Investigation into the circumstances surrounding the death of a man in November 2011 at hospital while in the custody of HMP & YOI Parc

Report by the Prisons and Probation Ombudsman for England and Wales

July 2012

This is the report of the investigation into the death of a man. He died in November 2011 at hospital at the age of 73. At the time of his death, he was a serving prisoner at HMP & YOI Parc. The post mortem examination found that he died as a result of ischaemic heart disease, narrowing of the arteries around the heart, and pneumonia.

The investigation was carried out by an investigator. Healthcare Inspectorate Wales (HIW) reviewed the clinical care the man received at Parc. Staff at Parc co-operated fully with the investigation. I am sorry that this report is slightly late.

The man was sentenced to 11 years imprisonment on 21 July 2011 and arrived at Parc that evening. The previous day he was discharged from hospital having spent seven weeks recovering from an operation to treat a potentially fatal condition. He suffered a number of health issues, including a lung condition and arthritis for which he was prescribed medication. He also used a wheelchair to move longer distances.

While at Parc, the man was housed on the unit designed for older prisoners. He was frequently examined by healthcare staff and referred for further tests as necessary. In late September, he often complained of being short of breath and, in October, spent four days in hospital. He returned to Parc on 28 October but due to further concerns about his health, was re-admitted to hospital on 29 October, where he remained until his death.

HIW concludes that the standard of healthcare the man received at Parc matched that he might have expected in the community. However, the investigation identifies a need to ensure effective communication between healthcare staff and also repeats recommendations made in previous reports from this office regarding the need for better record keeping in healthcare, and more considered risk assessments to justify the use of restraints on infirm prisoners in hospital. This final version of the report includes the National Offender Management Service (NOMS) response to the recommendations made.

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 **July 2012**

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SUMMARY

1. On 1 June 2011, the man, who was 72 years old, was convicted of sexual offences that he had committed some years earlier. He was due to be sentenced the following month, but on 24 June, he was admitted to hospital suffering an abdominal aortic aneurysm (a life threatening condition when part of the major blood vessel in the abdomen swells and is in danger of rupturing). He underwent emergency surgery and stayed in hospital until 20 July. On 21 July, he appeared in court and was sentenced to 11 years imprisonment. It was not his first time in custody.

2. On his arrival at Parc, his health was assessed by a nurse who recorded that he had a number of health problems, including a lung condition and arthritis, was prescribed numerous medications and had mobility problems. He said that he used a wheelchair and so he was given a disabled access cell on the unit housing older prisoners.

3. Over the following weeks, the man was examined frequently by doctors and nurses for a variety of health complaints. He often complained of being short of breath and his pulse, blood pressure and blood oxygen levels were monitored. He sometimes needed to be administered oxygen which restored his blood oxygen levels to normal.

4. On 20 August, a doctor requested a blood test for him. Another doctor reviewed the blood test results four days later and noted that the man had much lower than normal levels of haemoglobin. (Haemoglobin, a protein found in the red blood cells, carries oxygen around the body. Particularly low levels can be an indication of serious health problems.) Although the doctor recorded that another appointment should be made for him, the man was not seen again (for an unrelated matter) until 31 August. The doctor examining him in his cell noted the abnormal test results and said that he should be given a surgery appointment. In fact, the blood test results were not properly acted on until 13 September, by which time the haemoglobin levels in his blood had risen.

5. Following an examination, a doctor suspected that the man might have cancer and referred him for urgent tests. The man was adamant that he did not want to undergo any particularly intrusive examinations and did not want to know if he had cancer. Healthcare staff discussed his choices with him on several occasions and emphasised the importance of undergoing further tests. However, he continued to refuse certain procedures.

6. In late September, the man began reporting frequent episodes of shortness of breath and was assessed by healthcare staff. On 24 October, he was referred to the local hospital for treatment. He was admitted and stayed in hospital for four days. On 29 October, the day after he returned to prison, he was examined by a doctor who found his blood oxygen levels were very low. She referred him back to hospital.

7. The man underwent procedures to remove fluid from his lungs and remained in hospital. As his health was deteriorating, prison staff discussed with him whether

he wanted his family to be contacted, but he said that he did not. On 10 November, he contracted an infection. Over the following two days his condition got worse and he died.

8. The post mortem examination found that the man died as a result of heart disease, narrowing of the arteries around the heart and pneumonia. We conclude that he received a standard of care equivalent to that he might have expected in the community. However, we make three recommendations as a result of the investigation. Two relate to clinical matters and the other to the use of restraints.

