

**Prisons &
Probation**

Ombudsman
Independent Investigations

**Independent investigation into
the death of Mr Tudor Owen
Allsop, a prisoner at HMP
Cardiff, on 25 February 2019**

A report by the Prisons and Probation Ombudsman

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE



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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.

Mr Tudor Allsop died of acute peritonitis, caused by a perforated gastric ulcer, on 25 February 2019 at HMP Cardiff. Mr Allsop was 43 years old. I offer my condolences to Mr Allsop's family and friends.

Mr Allsop had been at Cardiff for five days when he became ill with acute abdominal pain which he said was similar to the pain he had felt when he had had a perforated ulcer some years earlier. He was taken to the prison's healthcare unit where he was observed for 24 hours before he died. While he was in the unit, he told staff he had swallowed a package of heroin, although this was not true.

The clinical reviewer considers that the clinical care Mr Allsop received at Cardiff was not equivalent to that he could have expected to receive in the community. Conclusions were reached and decisions were made about Mr Allsop's care that were not documented in his medical records. As a result, there was a series of misunderstandings and a breakdown in communication between healthcare staff in the 24 hours leading to Mr Allsop's death. The clinical reviewer is concerned that healthcare staff disregarded the potential diagnosis of a perforated ulcer and focused on what Mr Allsop had said about having swallowed heroin.

The clinical reviewer considers that Mr Allsop's death might have been preventable if he had been admitted to hospital, although he might not have survived even if he had been admitted.

I am concerned that this is the second investigation into a death at Cardiff in 2019 where we have found that healthcare was not equivalent to that in the community. The Governor, the healthcare providers and the NHS Commissioners need to address this worrying situation as a matter of urgency.

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

February 2023

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Summary

Events

1. Mr Tudor Allsop was released from prison on licence in January 2019 and then recalled to custody on 19 February for breaching his licence conditions.
2. Mr Allsop had a history of intravenous drug misuse, and in 2010 he had had a perforated gastric ulcer which had required surgical repair.
3. In the early hours of 24 February, Mr Allsop complained of severe abdominal pain. He asked to be sent to hospital, telling staff that the pain was the same as when he had the perforated ulcer. A nurse rang a prison GP for advice. As a result, Mr Allsop was moved to the prison's healthcare unit for monitoring. His clinical observations were taken hourly until 8.44am and were within normal limits.
4. At about 9.30am, Mr Allsop told a wing cleaner that he had swallowed a package of heroin and was worried that this was the cause of his severe stomach pain. A nurse rang the GP again for advice in the light of this information. Mr Allsop refused to have blood tests taken, but his clinical observations were taken four times over the next 10 hours. They were within normal ranges, although on the last occasion, just before 8.00pm, his pulse rate had increased significantly.
5. On 25 February, at 12.32am, a nurse checked on Mr Allsop. He was cold to the touch, and she was unable to feel a radial (wrist) pulse. She requested an emergency ambulance. Mr Allsop was conscious and denied that he had swallowed heroin, but the nurse administered naloxone (an opioid antidote) in case he had done so.
6. At 1.03am, paramedics arrived. Mr Allsop went into respiratory arrest. Paramedics began CPR, but they could not resuscitate him, and he was pronounced dead at 2.27am.
7. The post-mortem found that Mr Allsop died of acute peritonitis (an infection of the stomach lining) caused by a perforated gastric ulcer.

Findings

8. The routine questions Mr Allsop was asked during his reception health screen did not identify that he had previously had a perforated gastric ulcer.
9. Nurses made four telephone calls to a prison GP about Mr Allsop's condition and the GP based her diagnosis on these calls. No notes were made at the time about what was said in these calls. The nurses' recollections are different from the GP's, and it is impossible to say which accounts are correct.
10. The GP was aware that Mr Allsop had had a previous perforated ulcer, but the clinical reviewer is concerned that she disregarded this as a possible diagnosis early on and concluded instead that Mr Allsop had fabricated his pain in order to gain access to healthcare because he was worried about having swallowed heroin.

