PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the death of a man at HMP & YOI Parc in December 2009

Report by the Prisons and Probation Ombudsman for England and Wales

March 2011

Ashley House, 2 Monck Street, London SW1P 2BQ Tel: 020 7035 2876 Fax: 020 7035 2012
E-mail: mail@ppo.gsi.gov.uk www.ppo.gov.uk

The man died in Bridgend Hospital while in the custody of HMP Parc. He had been suffering from cancer. He was 65 years old. I offer my sincere sympathy and condolences to his family and friends affected by his death. I apologise for the delay in issuing this report and any additional distress this may have caused.

The investigation was carried out on my behalf by my colleague. A clinical review of the man's healthcare was undertaken by the Healthcare Inspectorate for Wales. I would like to thank her for the review, but must note that its late arrival delayed my report.

I would like to thank the Director of Parc and her staff for their co-operation and assistance. Particular thanks go to the Head of Safer Custody and Violence Reduction for his help throughout the investigation.

The man was transferred from an Irish prison in 2007, having lived there for a number of years. He was initially sent to HMP Cardiff, before moving to HMP Parc in December, via a number of other prisons. The man came into prison with a number of ailments but no serious illnesses. In February 2009, he was referred to the urology department of the local hospital having passed blood in his urine. In May, the first prison doctor who saw the man was told that the man was suffering from cancer. The man began chemotherapy at the end of June, but his health declined further in mid-December. When he was seen on the morning of 20 December, the doctor noted that he was in pain and had spent a bad night. The man's condition worsened and, the next morning, he was transferred to hospital. The man died the following evening. Following his death, the prison arranged a pagan funeral in accordance with his wishes.

Although staff supported the man throughout his illness, the clinical reviewer assessed that his medical care fell below appropriate standards in some areas. I make four recommendations regarding palliative care, record keeping and pain assessment, and highlight one area of good practice.

The 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.

Jane Webb
Acting Prisons and Probation Ombudsman **March 2011**

CONTENTS

SUMMARY

The man was born in March. He was charged with a number of serious offences and arrested in Ireland in October 2006. He was returned to the United Kingdom and remanded to HMP Cardiff on 3 August 2007. He told staff of his high blood pressure and prescribed medication, but said that he had no serious illnesses. He moved to HMP Swansea later in the month where staff continued to monitor his blood pressure.

The man was transferred to HMP Parc on 12 October and then, in December, moved briefly to Usk and Cardiff before returning to Parc. Once back at Parc, he again told staff of his high blood pressure but did not mention any severe ailments. In early 2008 he complained of suffering from a chest cold. Later that year, he applied for a promotion in the prison privileges system but this was rejected due to the number of written warnings he had received.

In December 2008, the man complained of passing blood in his urine. Blood tests were ordered, but were not followed up. It was not until February 2009 that the man was referred to hospital. He complained of chest problems around that time. Following tests, it was confirmed in May 2009 that he was suffering from lung and bladder cancer. The man took the news stoically, and said that he was happy to remain in his usual cell rather than move to the healthcare unit.

Unusually, staff decided that the man's wife should be contacted each time he went to an outside hospital to allow her to accompany her husband. Officers and healthcare staff told the man to ask staff whenever he needed more pain relief medication. He underwent chemotherapy in the summer, but began to suffer more pain in the autumn. The man's application to be released early from prison as a result of his ill health was unsuccessful because of the risk associated with his offence.

The man underwent palliative radiotherapy in an attempt to aid his swallowing but his condition continued to deteriorate throughout December. He was very weak by 20 December and, following a bad night, it was decided to transfer him to hospital the following day. His family were informed and were with him when he died on 22 December. The prison contributed to the cost of the funeral and arranged for a pagan chaplain to conduct it.

The clinical reviewer assessed the quality and timeliness of the man's care as falling below appropriate standards in a number of areas and I make four recommendations regarding palliative care, record keeping and pain assessment, and highlight one area of good practice.

THE INVESTIGATION PROCESS

1. My colleague was appointed to undertake the investigation. On his initial visit to the prison, my colleague met the Director, the man's cellmate, his personal officer and the senior officer on his wing. My colleague was shown the man's cell. Notices were issued to prisoners and staff to alert them to the investigation. No-one came forward in response to the notices.

2. My colleague wrote to Healthcare Inspectorate Wales to request a review of the clinical care the man received while in prison custody. The clinical reviewer was provided with all of the relevant documentation to assist her review. The clinical review was not completed until September 2010 which has resulted in a delay in issuing this report.

3. One of the Ombudsman's family liaison officers spoke to the man's wife to discuss the investigation and any issues or concerns. The man's wife was interested in the details of the medical care her husband received, and wanted some of his property returned to her. My colleague and the Ombudsman's family liaison officer visited her on 2 June to discuss the investigation. My colleague and the clinical reviewer travelled to Parc on 9 June to discuss the man's wife's concerns with the Head of Healthcare. My colleague returned to the prison on 21 September to clarify some outstanding issues.

4. The man's wife responded to the draft report and made a number of comments on it. The final report has changed in the light of these comments and, where the report has not been amended, I have written to the man's wife to explain why. The National Offender Management Service also responded to the draft report. They identified no factual inaccuracies, and I include their response to the recommendations at the end of the report.