THE INVESTIGATION PROCESS

9. The Ombudsman's office was notified of the man's death on 13 November. The investigator visited Parc on 21 November and met the Director and the deputy Controller who oversees the delivery of the contract for this privately managed prison on behalf of the National Offender Management Service (NOMS). She also spoke to a member of the Independent Monitoring Board (IMB) and a senior member of staff from the healthcare department. She was shown around the prison and visited U1, the unit the man had lived on, and the healthcare department. She was provided with copies of his medical record and prison files.

10. The investigator issued notices informing staff and prisoners of the Ombudsman's investigation and inviting them to contact her with relevant information. There was no response to the notices.

11. HIW carried out a review of the clinical care the man received at Parc. They reviewed his medical record and visited Parc in February 2012 to interview healthcare staff. The clinical review was not received until 27 April, which held up the production of this report. The delay is regretted.

12. HM Coroner for Bridgend and the Glamorgan Valleys was informed of the Ombudsman's investigation and provided a copy of the man's post mortem report. She will be sent a copy of this report to assist with her enquiries.

13. The man did not have any contact with his family while he was at Parc and instructed prison staff to direct all communication through his solicitor. However, his family was being offered support by the local victim support unit and our office made contact with the victim support officer. We were told that the family had declined further contact with the unit or the prison. After his death, his solicitor also said that he did not want any further involvement in our investigation.

HMP & YOI PARC

14. HMP & YOI Parc, which opened in 1997, is run by the private company G4S. It holds up to 1474 convicted male adult prisoners and young adults on remand or convicted.

15. Since October 2010, G4S has provided 24 hour primary general and mental healthcare services at Parc. The healthcare centre has a 14 bed unit for older prisoners with increased health needs (known as U1 and where the man lived while at Parc) and six emergency care beds for patients with acute physical or mental health needs. 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)

16. 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.

17. 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. However, G4S was 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)

18. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community which monitors all aspects of prison life to 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

19. The man was the 14th prisoner to die of natural causes at Parc since 2004, when the Ombudsman began investigating all deaths in prisons in England and Wales. Two prisoners have died of apparent natural causes since he died. We have made recommendations about improving record keeping in four previous investigations and about properly risk assessing the use of restraints in one other investigation. It is disappointing to find that we must repeat them in this report.

KEY EVENTS

20. On 1 June 2011, the man, a 72 year old, was convicted of sexual offences that he had committed some years earlier. The judge decided not to sentence him until the local Probation Trust had completed a report considering the most appropriate sentence. However, on 24 June, he was admitted to hospital suffering with an abdominal aortic aneurysm (a very serious condition when part of the major artery in the abdomen swells and is in danger of rupturing). He underwent an operation in which the damaged section of the artery was replaced by an artificial piece.

21. He was discharged from hospital on 20 July and appeared at Crown Court the following day. He was sentenced to 11 years in prison and arrived at HMP Parc later that day. It was not his first time in prison.

22. A nurse completed an Initial Screening Document (the purpose of which is to establish any immediate physical or mental health problems needing attention) and recorded that he needed help moving around and keeping himself clean and that he might need a disabled access cell. (Disabled access cells are designed to accommodate wheelchairs and have normally been adapted in other ways to help prisoners with disabilities.) The man told the nurse that he had been living on his own before coming to prison. He said that he suffered with emphysema and arthritis and sometimes felt dizzy. (Emphysema is a chronic lung condition which can cause shortness of breath, tiredness and wheezing. Arthritis is a painful condition which causes the bone joints to swell. Both conditions get worse over time.) The nurse recorded that he was prescribed peptac (to treat indigestion), tiotropium (to prevent wheezing and shortness of breath), lansoprazole (to reduce the amount of acid produced by the stomach), pravastatin (to lower cholesterol), lactulose (a laxative), ramipril (for high blood pressure), quinine (for night time leg cramps), aspirin (which can help prevent heart attacks and strokes) and paracetamol.

23. The man did not want to see a doctor. On 21 July, however, a doctor discussed his medication with a nurse that evening and, according the entry in the medical record, continued his prescriptions. The doctor suggested that the man should be examined by another doctor the following day. He also told the nurse that further information about the man's recent hospital treatment would need to be obtained.

