

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Marius Neacsu a prisoner at HMP Cardiff on 24 April 2018

A report by the Prisons and Probation Ombudsman

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

On 24 April 2018, Mr Marius Neacsu died of cancer of the hyoid bone (in the neck), which had spread to his lungs, while a prisoner at HMP Cardiff. He was 36 years old. I offer my condolences to his family and friends.

Mr Neacsu was at Cardiff for three days before he was transferred first to hospital, and less than a week later, to a hospice. He received a good standard of care for the brief period of time that he was in Cardiff's care, equivalent to that which he could have expected to receive in the community.

When it became clear that Mr Neacsu's health was declining, the prison appropriately contacted his family and arranged for his mother to stay in the hospice with him.

There is evidence that when Mr Neacsu was transferred to hospital, escort risk assessments were thorough, and prison staff restrained him in line with the risk that he posed at the time.

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

Elizabeth Moody
Deputy Prisons and Probation Ombudsman

March 2019

Contents

| | |
|---------------------------------|---|
| Summary | 1 |
| The Investigation Process | 2 |
| Background Information | 3 |
| Key Events | 4 |
| Findings..... | 6 |

Summary

Events

1. On 30 January 2018, Mr Marius Neacsu was remanded to HMP Cardiff for threatening to kill his partner.
2. The court was aware that Mr Neacsu had been diagnosed with cancer of the hyoid bone in his neck, and that his prognosis was limited.
3. When Mr Neacsu arrived at Cardiff, a nurse saw him and recorded that he was being treated palliatively, and that he should be admitted to the healthcare centre.
4. That day, a prison GP saw Mr Neacsu and reviewed his community medical records. They prescribed pain relief.
5. On 31 January, care plans were put in place so that staff could manage his condition, and he was referred to a local hospice so that a palliative specialist could visit him in prison.
6. On 1 February, Mr Neacsu's tongue became swollen. A prison GP liaised with a hospital ear, nose and throat specialist, and Mr Neacsu was admitted that day.
7. Mr Neacsu's health declined rapidly, and on 7 February, his offender manager applied for bail so that he no longer had to be in the care of HMP Cardiff. This was refused, and arrangements were made for Mr Neacsu to be transferred to a hospice that day.
8. On 24 April, Mr Neacsu died in the hospice, with his mother by his side.

Findings

9. We are satisfied that Mr Neacsu's care at Cardiff was equivalent to that which he could have expected to receive in the community. Mr Neacsu came into prison with an incurable form of cancer, and on arrival, healthcare staff assessed him, put care plans in place and located him in the healthcare centre.
10. When his health declined, we found that Mr Neacsu was appropriately transferred to a hospice.
11. When Mr Neacsu was admitted to hospital on 2 February, the prison correctly appointed a family liaison officer who maintained regular contact with Mr Neacsu's mother who was his next of kin, and arranged for her to stay with him in the hospice.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Cardiff informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
13. The investigator obtained copies of relevant extracts from Mr Neacsu's prison and medical records.
14. NHS England commissioned a clinical reviewer to review Mr Marius Neacsu's clinical care at the prison.
15. We informed HM Coroner for Cardiff, Bridgend & Glamorgan Valleys of the investigation. A post-mortem examination was not completed as Mr Neacsu was known to have a history of cancer, and was receiving palliative treatment. We have sent the Coroner a copy of this report.
16. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Cardiff

17. HMP Cardiff holds around 800 men, mostly from south-east Wales. Many of the prisoners come from local courts on remand. Cardiff and Vale University NHS Health Board is responsible for delivering primary, physical and mental health services at the prison. The prison healthcare department has a 22-bed inpatient facility, for prisoners with increased healthcare needs, with 24-hour nursing care.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Cardiff was in August 2017. Inspectors reported that the health centre, including the inpatient unit, was clean and had excellent clinical facilities.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to 31 August 2017, the IMB reported that inpatient care was always made available for those in urgent need of care and observation.

Previous deaths at HMP Cardiff

20. There have been fourteen deaths at HMP Cardiff since 2013, seven of which have been due to natural causes. There are no similarities between these cases and that of Mr Neacsu.