HMP & YOI PARC

4. HMP & YOI Parc is a category B local prison near Bridgend in Wales. This is a closed prison for prisoners who do not require maximum security, but for whom escape needs to be made very difficult. It holds approximately 1,200 male adults and young offenders. The prison opened in 1997 and is managed by G4S on behalf of the National Offender Management Service (NOMS). At the time of the man's custody, healthcare services at Parc were provided by Primecare and included a 24 bed in-patient centre.

Incentives and earned privileges (IEP) scheme

5. The IEP system is intended to encourage and reward good behaviour in prison. Prison Service Order (PSO) 4000 describes it as follows:

> "The IEP scheme complements the discipline system by rewarding good behaviour. In addition to any local aims, it is intended to encourage prisoners and YOs [young offenders] to behave responsibly, to participate in constructive activity, and to progress through the system. This will foster a more disciplined and controlled, and therefore safer environment for prisoners and staff. It should also contribute to the reduction of re-offending by encouraging prisoners to lead law-abiding, productive and healthy lives."

6. Prisoners are able to move up a level (basic, standard or enhanced) and earn various privileges. Poor behaviour can result in moving down a level or losing privileges. Privileges include association time and extra visits.

Restraints

7. Restraints or handcuffs are frequently used on prisoners who are required to leave the prison environment. Before they are used a security risk assessment is completed to ascertain the level of risk that a prisoner poses with regard to their potential to escape. The assessment informs the decision about the number of escorting officers and the type of restraint to be used (single cuffs or two metre long escort chain with cuff at either end). It also determines the circumstances and the authority required for the restraints to be removed.

Independent Monitoring Board (IMB)

8. Each prison has an Independent Monitoring Board (IMB) made up of members of the community whose role it is to ensure that the prison is properly run and that prisoners are treated decently. Each Board

produces an annual report, the most recent of which for Parc is dated March 2008 to February 2009. The report commented on the need for the personal officer scheme to be effectively managed and for more places to be available for both work and education.

9. The IMB's report referred positively to palliative care at Parc:

> "The Healthcare team have continued to provide excellent treatment and support to prisoners suffering from terminal illnesses, and such prisoners have been treated in a caring and appropriate manner during their final days."

10. The overall judgement of the Board was that:

> "HMP & YOI Parc has again made conspicuous ongoing efforts to ensure that all prisoners felt safe and were treated humanely, with dignity and fairness by all those charged with their care."

Her Majesty's Chief Inspector of Prisons

11. Her Majesty's Chief Inspector of Prisons conducted a full unannounced inspection of Parc from 7 to 11 July 2008. The report said that the prison was reasonably safe but suffered from a lack of education or work places for its population. The report notes that, although the prison had areas of concern, it had improved since the last inspection. However, the report said that the two key areas that needed to be addressed were the training of staff and the need to resource the prison effectively. The report said "Overall, we found that prisoners had good access to a wide range of clinical services, which were at least comparable with those found in the community."

Previous deaths at HMP & YOI Parc

12. Parc experienced two other deaths from natural causes in 2009, one of which was also due to cancer. This death also occurred in an outside hospital.

KEY FINDINGS

13. The man entered HMP Cardiff on 3 August 2007 charged with a number of serious offences. He went to the healthcare unit due to his status as a Rule 45 prisoner. (This is when prisoners who feel vulnerable either because of the nature of their offence or other reasons can be separated from the rest of the prison population.)

14. No significant issues were noted in the man's reception health screen, although he asked to see a doctor due to high blood pressure. He was assessed by the doctor on 8 August and discussed his history of hypertension and peptic ulcer. He also mentioned recent headaches and lower back pain. He was prescribed paracetamol and lisinopril (to treat high blood pressure and cardiac issues) and given a cell in the healthcare centre so that he could be monitored.

15. As there were no other clinical matters, it was deemed unnecessary for the man to remain any longer in the healthcare department. As a Rule 45 prisoner, he could not mix with other prisoners on a residential wing and so he was segregated on 20 August for his own safety. Staff conducted the checks to identify any healthcare concerns to prevent him staying in the segregation unit, and the man's segregation was reviewed regularly

16. On 21 August, the man was assessed by a prison doctor who requested a check of the levels of urea and electrolytes in his blood. The doctor noted that, until the results came back, the man's prescription of lisinopril should not be increased. However, if the results were satisfactory, the prescription could be increased to 10 milligrams (mg). The man's high blood pressure was noted in his medical record before he transferred to HMP Swansea on 22 August. His blood pressure was recorded as 155/92 with a pulse of 81. (This is quite a high blood pressure reading. A normal reading would be approximately 130/80. The pulse reading is normal.)

17. During the man's reception health screen at Swansea, he mentioned to the first nurse who saw him that he suffered from bad headaches and stomach ulcers but nothing of any further significance. He was not given lisinopril as the nurse wrote in his record that he was not allowed it until his urea and electrolytes levels had been checked. (The man was given lisinopril for the first time at Swansea on 30 August, and was subsequently given it every day from 3 September.) His blood pressure was high during his latter time at Swansea, and the doctor referred him to the chronic disease clinic.

18. On 12 October, the man transferred back to HMP Parc where he told the first officer during the induction assessment that he was glad to have left Swansea. The nurse who reviewed him noted his prescriptions and ulcer.

The man was seen by the doctor the following day who prescribed his medication and asked for blood tests to be undertaken. A nurse who saw him later that day noted his high blood pressure. The man was seen by a prison doctor on 6 November who prescribed him further medication and requested blood tests to be taken. These were completed the following week, and the results revealed no problems.

