Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Phillip Andrews a prisoner at HMP Cardiff on 15 March 2019

A report by the Prisons and Probation Ombudsman

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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*

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.

Mr Phillip Andrews died on 15 March 2019 of colorectal cancer while a prisoner at HMP Cardiff. He was 51 years old. I offer my condolences to Mr Andrews' family and friends.

Prior to being remanded into custody, Mr Andrews was under the care of his community GP who was investigating his symptoms of rapid weight loss, persistent diarrhoea and blood in his faeces. However, he was sent to prison before a diagnosis could be made.

I am satisfied that healthcare staff at Cardiff appropriately investigated Mr Andrews' symptoms and referred him to hospital specialists in a timely way. I am also satisfied that following his cancer diagnosis in February 2019, Mr Andrews received a good standard of care at Cardiff, which was equivalent to that which he could have expected to receive in the community.

When Mr Andrews was taken to hospital for the final time on 13 March 2019, he was accompanied by two prison officers and was unrestrained. Given his medical condition at the time, I consider that this was appropriate.

However, I am concerned that following a slight improvement in his condition the following day, Mr Andrews was restrained and remained restrained until the morning of his death. I consider that prison staff failed to take into account his medical condition when assessing his risk and that the use of restraints was disproportionate given his very poor health.

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

Sue McAllister CB
Prisons and Probation Ombudsman **November 2019**

Contents

Summary ..... **Error! Bookmark not defined.**

The Investigation Process 3

Background Information 4

Findings 5

Summary

Events

1. On 21 December 2018, Mr Phillip Andrews was remanded to HMP Cardiff charged with the murder of his partner.

2. Before his arrival into prison custody, Mr Andrews was under the care of his community GP because he was experiencing rapid weight loss, persistent diarrhoea and blood in his faeces. However, before a diagnosis could be made, Mr Andrews was sent to prison.

3. On 2 January, a prison GP reviewed Mr Andrews. She noted he still had diarrhoea, but she found no swelling or hardness in his abdomen. She considered Mr Andrews might have developed irritable bowel syndrome. She referred him for blood tests, and to hospital for further review. Careplans were created for his weight loss and rectal bleeding.

4. During a review on 27 February, hospital staff carried out a number of tests. The results showed that Mr Andrews had developed bowel and liver cancer. Further tests showed that the cancer had spread to his lymph nodes. Hospital staff considered his condition was terminal and that, without treatment, he would have approximately three months to live. Mr Andrews chose not to undergo any active treatment.

5. On 13 March, while his family were visiting him in prison, Mr Andrews became short of breath. A prison GP reviewed him and sent him to hospital. While in hospital, Mr Andrews' condition continued to deteriorate.

6. At 10.21pm on 15 March, it was confirmed that Mr Andrews had died.

7. The hospital gave Mr Andrews' cause of death as disseminated metastatic colorectal cancer (cancer that originated in the colon but then spread to other areas of the body).

Findings

8. Mr Andrews' health deteriorated very quickly following his diagnosis.

9. The clinical reviewer found that Mr Andrews received a good standard of clinical care at Cardiff. Healthcare staff appropriately assessed his clinical needs and sought advice from hospital specialists when appropriate.

10. We are satisfied that the standard of care Mr Andrews received at Cardiff was equivalent to that which he could have expected to receive in the community.

11. When Mr Andrews went to hospital on 13 March, healthcare staff noted on the risk assessment form that his condition was 'terminal' and prison staff decided, appropriately, not to restrain him.

12. However, we are concerned that restraints were applied the following day when the escorting prison officers thought that his condition was improving, and that

he remained restrained until the morning of his death. We are concerned that the decision to apply restraints was taken without medical advice and, given Mr Andrews' extremely poor health and terminal condition, we do not consider that restraints were necessary and proportionate over and above the control already available through the two escorting officers.

Recommendations

- The Governor should ensure that all staff completing and authorising risk assessments justifying the use of restraints on prisoners taken to hospital understand the legal position; and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Cardiff informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

14. The investigator obtained copies of relevant extracts from Mr Andrews' prison and medical records.

15. NHS England commissioned a clinical reviewer to review Mr Andrews' clinical care at the prison.

16. We informed HM Coroner for Cardiff, Bridgend & Glamorgan Valleys of the investigation. We have sent the coroner a copy of this report.