24. Following assessment, the man was given a disabled access cell on U1 unit for older prisoners who require additional staff support, and given a wheelchair. The unit has 14 cells, six of which offer disabled access. Association periods (when prisoners can mix with each other and use the showers) take place on the unit. All cells are fitted with a telephone so that prisoners can speak to friends and family from their cells. Prisoners collect their medication from healthcare staff on the unit and additionally either a doctor or nurse visits the unit every week to check the general health of the prisoners.

25. The following day (22 July), a doctor examined the man in his cell. The doctor wrote his notes in his medical record. (Until October 2011, Parc kept paper

medical records in which staff made hand written entries. Some of the entries are difficult to read and it is not always possible to identify the name or role of the individual making the entry. In October, the prison moved to the electronic medical record system, SystmOne. This means that all entries are made on a computer which automatically notes who is making the entry and at what time.)

26. The man told the doctor that he felt fine and was not experiencing any abdominal pain. The doctor recorded some information about his history of lung disease, arthritis, high blood pressure and acid reflux. The doctor wrote that he had recently spent seven weeks in hospital being treated for an abdominal aortic aneurysm.

27. The doctor carried out a series of checks and wrote that the man's blood pressure was 114/70 mmHg and his blood oxygen level (the amount of oxygen in the blood) was 96 per cent. Both readings were within the normal ranges. His chest sounded clear with no wheezing and his heart sounded normal. The doctor examined his abdomen and recorded that it was appropriately soft and was not tender. The doctor recorded that he should be reviewed by healthcare staff as required.

28. A Prison Custody Officer (PCO) completed a Personal Emergency Evacuation Plan (PEEP) with the man that day. (A PEEP must be completed with all prisoners with disabilities. It establishes their specific needs and the help they will require in the event of an emergency evacuation.) He said that he needed a wheelchair or walking frame to move long distances and so he would need help if the prison had to be evacuated in an emergency.

29. At 4.20am on 24 July, a nurse was called to the man's cell by the officer on duty. He had apparently been complaining of pain in his abdomen, but, when the nurse arrived, said that the pain had gone. He declined pain relief medication.

30. On 28 July, the man was assessed by a nurse in the disability clinic. She noted that he was a wheelchair user because his legs were weak and he was generally unwell. The nurse recorded that he could walk short distances using a walking stick, but needed the wheelchair for longer distances.

31. A doctor examined him on 3 August, because he was complaining of a cough and a lump in his abdomen. The doctor wrote that he was alert and able to speak at a normal rate. (Shortness of breath or chest problems may affect the patient's ability to speak in full sentences because they need to breathe more frequently.) However, the doctor concluded that he had a respiratory tract infection and prescribed antibiotics. He also examined his abdomen and felt a ten centimetre lump near his navel.

32. The doctor recorded that the man was not able to stand up for more than two or three minutes and that he needed to see the physiotherapist about his mobility issues. The doctor also concluded that he needed a follow up appointment with a doctor to assess his chest problems and the lump in his abdomen. A later entry in the medical record indicates that the man was referred for an abdominal X-ray that day (the appointment was scheduled for 21 September). The doctor

also asked healthcare staff to seek further information about him from the hospital that had treated the abdominal aortic aneurysm. The hospital was contacted and responded on 4 August. There is nothing to indicate who was responsible for referring him to the physiotherapist or whether the referral occurred.

33. On 5 August, the man was assessed by a doctor, who noted that his cough was much better. The doctor also examined his abdomen and noted that he had been referred for an X-ray. The doctor read his blood pressure, which was slightly low. As a result, he reduced his daily dose of ramipril (which can lower the patient's blood pressure).

34. A doctor examined the man's chest again in his cell on 17 August and recorded that it sounded clear with no wheezing. The man said that he was feeling better. Three days later (20 August), he was examined by another doctor, having complained that he could not stand as his legs felt weak. The doctor recorded that he had suffered two strokes in 1999 and 2002 but that they had not resulted in any ongoing problems. She checked for any signs that he was having another stroke and found none. He was not short of breath and did not have a cough. The doctor instructed nursing staff to check his blood pressure and take a urine sample as he might have a urinary tract infection. She also ordered a number of blood and organ function tests to take place the following Monday.

35. At 12.30pm that day, the man was seen in his cell by a nurse. His blood pressure was monitored and found to be within the normal range. He was unable to produce a urine sample. Just over four hours later, another nurse went to see him in his cell because he had been sick. The nurse recorded that he was lucid and alert. His blood pressure, pulse, blood oxygen level and temperature were taken and found to be within normal ranges. He was advised to contact healthcare staff again if he felt any worse. The nurse arranged for him to see a doctor the following morning.