Key Events

21. On 30 January 2018, Mr Marius Neacsu was remanded to HMP Cardiff for threats to kill.
22. A palliative care specialist wrote to the court before Mr Neacsu was remanded into custody to outline his medical history. The letter confirmed that he was terminally ill, with cancer of the hyoid bone (in the neck), which had spread to his lungs, and that his prognosis was limited. It did not specify a timescale.
23. When he arrived at HMP Cardiff, Mr Neacsu met a nurse, and with the help of a Romanian interpreter, completed his initial healthcare induction. The nurse noted that Mr Neacsu had advanced cancer and that he was being treated palliatively. He recorded Mr Neacsu's medications, and that he required a pureed diet and six supplement drinks per day.
24. Mr Neacsu was admitted to the healthcare centre that day and a prison GP reviewed him as part of his secondary healthcare induction. The prison GP reviewed his community medical records, and prescribed him medications for pain control. She recorded that Mr Neacsu was comfortable and settled in the healthcare centre.
25. On 31 January, a nurse completed a care plan with Mr Neacsu. The plan covered instructions about hygiene, nutrition, sleep, mobility and pain relief. The nurse noted that a Waterlow assessment should be completed on a weekly basis. (A Waterlow scale estimates a person's risk of developing a pressure sore.)
26. That same day, a prison GP spoke to a palliative care consultant who agreed to be a point of contact should anyone caring for Mr Neacsu have questions. They discussed that the prison GP would refer him to a hospice, and that a member of the hospice staff would visit him in prison on 3 February.
27. On 1 February, Mr Neacsu's tongue became swollen. A prison GP recorded that the healthcare department would need to obtain a syringe driver (a small pump, used to gradually administer small amounts of fluid to a patient) as the swelling on his tongue was making it difficult for him to swallow his medication. He then contacted a hospital ear, nose and throat specialist, who advised that Mr Neacsu should be admitted for diagnostic investigation.
28. The prison GP noted that an order not to resuscitate Mr Neacsu was not in place, and asked for this to be completed while he was an inpatient.
29. Mr Neacsu was taken to hospital that day, escorted by two officers and restrained by an escort chain.
30. On 2 February, a nurse spoke to the escorting officers in hospital, who explained that Mr Neacsu was now not able to swallow, and that he would remain an inpatient until 5 February, during which time he would undergo an esophagoscopy (a procedure used to diagnose and treat conditions of the oesophagus).

31. A nurse spoke to a hospital palliative care doctor later that day, who confirmed that Mr Neacsu did not want anyone to resuscitate him if his heart or breathing stopped and that he had signed an order to that effect.
32. Mr Neacsu's health continued to deteriorate and on 5 February, the Head of Security spoke to escorting staff to make sure that Mr Neacsu was no longer restrained.
33. As Mr Neacsu was nearing the end of his life, his solicitor asked the Court to bail him. On 7 February, Mr Neacsu's offender manager applied for bail for him but this was declined. As he was no longer required to be an inpatient, Mr Neacsu was transferred, unrestrained, to a hospice that day.
34. Mr Neacsu remained unrestrained while in the hospice, and bedwatch officers were told not wear a uniform for the dignity of Mr Neacsu, and so that other patients were not distressed.
35. Healthcare staff at the prison remained in contact with the hospice, and on 23 March, a prison GP spoke to Mr Neacsu's palliative care consultant who explained that Mr Neacsu had developed a fever, which was not responding to treatment, and that he was now believed to be approaching his last few days.
36. Mr Neacsu's health continued to decline, and on 24 April, he died in the hospice, with his mother by his side.

Contact with Mr Neacsu's family

37. On 3 February 2018, the Head of Residence contacted Mr Neacsu's next of kin to inform him that Mr Neacsu had been taken to hospital on 1 February and that his health was thought to be declining. Mr Neacsu's brother-in-law told her that Mr Neacsu's mother was planning to travel to England to be with her son.
38. On 10 March, at Mr Neacsu's request, the prison changed Mr Neacsu's next of kin details from his brother-in-law to his mother.
39. On 19 February, Mr Neacsu's mother arrived in the UK, and the prison arranged for her to stay with Mr Neacsu in the hospice so that she could care for him in his final weeks.
40. In line with national instructions, the prison offered a contribution towards Mr Neacsu's funeral. As Mr Neacsu was not a British national, his family wanted him to be returned to his country of origin for burial. Therefore, the prison paid for Mr Neacsu to be repatriated to Romania.

Support for prisoners and staff

41. After Mr Neacsu's death, a duty governor debriefed both bedwatch officers who had monitored Mr Neacsu to ensure they had the opportunity to discuss any issues arising, and to offer support.

Post-mortem report

42. The palliative care consultant established that Mr Neacsu's cause of death was an airway obstruction and cancer in the hyoid bone in his neck.

Findings

Clinical care

43. Mr Neacsu was at HMP Cardiff for only three days before he was admitted to hospital and then transferred to a hospice for palliative care.
44. We agree with the clinical reviewer, who concluded that the care Mr Neacsu received was equivalent to the care which he could have expected to receive in the community and that prison healthcare staff had provided appropriate and timely palliative care before he was transferred to hospital.
45. He noted that Mr Neacsu's physical condition was appropriately managed including assessment, care planning, monitoring, treatment and liaison. When it became apparent that he was too unwell to be cared for in the prison, he was appropriately transferred to hospital.

Assessment of risk

46. When prisoners have to travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk, taking into account factors such as a prisoner's health and mobility.
47. When Mr Neacsu was transferred to hospital on 1 February, an escort risk assessment was completed. He was assessed as posing a medium risk to the public, hostage taking, escape potential and likelihood of external assistance. At the time, although Mr Neacsu was terminally ill, he was still physically able and was considered to pose a significant risk of harm to his victim. The Head of Operations authorised that Mr Neacsu should be escorted by two officers and restrained by a single cuff and escort chain. The restraint was removed on arrival at the hospital, and was not replaced.
48. When he was transferred to the hospice on 7 February, Mr Neacsu was not restrained, and remained unrestrained until his death.
49. We are pleased that HMP Cardiff completed thorough risk assessments and considered the risk he posed at the time of his hospitalisation. We consider that the decision to restrain him initially with an escort chain was justifiable, and appropriately took account of his mobility and the risk that he posed at the time. When Mr Neacsu's health declined, the restraints were appropriately removed.

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