19. In mid-December, the man was briefly transferred to HMP Usk and then Cardiff but returned to Parc on 21 December. His health was again assessed during his reception health screen. The man said that he had recently seen a doctor for a repeat prescription. His medication was listed as Omeprazole (to control stomach acid), paracetamol, Bendroflumethiazide (to treat hypertension), lisinopril (to treat hypertension and cardiac issues), Beclometasone (to treat asthma and sinus conditions). He had no concerns about his physical health and the healthcare worker noted nothing of significance. The man told the nurse that he drank socially but did not use drugs. He did not acknowledge any mental health issues and said that there was no reason to see a doctor.

20. The man received a written warning on 28 December from a second officer for being in another prisoner's cell against the unit rules. The officer noted in his wing history sheet that he warned the man prior to issuing the written warning. The man moved cells in January after telling staff that he was concerned about his cellmate. It was noted in the wing history sheet that the man thanked staff for facilitating the move.

21. In early 2008, the man complained of a chest cold which had lingered for a while. He was given Amoxicillin 500mg (an antibiotic) three times a day and Prednisolone (an anti-inflammatory medication) 20mg daily and reviewed by a prison doctor. Staff attempted to collect sputum but he could not produce a sample. He was sentenced to 12 years in prison at the end of February.

22. The man applied for enhanced status under the IEP scheme on a number of occasions in 2008 but was turned down. He refused to engage in any behavioural programmes and had received a number of written warnings. One written warning concerned the man having another prisoner's property in his possession against unit rules on 20 March 2008. A third officer noted in the wing history sheet that the man admitted purchasing a T-shirt. The officer later wrote that the man denied purchasing it and said that he was frustrated as the warning would inhibit his chance of achieving enhanced status. The third officer noted that the man suggested that staff were attempting to prevent him achieving enhanced status. The officer wrote in his wing history sheet:

> "He does not see that his behaviour may need altering in order to attain his targets."

23. The third officer noted in the man's wing history file on 2 April that a visit with the man's family was allowed to go ahead despite the confirmation slip bearing the date of 7 April and not 1 April as the man had thought. His application for enhancement was not supported on 10 April by the third officer who wrote:

> "The man is not a disciplinary problem on the unit but he does not seem to understand that his behaviour results in him not achieving his targets. He does not see that only he can change this to reach his goals. Despite being told about query times, the man will always try and manipulate staff into dealing with them at the most inopportune times."

24. Two weeks later, the officer noted that the man attempted to talk about the failure of his application for enhanced status again shortly before prisoners were locked in their cells. He tried to speak to officers again on 3 March about enhanced status. The third officer wrote in the man's wing history file that he would now need to submit an application to talk to officers as he always began the conversations at inopportune times.

25. On 11 May, the third officer wrote in the man's wing history file that:

> "spoke to the man who now says that he has come to the realisation that he will not be getting his enhancement at present. He now states that he wishes to participate in all programmes open to him. A sudden change of heart now that he realises he needs to address his behaviour in order to gain enhancement."

26. The man applied for enhanced status again in June. However, it was noted by the first officer in August that the man continued to attempt to monopolise staff time. A fourth officer wrote in the man's wing history file that he contacted the IMB in August to ask about his application for enhancement but was told that, without undertaking the required courses, he would not be eligible.

27. On 17 August, the man wished to telephone his family in the evening. This was refused as a prisoner on the standard regime does not have association time on weekend evenings. He asked the first officer to telephone on his behalf from the office which was also refused as the number requested had not been cleared by security.

28. A further written warning was issued to the man on 14 September by a fifth officer:

> "Despite two warnings last week in which I informed you of correct time for telephone use and advised you that if you need to use the telephone to ask a member of staff. Regardless of this you still ignored unit rules and used the telephone at an unauthorised time. Furthermore when challenged you became argumentative and tried to justify your behaviour. You have been on the unit long enough to be aware of unit rules and was reminded of these only days ago."

29. The man told a nurse on 11 December that, for several weeks, he had passed blood in his urine. He was seen by the prison doctor the following day who confirmed that the man had an enlarged prostate and was passing blood in his urine. The doctor ordered blood tests, although the sample taken could not be tested. There is no evidence that this was followed up.

30. The fifth officer recorded in the man's wing history file on 31 December that he had refused to go to hospital because of being handcuffed. The officer explained to the man that it was standard practice to cuff a prisoner for an outpatients' appointment. The investigator asked about this issue and was told that it was standard practice for category B prisoners.

31. On 1 January, the man complained of a problem with his chest again and an appointment was made for him to see a second prison doctor on 4 January. At that appointment, the doctor noted that he had a cough and was wheezing. The man was given smoking cessation advice and prescribed Becofide and Salbutamol (medication used to aid breathing). There is no evidence that the outstanding matter of the urine sample taken in December was followed up at this appointment.

32. The man's chest problems continued into February and he complained of his chest feeling tight. The second prison doctor saw the man on 17 and 24 February and noted that he was short of breath and continued to pass blood in his urine. From the records, the second doctor could see that this had not been effectively investigated since December. The man was referred to the urology department of the local hospital on 24 February.

33. Less than a week later, the man went to the Princess of Wales Hospital for tests. Staff at the hospital were concerned that he might have a bladder tumour and he underwent further surgical procedures at Abertawe Bro Morgannwg University NHS Trust. He returned to Parc on 17 April.