36. A doctor examined the man on 21 August. He told the doctor that he was feeling better. The doctor carried out a number of checks and concluded that either he was still suffering with a respiratory tract infection or that there was some other underlying problem with his lungs. He prescribed a further course of antibiotics and requested a chest X-ray be undertaken. (There is no further information in the file to confirm whether this request was acted upon or the result. The next recorded X-ray is when he was taken to hospital as an emergency on 16 September.) The doctor also wrote that medical staff needed to discuss with him whether he wanted to be resuscitated if he stopped breathing. The doctor noted that unit staff should be informed of any decision he made. On 22 and 23 August medical staff took urine and blood samples for testing.

37. On 23 August, a nurse carried out another mobility assessment with the man. The nurse recorded that he needed to be referred to the physiotherapist to encourage him to walk. Although a referral was made, he had not been assessed by the physiotherapist before his death. The nurse also referred him to the asthma clinic because of his lung disease. She wrote that she had contacted

the prison maintenance department to arrange for hand rails to be fitted near the toilet and bed in his cell. She arranged to see him again in a week.

38. The following day, a nurse saw the man on U1. He wrote that he was finding it difficult to eat normal food, and emailed the prison kitchen to ask that he be given soups as well as the normal prison menu.

39. The man's personal officer made an entry in his prison file on 24 August. The PCO wrote that he had no problems apart from needing hand rails fitted in his cell. The maintenance department had been contacted and said that they were waiting for a work request form to be submitted. (The work request form sets out the details of what is required.) The PCO submitted a work request form that day. The prison said that he moved to another disabled access cell, with hand rails fitted, later that month.

40. Later on 24 August, a doctor reviewed the results of the urine and blood tests and found that the man's haemoglobin level was 8.5 g/dL. The normal range is between 12 and 18 g/dL, although this varies according to a number of factors. Low haemoglobin levels can indicate anaemia (when there are lower than normal levels of iron in the blood), the presence of an infection, or that the patient is losing blood. The blood test revealed other signs that he might have an infection or inflammation. The doctor noted that an urgent appointment for him should be booked. There is no further information about who was responsible for booking the appointment and he did not see a doctor again until 31 August.

41. A doctor was asked to see the man in his cell on 31 August and, during the appointment, again reviewed his blood test results. The doctor noted the abnormal results but wrote that he had actually been asked to examine him after a fall the previous day. The doctor wrote that he looked "generally unwell and pale" but was not having any trouble breathing and had not broken any bones. Because the doctor was examining him in his cell, he noted that he should be given another appointment to discuss the blood test results in the healthcare centre. Again, it is not clear whose responsibility it was to book the appointment and he did not see another doctor until two weeks later.

42. On 13 September, a doctor made an entry in the man's medical record, noting that, despite the worrying haemoglobin levels in the earlier blood test, no further action had been taken. He told the doctor that he felt fine but was struggling to eat very much and had lost a lot of weight in the last eight weeks. He said that he did not have any blood in his stools. The doctor wrote that he was pale and looked as if his physical health was deteriorating. The doctor performed tests and noted that his blood oxygen level was 75 per cent (below the normal range), however, he was not short of breath. The doctor thought that the low oxygen level was most likely to be the result of poor circulation rather than a more serious problem.

43. The doctor weighed the man and examined his abdomen but he refused a rectal examination. The doctor found no obvious causes for concern but wrote that his health problems might either be caused by blood loss as a result the abdominal surgery or a sign of gastrointestinal cancer. The doctor instructed that a second

blood test be performed that day and noted that if the haemoglobin level was the same or better, he should continue to take aspirin. If the level had fallen, he should stop taking aspirin. The doctor wrote that, if the haemoglobin level had fallen below 7.5 g/dL, he would need to be admitted to hospital for a blood transfusion.

44. The doctor wrote that he and the man had discussed his health problems at length. After the appointment, he referred him to the local hospital for further investigation under the two week rule because of his concerns that he might have cancer. (According to National Health Service guidance, when a doctor suspects that their patient might have cancer, the patient should be seen by a specialist within two weeks of the referral.)

45. The following day, 14 September, a doctor reviewed the second blood test results. This time the haemoglobin level was 9.9 g/dL and the doctor wrote that another doctor's instructions should be followed. The doctor recorded that he had advised him to make another appointment to see a doctor.