17. Mr Andrews' family received a copy of the initial report. They did not make any comments.

18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found one factual inaccuracy in respect of a change to the healthcare provider at the prison and this report has been amended accordingly.

Background Information

HMP Cardiff

19. 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

20. The most recent inspection of HMP Cardiff was carried out in July 2019, but the report has not yet been published.

21. The previous inspection was in August 2016, when inspectors reported that primary healthcare provision was generally good. However, they were concerned that there was evidence of damp in areas of the healthcare centre. They also noted that healthcare provision for those prisoners with long-term health conditions was of a good standard.

22. However, Inspectors were concerned that PPO reports into previous deaths at the prison were not being shared with healthcare staff, possibly leading to missed learning opportunities.

Independent Monitoring Board

23. 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 August 2018, the IMB noted that issues with damp in the healthcare department had been addressed and that old or damaged furniture and equipment was being replaced.

24. They also noted the working relationship between healthcare providers and the prison was co-operative. They considered healthcare staff were conscientious and hardworking, maintaining a high standard of care for prisoners, often in difficult circumstances.

Previous deaths at HMP Cardiff

25. Mr Andrews was the 14th prisoner to die at Cardiff since March 2014. Six of the previous deaths were from natural causes, one from drug misuse, five were self-inflicted deaths, and one is still awaiting classification. There are no similarities between Mr Andrews' death and the previous deaths.

Findings

The diagnosis of Mr Andrews' terminal illness and informing him of his condition

26. On 21 December 2018, Mr Phillip Andrews was remanded to HMP Cardiff, charged with the murder of his partner.

27. On his arrival at Cardiff, healthcare staff reviewed Mr Andrews and noted he had bruised ribs for which he was receiving pain killers, was blind in one eye and had mild asthma. Mr Andrews also had a long history of substance misuse including cannabis, diazepam (a strong sedative) and intravenous use of heroin.

28. Healthcare staff noted that before being sent to prison, Mr Andrews had been under the care of his community GP for rapid weight loss, persistent diarrhoea and blood in his faeces. Healthcare staff attempted to obtain Mr Andrews' community GP records, but he had moved shortly before being sent to prison and his community GP was unable to give them a copy.

29. On 2 January 2019, Mr Andrews was reviewed by a prison GP. He told the prison GP that his community GP had taken a stool sample for analysis, but that he had refused a rectal examination. The prison GP examined him but found no swelling or hardness in his abdomen or any evidence of haemorrhoids. She considered he might have developed irritable bowel syndrome and referred him for a full blood count. She also referred him to a hospital for further review. Careplans were created for his weight loss, diarrhoea and rectal bleeding.

30. The results of the blood tests showed that Mr Andrews had iron deficiency anaemia (without enough iron, the blood cells cannot carry enough oxygen around the body). A prison GP prescribed iron supplements.

31. On 6 February, Mr Andrews was reviewed by a prison GP after he complained of diarrhoea on six occasions that morning. She took a sample of his faeces for analysis, which showed a Bristol faecal score (a diagnostic medical tool) of 5, which indicated mild diarrhoea. She prescribed dioralyte (a rehydration supplement) and referred him to a prison GP for further review.

32. On 8 February, a prison GP reviewed Mr Andrews. She noted the results of another prison GP. She also noted that despite her referral on 7 January, Mr Andrews had still not been reviewed by hospital staff. She asked the healthcare administration team to contact the hospital to find out when Mr Andrews would be reviewed.

33. On 11 February, hospital staff informed healthcare staff that they had not received a prison GP's referral, but they would place him on a waiting list.

34. A prison GP reviewed Mr Andrews again on 20 February. She noted that although his diarrhoea and weight loss had stabilised, he had a mass in his stomach that she suspected could be bowel cancer. The prison GP contacted hospital staff to inform them of her findings and hospital staff said that Mr Andrews had a colorectal review booked for 27 February.