11. Although the GP had asked for Mr Allsop's clinical observations to be taken hourly, after 9.39am they were taken less frequently, although nurses said that they had taken additional observations, which they did not record.
12. The clinical reviewer considers that healthcare staff over-relied on the fact that the observations were within normal ranges.
13. When Mr Allsop's pulse rate increased significantly just before 8.00pm, nothing was done.
14. We are not satisfied that the healthcare Mr Allsop received at Cardiff was equivalent to that he could have expected to receive in the community. We are concerned that this is the second death at Cardiff in 2019 in which we have reached this conclusion.
15. We are also concerned that not all staff received support after Mr Allsop's death.

Recommendations

- The lead GP/Clinical Director and Head of Healthcare at Cardiff should ensure that immediate steps are taken to assess, monitor and improve the standard of note keeping in the medical records. (This should include, but need not be restricted to, the actions set out in paragraph 6.1 of the Clinical Reviewer's report.)
- HM Prison and Probation Service should discuss with the Welsh Government and the Local Health Board and NHS England and NHS Improvement whether a protocol for the management of prisoners with abdominal pain should be introduced in all prisons in England and Wales (see section 6.4 of the Clinical Reviewer's report).
- HM Prison and Probation Service should discuss with the NHS England and NHS Improvement, the Welsh Government likewise with Public Health Wales whether the measures recommended by the Clinical Reviewer to ensure that details of serious but acute health issues are documented in prisoners' medical records, should be introduced in all prisons in England and Wales (see sections 6.2 and 6.3 of the Clinical Reviewer's report).
- The Governor and Head of Healthcare should ensure that all members of staff are offered support after a death in custody, including offering support when staff return to work.

The Investigation Process

16. 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.
17. The investigator obtained copies of relevant extracts from Mr Allsop's prison and medical records.
18. The investigator interviewed six members of staff at Cardiff on 8 May. Healthcare Inspectorate Wales commissioned a clinical reviewer to review Mr Allsop's clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff. A nurse, who was not available for interview, was asked questions by email.
19. We informed HM Coroner for Bridgend and Glamorgan Valleys of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
20. One of the Ombudsman's family liaison officers contacted Mr Allsop's next of kin, to explain the investigation and to ask whether she had any matters they wanted the investigation to consider. She asked:
 - Why did it take so long for the prison to get help for Mr Allsop when he complained of pain?
 - Why was Mr Allsop's past medical history not taken into consideration?
 - Why did Mr Allsop have to claim he had swallowed a package of drugs to be taken seriously?

We have addressed those questions in this report.

21. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS identified some factual inaccuracies and we have amended our report accordingly.

Background Information

HMP Cardiff

22. 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

23. The most recent inspection of HMP Cardiff was carried out in July 2019, but the report has not yet been published. The previous inspection was in August 2016, when inspectors reported that, overall, healthcare was good. The health centre, including the inpatient unit, was clean and had excellent facilities. Healthcare professionals had excellent access to training and were considered up to date with requirements. Inspectors were, however, concerned that health services staff were not examining reports from death in custody clinical reviews, which meant that learning opportunities were being missed.

Independent Monitoring Board

24. 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 2018, the IMB reported a cooperative relationship between healthcare and custodial staff. They commended healthcare staff's efforts to provide a high standard of care for prisoners.

Previous deaths at HMP Cardiff

25. Mr Allsop's was the sixth death to occur at HMP Cardiff since January 2017. Of the previous deaths, three were from natural causes, one was drug-related and one self-inflicted.
26. In our report into the previous death from natural causes in January 2019, five weeks before Mr Allsop's death, we made a recommendation about poor record keeping and concluded that clinical care was not equivalent to the care that could have been expected in the community. We are concerned that we have made the same findings in Mr Allsop's case.