46. At 2.40am on 16 September, wing staff called a code blue emergency because the man was struggling to breathe. (Code blue is the radio call used to alert staff to a medical emergency where the prisoner is having trouble breathing. Code systems are in place in most prisons in England and Wales and help medical staff bring the right equipment to the scene.) A nurse attended and checked his blood pressure, which was low at 96/50 mmHg. His oxygen saturation level was 82 per cent (which was low) and so he was given oxygen to breathe and the level returned to normal. The nurse decided that he should be taken to hospital for further assessment and so an ambulance was called.

47. The man returned from hospital at 6.00am. Hospital staff had carried out tests, the results of which were within the normal limits. A chest X-ray had been taken and indicated no further serious problems. Hospital staff said that they thought he might have suffered a panic attack.

48. A doctor examined the man later that day. He said that he was feeling fine. The doctor wrote that he was not short of breath and his chest sounded clear. He had no cough or fever and his pulse and blood pressure were normal however, his oxygen saturation level was slightly low at 88 percent. The doctor reassured him that healthcare staff would reassess him if necessary.

49. On 17 September, the man fell in his cell. As a result, a nurse examined him and checked his pulse, blood pressure, oxygen saturation level and pupil response to light. All the results were normal.

50. At 4.45am on 20 September, the man complained of difficulty breathing again and a nurse was called to see him. The nurse took a blood pressure reading (which was low), but his oxygen saturation level was normal at 98 per cent. The nurse wrote that he was very anxious and needed reassurance. When he began to relax, his breathing improved. He did not need any further treatment.

51. The man was due a hospital appointment the following day for an ultrasound examination of his abdomen (which had been requested on 3 August) but he refused to attend the appointment. A nurse visited him on U1 and explained the importance of the examination. The nurse wrote that he was very worried that he might have cancer. Although it was now too late for him to attend the original appointment, he agreed to the procedure and the appointment was rescheduled for the following week.

52. On 22 September, the man refused to go to hospital for an endoscopy (when a thin, flexible tube with a light and camera is passed through the nose into the digestive system). A doctor visited him on U1 to discuss the procedure. He said that he did not mind having X-rays and ultrasound examinations but did not want an endoscopy. He also said that, if he had cancer, he did not want to know. The doctor explained the implications of not having the endoscopy and told him that he was worried about him. Despite the doctor's advice, he refused to have an endoscopy or colonoscopy (when the tube is passed through the rectum into the digestive system). The doctor recorded that he had full mental capacity and so his wishes should be respected. He signed a disclaimer acknowledging that he was refusing treatment against the doctor's advice.

53. The man was due to attend a hospital appointment on 26 September, but he was not collected by officers. The duty director said that the appointment was not logged in the escort diary. The healthcare administrator noted that she was certain the correct department had been notified of the appointment the previous day. The appointment was rescheduled for 27 September and he attended.

54. A doctor examined him on 28 September. The doctor recorded that a hospital surgeon had assessed the lump in his abdomen. He was due to undergo an advanced scan of his abdomen but again said that he did not want to know if something was seriously wrong. The doctor discussed his future medical treatment with him. He said that he wanted to be resuscitated if he stopped breathing. The information was recorded in his medical record and passed to staff on U1 and at the hospital on his next admission.

55. A nurse spoke to him later that day to discuss his decision to refuse the endoscopy. He remained adamant that he did not want the procedure. He repeated that he did not want to know if he was seriously ill. On 29 September, healthcare staff tried again to persuade him to undergo to the procedure. However, they reassured him that he would not have any treatment that he did not agree to. He was advised to tell the hospital consultant that he did not want to know if he had cancer.

56. At 7.15pm on 29 September, the man complained of being short of breath again and a nurse went to his cell. His blood oxygen level was 88 per cent and he was given oxygen until the level rose to 99 per cent. The nurse stayed with him for a while and his oxygen levels remained stable.

57. A doctor examined him on 30 September and wrote that he had an ulcer at the bottom of his spine, which had been there for about three or four weeks. (Such ulcers can occur if the patient spends a great deal of time sitting or lying in the

same position.) The presence of the ulcer had not been noted previously in his record. The doctor instructed nursing staff to review how the ulcer was being treated and dressed.