34. The man applied for enhanced status again in December 2008 which was granted in April 2009.

35. In May, the prison received correspondence from the hospital that confirmed that the man was suffering from cancer. The tests revealed that he was suffering from cancer in his lungs and bladder. A sixth officer recorded that the man took the news relatively well and staff did not consider there was need for suicide prevention procedures to be put in place. The officer offered the man the opportunity to telephone his wife, but he declined. The prison chaplain also visited the man and offered him her support. She arranged for the man to have a telephone call to his family. She visited the man again at the start of June and, although she offered him an opportunity to see a pagan chaplain, he told her that he was happy with the support offered by the prison.

36. On 3 June, the man went to hospital for a bronchoscopy (a procedure where an instrument is inserted through the patient's nose or mouth to examine the lungs and airways). Upon his return, staff wanted him to spend the night in the healthcare unit so that he could be monitored. However, the man was determined to return to his usual cell and signed a disclaimer to confirm this. He returned to his cell that evening.

37. Four days later, on 7 June, the man felt ill and the alarm was raised via a code blue alert. (A code blue indicates a medical emergency relating to breathing.) He complained of sudden chest pain. The notes in the medical record described the man as cyanosed (blue skin) and suffering from haemoptysis (coughing up of blood). He was wheezing and described as cold and clammy. His pulse was high, 78 beats per minute. The man was taken to hospital, and staff telephoned his wife to tell her that he was there. He returned from hospital two days later, on 9 June, but was unhappy that the medication the hospital had prescribed for him was not available at the prison. He spoke to the doctor the following day to resolve this.

38. The man told staff in mid-June that he was not taking his pain relief as he did not feel it was necessary. He was taken to hospital on 25 June after becoming unwell but returned that day. A multi-disciplinary case conference was held on 26 June to discuss the man's care. This was an opportunity for a range of people responsible for the man's care to discuss any issues or concerns. It was decided that the prison chaplain would tell the man's wife whenever he was taken to an outside hospital so she could accompany him. (This would not normally happen because of practical and security constraints.) The man was told to press his cell bell whenever he needed pain relief so that staff could provide it for him.

39. At the end of June, the man told staff that he was suffering from pain at night. Arrangements were put in place for the night nurse to give him pain relief medication every night. Chemotherapy was begun on 30 June, and often left him tired. The man had been given an information leaflet about

his therapy. He was concerned about his temperature rising so staff arranged for it to be taken when the medication was administered at night. A second nurse wrote in the man's medical record that he was happy with this arrangement.

40. The man went to hospital on 8 July to have an X-ray and MRI [magnetic resonance imaging] scan. A note was made in the PER relating to the issue of restraints:

> "Permission given by the Head of Safer Custody and Violence Reduction for closet chain to be removed for scan." [The Head of Safer Custody and Violence Reduction was required to authorise such decisions.]

41. On 21 July, the man was taken to Velindre Hospital. However, on arrival he was told his blood tests results from the day before meant that he would not be able to have chemotherapy on that day. The hospital contacted the prison to arrange another date.

42. The first prison doctor carried out a full assessment of the man on 12 and 13 August. He noted that, although the man had suffered from diarrhoea and had a tender stomach, his clinical observations (that is pulse, temperature and blood pressure) were within normal limits. The man returned after a day of treatment at hospital on 19 August and, again, his prescribed medication was not available for him in the prison. The man's wife telephoned the hospital, who told her they had contacted the prison to let them know that he had been given more medication. The medication was found in the admissions department of the prison. A third nurse told the man that, in future, he should see a nurse in the prison admissions department on his return from hospital to ensure that he had his medication.

43. Another case conference was held on 3 September. Nursing, safer custody and chaplaincy staff attended. A senior nurse recorded in the man's medical file that he raised no concerns about his care, and it was noted that his wife continued to attend all of his outpatient appointments. The fourth officer, in the man's wing history sheet, described him as "a polite and mature inmate".

44. On 7 September, the hospital told the man that he would not be able to have his chemotherapy until he had a blood transfusion. A note was also made in his medical file regarding the contact details of the lead palliative care nurse at the Princess of Wales Hospital in Bridgend, saying that she was available on the telephone if required. The prison had further contact with the lead palliative's colleagues at the end of the month.

45. A letter sent to the second prison doctor on 6 October by a doctor explained that the man was reviewed during a hospital appointment in early October. It confirmed that the pain was caused by his tumour and he should continue to take Oramorph (liquid morphine) when required. On 7 October, the third nurse recorded that the man was suffering from more pain but the Oramorph was helping.

46. The man's condition was reviewed by the lead palliative nurse on 22 October. She noted that he was clear about his prognosis and graded him as five to six on the pain scale. (This was described by the clinical reviewer as a scale of zero to ten with zero being no pain and ten being the worst pain.) He continued to take Oramorph when in pain. The lead palliative nurse noted that she was scheduled to see the man again in four weeks time, but offered further support should it be required.

47. On 13 November, the man was sick in the morning, but told a fourth nurse that he was not in pain.

48. A third prison doctor reviewed the man two days later as he had developed a large swelling on his neck. He was referred to the oncology department of the hospital as it was feared that it might be cancerous.

