and there was a lack of effective communication between hospitals and Parc. He was restrained during some hospital stays but this was not backed up by thorough risk assessments which took into account his state of health. Record keeping and appropriate risk assessments to justify the use of restraints for ill prisoners are both matters which we have previously raised with Parc.
93. We are satisfied that during the man's illness and after his death Parc appropriately kept in contact with his friend, who was his nominated next of kin.

RECOMMENDATIONS (*Service response below each*)

1. The Head of Healthcare should ensure that there is a clear process to request and obtain medical records from community doctors for newly arrived prisoners.

Accepted: *A system is to be implemented whereby Healthcare Admin staff routinely request medical records for community GPs.*

2. The Head of Healthcare should agree a protocol with local hospitals to ensure that necessary patient information is shared between the prison and hospital to allow appropriate continuity of care.

Accepted: *This matter is to be raised at the next Partnership Board as a protocol needs to be agreed with the hospital.*

3. The Head of Healthcare should ensure that all healthcare staff comply fully with the requirements for accurate and contemporaneous record keeping in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.

Accepted: *It is acknowledged that the request for bloods was not carried out but this was due to an ineffective request system and not poor record keeping. A new system for requesting bloods was implemented in July 2012.*

4. The Director should ensure that hospital escort risk assessments fully take into account and record the prisoner's state of health and how this impacts on his security risk at the time.

Accepted: *Risk assessment process revised and implemented which takes account of individual circumstances. Audited during recent external IAA audit and all baselines identified as compliant.*