58. A nurse was called to the man’s cell at 3.30am on 3 October because he was short of breath again. His blood oxygen level was normal and he said he was not in any discomfort. The nurse reassured him and told him to tell unit staff if he felt any worse.

59. At 7.45pm on 4 October, a nurse assessed him once more because he was short of breath. His blood oxygen level was again normal and he did not need to be given oxygen.

60. A doctor examined him on 11 October and noted that he had swollen feet. The doctor thought that this was because he had recently stopped taking furosemide (which is used to treat heart conditions and helps to remove excess water from the body). He said that he was not short of breath. The doctor re-prescribed a one-off dose of furosemide and directed that he be reviewed by a doctor in two weeks. (There is no record of him having previously been prescribed furosemide.)

61. A doctor saw him again on 24 October. The doctor wrote that nurses had been called to see him twice over the preceding weekend because he was having trouble breathing. (No entries were made in his medical record over the weekend, but the prison moved from handwritten medical notes to the computerised SystmOne at about this time, which might account for missing entries.) The doctor took his blood pressure, which was 115/60mmHg and normal. However, the doctor wrote that he looked unwell and that, when examined with a stethoscope, his lungs made crackling noises. He recorded that he might be suffering with pulmonary oedema (when fluid leaks from the blood vessels near the lungs into the lungs). He referred him to hospital for further assessment. He was admitted later that day.

62. A risk assessment was carried out to decide whether the man needed to be restrained while in hospital. Staff noted that he used a wheelchair, posed a medium risk to the public and to staff but had been well behaved in prison. He was not to be allowed contact with children while in hospital. Staff decided that he should be accompanied by two members of staff and restrained by an escort chain because he was a category B prisoner. (An escort chain is a length of chain with a handcuff at each end. The prisoner wears one handcuff and a member of staff the other.)

63. The following day, another risk assessment was conducted. This time, staff did not mention that he used a wheelchair and concluded that he would be able to escape unaided. There were no medical objections to him being restrained. He was again judged to pose a medium risk to the public and to staff. He remained restrained by the escort chain while at the hospital.

64. The man returned to the prison from hospital on 28 October. He said that he felt well and was described as being in good spirits. However, the following day, a

doctor examined him because he was increasingly short of breath. She noted that his blood oxygen level was 77 per cent and he was having trouble breathing normally. She treated him with oxygen, and although his condition improved, she arranged for him to return to hospital by emergency ambulance.

65. He was admitted as an inpatient and was treated with medication via a nebuliser (which dispenses medication in a mist which is easier for the patient to breathe). Hospital staff were told that he wanted to be resuscitated if he stopped breathing.

66. Another risk assessment was carried out. The man, although judged unlikely to try to escape, was considered to be mobile enough to do so if he wanted. (The assessment makes no mention of him needing a wheelchair.) Healthcare staff said that there was no medical reason why he should not be restrained. The duty director instructed that, because of "poor security" at the hospital, he should be restrained by an escort chain, which could be removed during treatment. Two members of prison staff remained with him at the hospital (this is known as a bedwatch).

67. On 30 October, hospital staff decided that the man needed to undergo a kidney function test. He had fluid on his lungs and so he had to stay in hospital. That day, bedwatch staff noted that all restraints had been removed (and they were not reapplied).

68. The prison chaplain visited the man in hospital on 1 November. He confirmed that he did not want any members of his family to be contacted. He said that his brother had refused any further contact when approached by his solicitor.

69. That afternoon, a case conference meeting was held at the prison to discuss him. The meeting was attended by people from a range of departments, including the chaplain, healthcare staff and the prison's safer custody representative. The chaplain told the group that she had visited him in hospital that day and that he still had fluid on his right lung. However, hospital staff had advised the prison that he might be well enough to return to prison by the end of that week. The group noted that he had discharged himself from hospital in the past, even though he was unwell.

70. Staff discussed the man's lack of contact with his family. They noted that his solicitor had been granted Power of Attorney (meaning that he could manage his affairs for him). The chaplain agreed to draft a letter for him to sign confirming that he did not want his family to be contacted about his ill health. Staff agreed that, in any case, as the victims of his offences, they would need to be told of his death and that this would be done through the victim liaison officer.

71. The chaplain told the group that she visited the man every day that she was working. Other staff present at the meeting agreed to visit him too.

72. Following the case conference, healthcare staff also met to discuss the man's future. An entry made in his medical record noted that staff would need to liaise with hospital staff to plan for his discharge to the prison. A member of the prison

nursing staff telephoned his ward and emphasised that the prison would need plenty of warning before he could be discharged to them.