49. The fourth officer had noted on 2 November that the man has said that he was considering applying for release on compassionate grounds. However, the second prison doctor confirmed on 24 November that the man was still physically active. He described the man as in "remarkably good health" for the type of problems he had. This meant that he posed too great a risk and so the application for release on compassionate grounds was not supported by the prison. A seventh officer was asked by the man to take over as his personal officer on 29 November.

50. The man attended the outpatient clinic at Velindre Hospital on 26 November. It was decided that, although further chemotherapy would not be of benefit, radiotherapy could improve his swallowing. The palliative lead nurse telephoned to say that she thought that the man was deteriorating and might only have months to live. It was noted that the palliative lead nurse would be invited to the next case conference.

51. On 1 December, the man applied for release on temporary licence (ROTL) on special purpose leave on 24, 25 and 26 December to try to spend his last Christmas with his family. This type of release is described in PSO 6300 as:

> "This is a short duration temporary release, often at short notice, that allows eligible prisoners to respond to exceptional, personal circumstances and to wider criminal justice needs."

52. On 3 December, the prison chaplain said she supported the ROTL application on compassionate grounds, but understood the security implications.

53. A note was made in the man's medical record by the third prison doctor on 5 December that he had no complaints, and was awaiting his first session of radiotherapy. The man went to Velindre Hospital on 9 December for a CT (computerised topography) scan. The Head of Safer Custody and Violence Reduction gave permission for cuffs to be removed during the scan.

54. A case conference was held on 9 December with the palliative lead nurse to discuss the man's application for release on temporary licence. The man was not present at the meeting. The application was not supported by the man's unit manager or his offender supervisor as the man was still mobile enough to be considered a security risk. The seriousness of his index offence was also taken into consideration. The staff agreed to suggest that the man move to a single cell. They agreed that the man should move to an outside hospital if his health deteriorated any further. It was noted that the man saw healthcare staff twice a day and was able to contact Macmillan nurses on the telephone if he wished to. (Macmillan nurses specialise in cancer and palliative care.)

55. The outcomes of the case conference were discussed with the man the following day. He said that he was happy with the care he had received and preferred to stay in his cell as he got on well with his cellmate. The man's cellmate told the investigator he had been happy with this arrangement. He acknowledged that he could speak to the Macmillan nurses on the telephone should he wish to. The seventh officer wrote in his wing history sheet that he received a visit from his family on 16 December which he said he enjoyed.

56. From 16 December, the man's health began to deteriorate. The seventh officer wrote in his wing history sheet that he was "starting to go downhill a bit, health wise". The man signed a form confirming consent for a flu and swine flu jab, which he received on Thursday 17 December.

57. On 18 December, the man's application for ROTL was rejected due to concerns regarding security and the victim of his offence:

> "Due to the fact there are victim issues, community local issues, the risk is too high for the man to be considered at this stage, any further applications must be passed through Offender Supervisor as Social Services and victim liaison would also have to be contacted."

58. The second prison doctor requested an extra mattress for the man as he was becoming incontinent at night. The following day, a note was made in his record for all staff to monitor him as he was becoming increasingly frail. My investigator spoke to the man's cellmate who said that he continued to look after the man and assist him in his daily routine at this time.

59. On the morning of 20 December, it was recorded by an eighth officer that the man had not had a good night. He had been in pain but his cell-mate kept staff aware of any changes in his condition. He was reviewed by the third prison doctor and assessed as deteriorating and becoming disorientated. It was also noted that, while he denied it, the man was clearly in pain when he moved. The doctor noted that he was again offered the opportunity to go to the healthcare centre, but he wished to stay where he was. The doctor wrote that the man would not want to go to hospital but "wants to stay where he is". The sixth officer recorded that a visit was organised for his family in the care room on D wing as the man was too ill to go the visits hall.

60. The man deteriorated further the following morning and was unable to get out of bed. Healthcare staff, having reviewed the man, decided to transfer him to hospital. The second prison officer spoke to the Princess of Wales Hospital to arrange the move.

61. The prison undertook a risk assessment for the man's transfer to hospital. In the section 'Approval of Head of Security or Head of Operations', it was recorded that restraints were not to be used. A later assessment at 3.30pm confirmed that restraints were not to be used "due to serious nature of his illness". The second assessment also reduced the level of the escort to one staff member.

62. The prison chaplain telephoned the man's wife to tell her that her husband was being taken to hospital. He was escorted to the Princess of Wales Hospital in Bridgend at 10.30am. His family were told, and arrived at the hospital at 11.20am. The prison chaplain came to the hospital at 3.50pm. The man died the following day at 6.35pm.

63. Following the man's death, other prisoners were informed and offered support from Listeners and chaplaincy. (A Listener is a prisoner trained by the Samaritans to provide emotional support to other prisoners. It is confidential, but is not a counselling service.)

64. The man's cellmate was told individually and staff kept a close eye on him. The officers were offered support from the care and support team and chaplaincy.

65. The prison organised and contributed to the cost of the funeral. The man was a pagan so the prison chaplain, arranged for a pagan chaplain to carry out the service. She also returned the man's property to his wife. The prison held a memorial service to which prisoners and the man's family were invited.

ISSUES

Clinical issues

66. The clinical reviewer assessed the overall medical care received by the man in prison. She finds that there were several areas where it could have been improved. I make a number of recommendations based on the findings of the clinical reviewer, and also include some recommendations directly from the clinical review. I include in this report the key areas of interest from the review and encourage the Head of Healthcare to closely study all the findings and recommendations in the clinical review.