Key Events

27. On 25 April 2018, Mr Tudor Allsop was sentenced to eight months and 14 days imprisonment for breaching a supervision order. He was sent to HMP Cardiff and subsequently released on licence on 25 January 2019. He was recalled to custody on 19 February for breaching his licence conditions and returned to Cardiff.
28. At his first reception screen with a nurse, Mr Allsop said he had epilepsy (for which he said he was prescribed clonazepam, a tranquiliser) and a history of illicit intravenous drug use, including heroin. He raised no other concerns about his physical or mental health and was keen to end the assessment and 'get on the wing'. The nurse carried out routine clinical observations which were all within normal limits.
29. On 20 February, a nurse carried out the second reception screen and again noted Mr Allsop's history of epilepsy.
30. Mr Allsop had a history of a perforated gastric ulcer, which had needed surgical repair in 2010, but he did not mention this at either health screen. (A perforated ulcer is a condition in which an untreated ulcer can burn through the wall of the stomach, allowing digestive juices and food to leak into the abdominal cavity. This can be very serious because it enables bacteria from the stomach to infect the lining of the abdomen causing peritonitis. In peritonitis, the infection can rapidly spread into the blood (sepsis) before spreading to other organs. This carries the risk of multiple organ failure and can be fatal if left untreated.)
31. On 22 February, the prison received Mr Allsop's community medical records. These showed that Mr Allsop did not have a formal diagnosis of epilepsy, and that he had not been prescribed clonazepam since October 2018. Given Mr Allsop's lack of seizures, and the risks of abuse and addiction with clonazepam, a prison GP decided not to prescribe further medication.

Events of 24 February and 25 February

32. On 24 February at 1.00am, a nurse and a Healthcare Assistant (HCA) saw Mr Allsop in his cell at the request of staff. He had vomited and was complaining of stomach pain, and the nurse noted that he appeared to be hyperventilating. He told her that the pain felt the same as when he had had a perforated stomach ulcer. She took his clinical observations (which were normal) and reassured him. She went back to check on him 10 minutes later and recorded that he was lying on his bed and feeling a lot calmer and that he asked her to go away.
33. At 3.53am, a nurse was called to see Mr Allsop again as he was continuing to complain of stomach pain. His observations were normal, but she noted that he looked sweaty and was bent over his sink and repeatedly asked for an ambulance.
34. At about 4.00am, Nurse A rang a prison GP for advice. The GP told her to transfer Mr Allsop to the healthcare unit for observation, to check his vital signs hourly, and to arrange for him to be taken to hospital if he developed signs of shock.
35. The GP and Nurse A agree that Nurse A told the GP that Mr Allsop had required surgery for a perforated ulcer in 2010 and that he said the pain was similar. The GP

said in interview that the nurse also said that it looked as though Mr Allsop was withdrawing from something, but the nurse denied that she said this or that she offered any opinion on the cause of Mr Allsop's pain.