35. Mr Andrews attended a hospital in Wales for his planned colorectal review. Hospital staff admitted him as an inpatient to carry out further tests. The results showed that Mr Andrews had developed bowel and liver cancer. Further tests showed that the cancer had spread to his distant lymph nodes (a condition where cancer cells travel around the body to lymph nodes further away from where the cancer originated). Hospital staff considered his condition was terminal and that, without treatment, he would have approximately three months to live.

36. On 2 March, Mr Andrews was discharged from hospital and was sent back to Cardiff.

37. Following his diagnosis, Mr Andrews was reviewed regularly by healthcare staff and a cancer care plan was created.

38. On 7 March, a prison GP reviewed Mr Andrews. She discussed his diagnosis and the treatment options open to him. Mr Andrews told her that he had decided not to accept any palliative treatment. She said that if Mr Andrews chose to accept palliative chemotherapy, his life expectancy could increase. Mr Andrews was adamant that he did not want any treatment, other than pain management.

39. During her review, the prison GP asked Mr Andrews if he had considered the issue of resuscitation. Mr Andrews confirmed he did not wish to be resuscitated and signed a do not attempt cardiopulmonary resuscitation (DNACPR) order to that effect. She considered that Mr Andrews had the mental capacity to make decisions about his care and treatment.

40. We are satisfied that healthcare staff appropriately investigated Mr Andrews' symptoms, made timely referrals to secondary care providers and discussed his diagnosis with him.

Mr Andrews' clinical care

41. Following her review on 7 March, the prison GP referred Mr Andrews to palliative care nurses. She also made a referral to occupational health services to ensure that Mr Andrews had all the equipment he would need to keep him as comfortable as possible as his condition deteriorated.

42. Over the days that followed, Mr Andrews was regularly reviewed and supported by both healthcare and the mental health in-reach team.

43. On 12 March, a prison GP reviewed Mr Andrews after he complained of having a persistent cough for the previous three days. She diagnosed him as having an upper respiratory tract infection and prescribed antibiotics.

44. The following day, while his family were visiting him in prison, Mr Andrews became increasingly short of breath. A nurse from the prison's healthcare team, reviewed Mr Andrews. She took his observations (the level of oxygen in the bloodstream, temperature and blood pressure used as an indicator of a patient's physical condition) and noted nothing of concern other than he was cold to the touch but had a raised body temperature, and that he also had extremely swollen feet. She asked a prison GP to review him.

45. A prison GP took Mr Andrews' observations again and noted he had become tachypnoeic (experiencing a rapid rate of breathing) and tachycardic (an increased heart rate). She was aware that Mr Andrews had been prescribed antibiotics for an infection, so decided to send him to hospital for further review. He was accompanied by two escort officers and was not restrained. Following a review, hospital staff admitted Mr Andrews as an inpatient for observation.

46. On 14 March, a nurse from the prison's healthcare team, telephoned hospital staff for an update on Mr Andrews' condition. She was told that he had had some blood tests, an ECG (electrocardiogram used to measure the electrical output of the heart) and a chest X-ray and they were awaiting the results.

47. The prison officers accompanying Mr Andrews noted his condition had improved slightly and updated prison managers. As a result, Mr Andrews was restrained using an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer).

48. At 8.00am on 15 March, a Duty Governor decided to remove Mr Andrews restraints.

49. Mr Andrews' condition continued to deteriorate. At 10.21pm, the prison officers accompanying Mr Andrews noticed he had stopped breathing. At 12.40am on 16 March, a hospital confirmed that Mr Andrews had died.

50. We agree with the clinical reviewer that the standard of clinical care Mr Andrews received at Cardiff was equivalent to that which he could have expected to receive in the community.

51. The clinical reviewer noted that as Mr Andrews' symptoms developed, he was appropriately referred to hospital specialists and that there were no delays when he needed to transfer to hospital in an emergency.

52. Following his diagnosis, healthcare staff regularly reviewed him and assessed his healthcare needs in line with NICE guidelines.

Mr Andrews' location

53. When Mr Andrews arrived at HMP Cardiff, healthcare staff considered that due to the nature of his offence, and his pre-existing medical conditions, he would benefit from admission to the prison's healthcare inpatient unit.