Quality and timeliness of care

67. The clinical reviewer makes reference to a number of occasions when the quality and timeliness of the man's care fell below appropriate standards. A number of recommendations are made with regard to this, and I would encourage the Head of Healthcare to review them.

68. When the man was seen by the second prison doctor in December 2008 there were delays organising blood tests to assess the symptoms the man was presenting with. The clinical reviewer was concerned by these delays and commented that the:

> "Blood test should have been repeated and other results should have been followed up. An indication of cancer may have been diagnosed at this time and treatment commenced. It would seem likely that even if an earlier diagnosis was made the final outcome would likely be the same, however it would have allowed the man to be assessed by specialists and allowed the appropriate management of his pain, care and treatment at an earlier time."

69. This oversight is worrying and may have meant that the man experienced more discomfort than was necessary. The clinical reviewer did not make a specific recommendation regarding this issue, but I would encourage the Head of Healthcare to consider the implications.

70. The clinical reviewer also considers that the man did not receive appropriate pain relief medication at various points during his time in custody. With regard to the pain in his chest, she writes:

> "Over time, the man experienced a physical pain in his chest which was complex in nature. Overall pain management was reactive and the type of pain experienced, location, and severity, were not routinely assessed once the prognosis was clear. It is evident that there was informal discussion with the man and that this prompted

> some changes and increases in his analgesia however there was no regular pain self assessment such as the VAS (Visual Analogue Scale - a pain self rating out of 10) nor a specific assessment documenting the sites, number, and types of pain."

71. In light of the clinical reviewer's findings, I make the following recommendation:

The Head of Healthcare should ensure that healthcare staff use relevant pain assessment guides to ensure appropriate provision and effectiveness of pain medication, in accordance with current guidance.

72. The man's wife told the investigator that no Macmillan nurses visited her husband, despite his wish for them to do so. Macmillan nurses were involved in his care although it does not seem that they visited him at any point. The contact details for Macmillan nurses were put into the man's medical record at an early stage to allow for consultation. They were also involved in the case conference held on 9 December. It is a matter for the Macmillan nurses to decide whether to visit a patient and I am satisfied that the prison did not put any obstacles in their way. The clinical reviewer also comments on palliative care services for the man:

> "Whilst a review of the care he required was undertaken on 15th June 2009, no contact was considered or made to access palliative care services or support for the man until September 2009. Staff did not collaborate with Clinical Nurse Specialists, Palliative Care Specialist Nurses, or voluntary organisations to access specialist advice and support to ensure he received the best possible care.

73. I agree with the clinical reviewer. I make the following recommendation:

The Head of Healthcare should ensure that patients requiring palliative care are treated in accordance with the prescribed pathway, including visits from the Macmillan nurses.

Sharing information

74. The clinical reviewer refers to a number of occasions where poor communication and liaison affected the care provided to the man.

75. When the man returned from his chemotherapy sessions he was provided with medication by the hospital. This was not always provided to him and did not appear to get through the reception area of the prison. The man's solicitor was obliged to contact the prison to alert them to the man not receiving the correct medication. The clinical reviewer was also

concerned about the man's visits to hospital not being effectively recorded in the prison's clinical records:

> "On a number of occasions, no entries were made in the prison clinical record of the man's attendance at hospital for clinic appointments or his admission into hospital detailing the appointments, the outcomes or actions required."

76. I agree with the clinical reviewer regarding the importance of effective communication, and make the following recommendation:

The Head of Healthcare should ensure that all hospital visits are documented in the medical notes to ensure effective continuity of care.

Record keeping

77. In her clinical review, the clinical reviewer criticises the standard of record-keeping by healthcare staff at Parc. She specifically notes that the reason for lisinopril not being administered at Swansea was not noted on the man's medication chart, and no prescription charts appear to have been completed after 30 July 2009. She described the record keeping in the following manner:

> "The clinical records were generally in poor order, with entries being illegible, abbreviations used throughout the records and lines left blank between entries."

78. I endorse the clinical reviewer's recommendation:

The Head of Healthcare should ensure that the entries made by healthcare staff in medical and nursing records are legible, signed, lines are not left blank and that abbreviations are not used in accordance with the standards set out in the NMC [Nursing and Midwifery Council] Guide to Record Keeping.

Concerns about a particular doctor

79. The man's wife was concerned that one of the doctors at Parc did not provide the right care to the man. Unfortunately, she did not give the name of the doctor. The man received medical care from a number of healthcare staff, including several doctors during his time in the prison. He did not make any formal complaints about his medical care, nor is there any record that he mentioned to staff that he was unhappy. In fact, when he was told of the outcome of the ROTL case conference on 9

December 2009, the man told staff that he was happy with the care he had received to date.

80. Although I am not able to identify the doctor to whom his wife referred, the clinical review considers the man's care overall. It takes into account the conduct of every healthcare professional who he came into contact with. At no point in the review is an individual's conduct specifically called into question, although over-arching issues are identified. In light of the fact that the man did not raise his concerns with staff and in line with the clinical review, I make no comment on the conduct of any individual doctor in this report.

The swine flu jab

81. The man's wife was concerned that her husband received flu and swine flu vaccinations at the same time on Thursday 17 December. She explained that she spoke to him the following day, when he seemed very ill. She was concerned that, since his immune system was already compromised by his treatment, he should not have been given the injections.