73. On 2 November, the man signed the letter prepared by the chaplain confirming that he did not want his family to be notified of his ill health. The following day, prison staff reported that the victim liaison officer had been contacted and informed of the situation. The chaplain visited him again on 6 November. She noted that he had lost weight since her last visit and that he looked unwell.

74. On 9 November, the man contracted Clostridium Difficile (a bacterial infection which can cause serious health problems in those who are already unwell) and needed to be moved to an isolation room away from the hospital ward. Escort staff were told that they should remain outside his room. Later that day, the chaplain emailed colleagues to confirm that his health was deteriorating. She said that he was being treated with oxygen but was confused. Bedwatch staff noted that he was becoming increasingly frail. He reiterated that he did not want his family to be contacted and asked prison staff to instruct his solicitor to arrange his funeral in the event of his death.

75. At 4.00am the man's condition deteriorated further. At 7.15am, hospital staff began to administer emergency treatment, but despite this, he died at 7.25am.

76. His family was informed of his death by a victim liaison officer on 15 November. He left money and instructions for his funeral with his solicitor, at which the chaplain officiated.

Results of the post mortem

77. The post mortem examination revealed the cause of the man's death to be:
    1a. Ischaemic heart disease
    1b. Coronary atheroma
    2. Right lower lobe pneumonia

ISSUES

Clinical care

78. HIW reviewed the clinical care the man received at Parc. They note that he arrived at Parc an elderly and unwell man. He had recently undergone major surgery for a life threatening condition and also suffered with emphysema and arthritis and was prescribed a variety of medications.

79. He was examined by nurses and doctors frequently because of a range of complaints, including shortness of breath, sickness, abdominal pain, unsteadiness on his feet and falls. Generally, HIW find that appropriate investigations were undertaken and treatment provided. On two occasions, he suffered serious shortness of breath and he was appropriately referred to the local hospital for treatment.

80. On 13 September, a doctor referred him to the local hospital because he thought that he might have cancer. He was clearly anxious about the possible diagnosis. He said that he did not want to know if he had cancer and, on 22 September, began refusing to undergo some more intrusive examinations. It is good to see that nurses and doctors took time to explain the purpose of the examinations and encouraged him to agree to the tests. They made several attempts to persuade him but recognised that he had the mental capacity to understand the implications of his refusal. His medical record properly reflected both the efforts that staff made to persuade him and the decisions that he made.

81. HIW conclude that the clinical care the man received at Parc was equivalent to that he might have expected in the community. However, the investigation identified two clinical issues.

Record keeping

82. For the majority of the man's time at Parc, medical records were not computerised and staff made handwritten entries. In many cases, the entries were illegible and it was not possible to identify which staff made the entry. SystmOne was introduced in October 2011 and should have remedied these problems. However, on a number of occasions information was not recorded in his record. HIW also identified that a letter relating to another prisoner had been wrongly filed in his record. We cannot be certain that the introduction of SystmOne will ensure that such omissions do not occur in the future. HIW argue that clear systems and processes and a programme of staff training might help to prevent future issues. We make the following recommendation:

    The Head of Healthcare should, by a process of regular audits, 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.

Communication

83. HIW note that communication between healthcare professionals in relation to the man's care was not always efficient or effective. Because he was housed on U1, he was often examined in his cell by the doctor responsible for visiting the unit that week. On such occasions, it was not unusual for the doctor to record instructions about, for example, X-rays being arranged or appointments being booked for the scheduled GP surgeries. It was not always clear whether these instructions had been acted upon. The most serious of these examples concerns his abnormal blood test results.

84. On 24 August, a doctor reviewed the blood test results which indicated that the man's haemoglobin levels were very low. The doctor instructed that an urgent appointment be arranged. It was not made clear whether the man was responsible for booking an appointment himself or whether healthcare staff should arrange this, but no follow up appointment took place. On 31 August, a doctor, who was examining him in his cell, commented on the abnormal results. He also instructed that a surgery appointment be arranged so that the results could be discussed with him. Again, it was not made clear who was responsible for arranging the appointment. He did not have another appointment until two weeks later, 13 September, when the doctor put in place a treatment plan and arranged for the blood test to be repeated.

85. When the blood test was repeated, the haemoglobin levels had risen. The man also refused to undergo some procedures to ensure that he was not losing blood internally. HIW conclude that the failure to follow up the abnormal blood tests did not lead to any adverse outcome on this occasion, but it was nevertheless a serious oversight.