54. After his cancer diagnosis, healthcare staff appropriately referred Mr Andrews to an occupational therapist to ensure he had the necessary equipment to keep him comfortable as his condition deteriorated. Mr Andrews was assessed on 11 March 2019, and it was decided he would benefit from specialist pillows and a commode, which were ordered the same day.

55. Healthcare staff asked Mr Andrews if he would consider moving to a hospice for end of life care but he said that he would prefer to stay in prison surrounded by his friends. Mr Andrews stayed in the prison's healthcare inpatient unit until his final admission to hospital.

56. We are satisfied that Mr Andrews was appropriately located throughout his illness and that his wishes were taken into account. We are also satisfied that he was quickly taken to hospital when his condition deteriorated.

Restraints, security and escorts

57. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility.

58. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

59. On 13 March 2019, a prison GP asked for Mr Andrews to be taken to hospital for review. A nurse noted on the medical section of the risk assessment form, that restraints would not be necessary for Mr Andrews as his condition was 'terminal'. At 22.45pm, when Mr Andrews was taken to hospital by emergency ambulance, he was accompanied by two prison officers and was unrestrained.

60. At 8.50am the following morning, the prison officers accompanying Mr Andrews noted his condition had improved slightly. They contacted a Custodial Manager (CM) to inform him. The CM informed the Duty Governor of the change in Mr Andrews' condition. The Duty Governor decided Mr Andrews should be restrained with an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). The Duty Governor told us that, when he took this decision, he did not know that Mr Andrews' condition was as serious as it actually was.

61. At 8.00am on 15 March, bedwatch staff informed prison managers that Mr Andrews' condition was deteriorating. The Duty Governor decided to remove Mr Andrews restraints. He remained unrestrained until his death at 10.21pm the same day.

62. Although Mr Andrews was an unsentenced prisoner charged with murder and judged to be of medium risk, he was terminally ill and very unwell when he was taken to hospital on 13 March. We are satisfied that in these circumstances the decision not to restrain him was appropriate.

63. However, we are concerned that restraints were applied the following day on the basis of the opinion of the bedwatch officers. We query whether restraints were necessary and proportionate over and above the control already available through the escorting officers, and we are concerned that when the Duty Governor, decided that restraints should be used, he did not obtain clinical advice and did not appropriately consider Mr Andrews' health. As a result, Mr Andrews remained in restraints until the morning of the day he died.

64. We make the following recommendation:

The Governor should ensure that all staff completing and authorising risk assessments justifying the use of restraints on prisoners taken to hospital understand the legal position; and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

Liaison with Mr Andrews' family

65. When Mr Andrews was diagnosed with terminal cancer, hospital staff contacted his sister, who he had named as his next of kin, to inform her of his diagnosis.

66. Mr Andrews' sister has expressed concern that the prison did not contact his family to inform them of his diagnosis. However, Mr Andrews was an adult and it was for him to decide if and how he wanted to inform his family.

67. On 13 March, the prison appointed a nurse to act as his family liaison officer (FLO). She met with Mr Andrews and his family, who were visiting him at the prison, the same day.

68. Following his admission to hospital on 14 March, the FLO telephoned Mr Andrews' mother to inform her of his admission to hospital.

69. The following day, the FLO contacted hospital staff for an update on Mr Andrews' condition. They told her that Mr Andrews' condition had deteriorated. She telephoned Mr Andrews' mother to inform her of the change in his condition, and arranged to meet her, and the rest of Mr Andrews' family, at the hospital later that day to offer them support.

70. Mr Andrews' funeral was held on 9 April. The prison offered a financial contribution towards the cost of the funeral in line with national guidance.

Compassionate release

71. As a remand prisoner, Mr Andrews was not eligible to be considered for compassionate release.

72. However, on 14 March, following his final admission to hospital, an officer contacted Mr Andrews' solicitors and told them of his condition and prognosis. He advised them to consider making a bail application on his behalf. However, they were unable to process an application before he died.

73. Whether Mr Andrews was granted bail or not, would not have affected his medical treatment. If he had been granted bail – and there is no guarantee that an application would have been successful – he would no longer have been in prison custody and would not have required a prison officer escort. It was for his solicitor, and not the prison, to make an application for bail on Mr Andrews' behalf.

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