82. The clinical reviewer examined this issue and consulted colleagues. She wrote in her report that:

> "We have sought the views of a consultant oncologist in this matter, and he has concluded that taking into account the man's condition, and the fact that his chemotherapy treatment had been concluded three months previously, receiving two flu injections at the same time would not have compromised the man's condition or speeded up his death."

83. When the investigator spoke to the man's cellmate, he explained that they voluntarily put their names forward for the vaccinations. The cellmate said that he suggested that the man discuss it with the pharmacist. The man told his cellmate that the pharmacist described the jabs as "not a bad idea". The man signed a form acknowledging his decision to undertake the injections. Given that the man made the decision voluntarily, and the clinical reviewer has identified no risk with the procedure, I think it was reasonable to give him the flu and swine flu jabs at his request.

Whether a nurse saw the man on the morning he went to hospital

84. The man's wife wanted clarification as to whether the man saw a nurse on the morning that he was taken to hospital. I can confirm that healthcare staff did attend the man to help him get out of bed. They decided to transfer him to hospital.

Whether the man should have been admitted to hospital earlier

85. The man's wife felt that he was sufficiently ill to have been admitted to hospital earlier. The clinical reviewer had sympathy with this opinion saying:

> "Whilst it is clear that given the man's condition it would have been appropriate to admit him to hospital on 20 December, the decision by the doctor and prison staff to respect the man's wishes at this time was reasonable, particularly as to do otherwise would have caused the man more distress as he was adamant that he did not want to be admitted to the Healthcare unit or to the hospital."

86. The man told his cellmate and staff that he was adamant he did not want to go to hospital before he had to. Given his strong personal desire to stay at Parc as long as possible, it is clear that staff there sought to fulfil his wishes. It is very difficult for staff in this type of situation to balance the medical needs of a patient with their previously stated wishes.

87. I think it is worthy of note that the clinical reviewer identified that any earlier transfer of the man may have caused further distress. I do not criticise the prison for the difficult choice they made because it is clear that they reached it with regard to the man's wishes. The clinical reviewer also judges it to be reasonable under the circumstances.

Good practice

88. The prison chaplain contacted the man's wife when he was taken to hospital on 7 June 2009. In the subsequent case conference, they agreed that the chaplain would contact his wife each time he was taken into hospital for treatment. This allowed his wife to see him relatively regularly and was appreciated by her. This contact was continued up to and including the man's final transfer to hospital. This is an example of good practice.

Prison transfers and the complications arising from them

89. The man's wife was upset by his frequent moves to different prisons following his initial arrival into custody. The moves also complicated matters such as telephone calls, visits and money. I understand that the man exchanged correspondence with a number of prisons regarding the money and telephone call issues.

90. Moving between prisons can be difficult for prisoners and their families. It is unfortunate that this was true for the man. However, the prison

authorities and processes require prisoners to transfer for a variety of reasons such as population pressures, security matters and court appearances, even if it is inconvenient for those concerned. My remit means that I have not considered all the transfers at the start of his time in custody but I can provide some information. The man moved to Usk in December 2007 while serving a short sentence. Usk is unable to hold remand prisoners so he transferred to Cardiff later in the month once that sentence was complete and he was on remand again. However, Cardiff was unable to take vulnerable prisoners so the man was transferred again to Parc.

Refusal of enhanced status

91. The man was not granted enhanced status in 2008 due to a number of written warnings. His wife disputed the validity of these warnings following her husband's death. The investigator has looked into this issue and found nothing irregular in the application or consequence of these warnings. The warnings were issued for a number of reasons including using the telephone at unauthorised times. Although the man's wife expressed her belief that there were mitigating circumstances regarding the use of the telephone, the nature of a prison wing with 120 prisoners, each with their own individual circumstances, means that the prison can often not exercise such discretion. I conclude that it was reasonable for officers to refuse enhanced status.

92. It is clear from his records that the man struggled, at first, to adapt to the requirements of the regime at Parc. However, this changed as the man changed his behaviour. He achieved enhanced status and was described as polite and mature by an officer.

Compassionate release

93. Prisoners who are suffering from a terminal illness and for whom death is thought likely to occur soon can be released from prison by early release on compassionate grounds. In order to be released, an application must be sent to the Public Protection Unit in National Offender Management Service. The form includes sections to be completed by the Governor, a prison doctor and an offender manager. A full prognosis must also be provided. Once the form is submitted, caseworkers in the Public Protection Unit determine whether the application meets the criteria set out in PSO 6000 (the instruction that deals with the release and recall of prisoners). In making this decision, they consult with the Parole Board and specialist medical advisors in the Department of Health. PSO 6000 states:

> "The criteria applied in medical and tragic family circumstances cases are as follows:

(i) Medical

- the prisoner is suffering from a terminal illness and death is likely to occur soon; or the prisoner is bedridden or similarly incapacitated; and
- the risk of re-offending is past; and
- there are adequate arrangements for the prisoner's care and treatment outside prison; and
- early release will bring some significant benefit to the prisoner or his/her family."

94. The man applied for compassionate release toward the end of his life but it was rejected. I understand that this was due to the medical opinion that the man was still well enough to re-offend. The man subsequently applied for temporary release on special purpose licence in an attempt to spend his last Christmas at home. This type of release is described in PSO 6300 (Release on Temporary Licence) as follows:

> "This is a short duration temporary release, often at short notice, that allows eligible prisoners to respond to exceptional, personal circumstances and to wider criminal justice needs."