86. The healthcare practice manager assured HIW that, since the introduction of SystmOne, follow up appointments or actions for other staff to complete are managed electronically. She explained that this meant it was much easier to monitor and audit processes. However, HIW make the following recommendation, which we endorse:

    The Head of Healthcare should ensure that a robust process is in place to monitor and audit referrals and requests by healthcare staff at Parc, to ensure that they are promptly and appropriately actioned.

Multi-disciplinary care planning

87. The man was admitted to hospital for the final time on 29 October and on 1 November, a multi-disciplinary case conference was held at Parc. The multi-disciplinary approach adopted meant that a number of relevant issues were discussed and strategies promptly drawn up. As a result of the meeting, he was asked about the level of contact he wanted with his family, the Victim Support Unit was contacted and staff agreed a visiting rota. Given that his health deteriorated relatively quickly, it was helpful that some key aspects of his care had been resolved at an early stage.

88. We are also pleased to note that healthcare staff took a proactive approach when the man was admitted to hospital. They liaised regularly with hospital staff, particularly about his potential discharge to the prison.

Use of restraints

89. When the man was admitted to hospital on 24 October he was restrained by an escort chain. Two risk assessments were carried out during the four day period he was in hospital. One noted that he used a wheelchair, one did not. He was judged to have behaved generally well in prison but was considered to pose a medium risk to the public and to staff. It is not clear how this latter conclusion was reached as there is no evidence in his file to suggest that he behaved inappropriately with healthcare staff or officers. Only one risk assessment gave some reason for using restraints, which was that he was a category B prisoner.

90. The man was re-admitted to hospital on 29 October. The initial risk assessment did not mention that he needed a wheelchair to move any distance and staff concluded that he would be able to escape unaided. The evidence seems to suggest otherwise. This assessment noted that there was no evidence to suggest that he posed a risk to the public or staff. Nor was there any evidence that he had any friends or family who might help him to escape. However, the member of staff completing the assessment decided that, because of poor security at the hospital, he should be restrained by an escort chain. The lack of consistency between the three risk assessments is puzzling. Only two assessments answered the specific question about why restraints were being applied, and neither answer reflected the individual risk that he had been assessed as posing. In the latter assessment, he had been judged not to pose a risk and, in our view, should not, therefore, have been restrained. It is hard to believe that two officers would not have been able to prevent a 73 year old infirm and unwell man from escaping, had he attempted to.

91. The following day (although the risk assessment was not updated) the bedwatch officers noted that all restraints had been removed and they were not reapplied before the man's death.

92. Assessments of risk should be based on the specific risks each individual poses, rather than a standard default application of general criteria for a category of prisoners. On that basis, we make the following recommendation:

    The Director should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents.

CONCLUSION

93. The man was 72 years old and suffering a number of health issues when he arrived at Parc. This investigation found that his health needs were generally well met. He was regularly examined by nurses and doctors and was referred for appropriate further tests. When he refused to undergo certain procedures, staff tried to encourage him, but ultimately recognised his right to refuse treatment. He said that he wanted to be resuscitated if he stopped breathing and this information was passed to unit staff and the local hospital on his admission. When his condition deteriorated, hospital staff administered emergency treatment but he died.

94. HIW find that the clinical care the man received at Parc was equivalent to that he might have received in the community. However, we make three recommendations as a result of the investigation. Two relate to record keeping and communication in healthcare and one to the appropriate assessment of risk and the use of restraints.

RECOMMENDATIONS

The NOMS response is recorded in italics under each recommendation.

1. The Head of Healthcare should, by a process of regular audits, 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.

   This recommendation has been accepted. NOMS write: "SystmOne is now fully operational. Regular audits of the standards of record keeping are conducted and the findings fed back to the team to support continuous improvement."

2. The Head of Healthcare should ensure that a robust process is in place to monitor and audit referrals and requests by healthcare staff at Parc, to ensure that they are promptly and appropriately actioned.

   This recommendation has been accepted. NOMS responded: "SystmOne tasking ensures the referral process is auditable and actioned."

3. The Director should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents.

   NOMS has accepted this recommendation, noting "A new process of Risk Assessment has been introduced, that takes full account of healthcare concerns. Risk assessments are regularly reviewed by the Senior Management Team and the Head of Security following managerial visits."