95. Following a case conference on 9 December, the man's application was rejected on 18 December due to security and victim concerns. The verdict noted that any further applications would need to involve Social Services and victim liaison. The investigator was told by the prison during the investigation that such liaison could not begin before the man's health deteriorated. Although the man was keen to be released, it is understandable that the prison was cautious about doing so due to his offences and reasonable level of health up until very near to the end of his life.

Authorising a visit to the man

96. The man's wife said that she was upset by the delay in allowing her daughter's fiancé to visit the man. She explained that in June 2010 they wanted the two men to meet but the prison took time to authorise his visit. The investigator has seen a letter from the man's solicitor sent on 24 August requesting the visit be allowed. The Head of Operations at Parc, responded the following day granting special dispensation for the man's daughter's fiancé to visit the man.

97. Despite this authorisation, the man's wife told the investigator that the first visit did not occur until 1 November, more than three months later. However, the man's wife did say that part of the delay may have been caused by the family's solicitors neglecting to tell the family that her

daughter's fiancé had been given approval to visit her husband. Although the delay is regrettable, since the Head of Safer Custody and Violence Reduction replied to the letter from the man's solicitor, I consider him to have fulfilled his obligations in this regard.

98. The man's wife, while acknowledging the possible delay on the solicitor's behalf, said that officers repeatedly refused to allow the man to arrange a visit for his daughter's fiancé until November. My investigator looked into this and asked the prison to review the authorisation process. The investigator was told that the prison was unable to check whether there was any delay in the authorisation of the visit following the decision taken by the Head of Safer Custody in August. It is regrettable that there is insufficient evidence to answer this question fully.

The use of restraints during the man's hospital visits

99. The man was restrained while he was escorted for hospital appointments. He was unhappy with the level of restraint and the differing approach escort officers took to the issue. The man's solicitor wrote to the prison to request that restraints to be removed to allow private consultations with the hospital staff. I understand that the prison responded by agreeing to use a longer escort chain that secured the man but meant he could meet with hospital staff in more privacy. This allowed greater privacy without removing the restraint entirely.

100. I understand that restraints are an emotive issue, particularly during medical visits, due to the impact they have on prisoners' dignity. However, the prison has a responsibility to the public to ensure that prisoners are restrained during any time spent out of direct prison custody. The prison responded to the request from the man's solicitor and I am pleased that they allowed him to consult hospital staff privately without compromising their responsibility for security.

Liaison with the man's family

The funeral

101. I am pleased that the prison not only paid for the funeral but also arranged it. The man was a pagan, and the prison chaplain helped locate a suitable person to conduct the funeral. This level of involvement is to be welcomed, and is an example of the efforts made by the prison chaplain to support the family after the man's death.

The man's property

102. The man's wife told my investigator that she wanted some computer discs that the man had been writing his life story. The investigator spoke to the prison on her behalf but was told that the prison had no such discs. This is, of course unfortunate and I remind Parc of the vital importance of ensuring that all property is returned to the bereaved family.

CONCLUSION

103. The man spent a number of years in custody before becoming terminally ill. Although the clinical review outlines a number of issues that could have been improved upon regarding the man's clinical care, I believe that staff sought to care for his clinical and personal needs. His wish to stay in his cell was respected, and he was supported by discipline and chaplaincy staff. I am pleased that the prison informed the man's wife of his hospital appointments which allowed them to attend together. This type of support was continued by the chaplain after the man's death. I realise that the man's wife has a number of concerns regarding his care, and I hope that this report provides further information about his time in custody.

RECOMMENDATIONS

Recommendations

1. The Head of Healthcare should ensure that healthcare staff use relevant pain assessment guides to ensure appropriate provision and effectiveness of pain medication, in accordance with current guidance.

   The National Offender Management Service accepted this recommendation:

   > "New pain assessment guides are currently being reviewed collectively with GP practitioners, Medical Director and Pharmacy supplier. To be discussed and taken forward in our Medicines Management meetings."

2. The Head of Healthcare should ensure that patients requiring palliative care are treated in accordance with the prescribed pathway, including visits from the Macmillan nurses.

   The National Offender Management Service accepted this recommendation:

   > "Links with Macmillan Nurses have been made and our Healthcare department will be visited and reviewed with MacMillan in order to develop working practices. Plans are under development to provide a palliative care suite on our new Older Persons Unit."

3. The Head of Healthcare should ensure that all hospital visits are documented in the medical notes to ensure effective continuity of care.

   The National Offender Management Service accepted this recommendation:

   > "A new policy will be implemented to ensure that all secondary care provision/ interactions are kept and documented in the IMRs and an audit trail provided from referral to discharge from secondary care."

4. The Head of Healthcare should ensure that the entries made by healthcare staff in medical and nursing records are legible, signed, lines are not left blank and that abbreviations are not used in accordance with the standards set out in the NMC [Nursing and Midwifery Council] Guide to Record Keeping.

   The National Offender Management Service accepted this recommendation:

   > "Defensible documentation training will be provided for all medical staff. All staff are to receive a copy of NMC guidelines and policies and procedures."

Good practice

1. Telling the man's wife of his upcoming hospital appointments allowed her to be with him, and is an example of good practice.

   The National Offender Management Service noted this good practice:

   > "This good practice continues to be carried out wherever possible."