36. Nurse A rang the GP again five minutes later to tell her that Mr Allsop had walked to the healthcare unit and that his clinical observations were still normal. An Operational Support Grade (OSG) said that she was in the healthcare unit when Mr Allsop arrived. She said he was quite pale and sweaty but was able to walk and get himself a drink. He sat on and off the toilet a lot because he said he was more comfortable on it.
37. The GP said at interview that she told the nurse to look out for continued or worsening pain, vomiting and vomiting blood (a sign of a bleeding rather than perforated ulcer). She said that at this stage she felt that the most likely diagnosis was 'withdrawal'.
38. At 4.14am, Nurse A set up a care plan for Mr Allsop, and reviewed him a further four times: at 4.28, 4.57, 5.45 and 6.43am. She recorded that the plan was to monitor him closely and check his vital signs hourly. His observations were within the normal ranges, but she noted that he still appeared agitated and in pain. At 5.45am, she noted that he said his pain had reduced from 15/10 to 8/10. At 6.43am, she noted that Mr Allsop was unhappy that he had not been sent to hospital. She also noted that he was not given pain relief at the GP's request, in case this masked his symptoms.
39. Nurse B took over from Nurse A at about 7.15am. At about 7.54am, a HCA called a code blue medical emergency because Mr Allsop was lying on the floor of his cell. Nurse B said at interview that 'Tudor [had] decided to put himself on the floor to cool himself down'. She took Mr Allsop's observations and examined his abdomen, which she noted was soft when touched and that he did not flinch or appear to be in further pain. She recorded that he was demanding to go to hospital and was very verbally aggressive with her. She noted the GP's instruction not to give pain relief. At interview she said Mr Allsop looked a bit pale and unwell, but his observations were normal, although his blood pressure was a bit low, and she saw no need to call the doctor for advice. She cancelled the code blue.
40. Nurse C took over from Nurse B at about 8.15am. Nurse B told her Mr Allsop needed 'regular observations'. Nurse C did a routine check at 8.44am and noted that his clinical observations were stable and within normal limits and that Mr Allsop had accepted a cup of tea and was sitting on his bed. She also noted that Mr Allsop was unhappy with the regular observations and wanted to go to hospital. There were no signs of vomiting or blood. She noted that by the end of the consultation Mr Allsop was 'now lying on his bed curled up as he says it helps with the pain'.
41. Nurse C said that about 9.30am, a prisoner, who was working as a wing cleaner in the healthcare unit, told her that Mr Allsop said that he had swallowed a heroin package in cling film before entering custody and was concerned that it had burst and was causing his severe abdominal pain. She telephoned the GP to tell her this. The GP asked her to take some blood tests from Mr Allsop in view of the new information received about swallowing drugs.
42. At interview, the GP said that Nurse C told her during that phone call that Mr Allsop had 'made a miraculous recovery', that he was pain free, walking around the

landings, having cups of tea and waiting for his lunch. She said that the nurse said Mr Allsop had changed his story and was saying that he had not had any pain but had swallowed a package of heroin. She said that she and the nurse 'both concluded he must have got a scare and maybe tried to vomit this package up'. She said that, given the information they had received that Mr Allsop had swallowed heroin, they had jointly assumed that he had 'fabricated the pain in order to access healthcare'.

43. Nurse C did not mention that she and the GP had come to this conclusion when she was interviewed, and there is nothing in Mr Allsop's medical records to this effect.
44. Nurse C said Mr Allsop refused to have his blood taken but he allowed her to take his clinical observations throughout the day. She recorded that she had taken them at 9.39am, 1.55pm (when she recorded Mr Allsop had used his cell bell frequently and that he felt he was being ignored, that he had been moving around his cell and that the GP had been updated on his condition), 5.19pm and 7.54pm. At interview, she said she may have taken other observations which she did not record.
45. Nurse C said she was also able to observe Mr Allsop on the screen in the office as he was in a cell with a camera. At various times he lay or sat on his bed, walked around the cell and sat on the toilet. She said she assumed Mr Allsop was not in pain if he was walking around the cell or going to the toilet. She said he did seem to be in pain at times but at other times seemed angry and frustrated. She told the interviewer that she could not remember if she knew Mr Allsop had had a perforated ulcer in the past.
46. Nurse C recorded that at 5.19pm Mr Allsop's observations were oxygen saturation 98%, blood pressure 110/70 and pulse rate 68 bpm. At 7.54pm they were oxygen saturation 91%, blood pressure 100/60 (low) and a pulse rate of 100 bpm (at the upper range of normal). At interview, she said the final observations 'could be a potential shock situation', but Mr Allsop was sitting on the bed at the time and did not seem to be in shock.
47. Nurse C's shift ended at about 8.15 pm, when she handed over to Nurse A. A HCA started his shift at the same time. He said they were told that Mr Allsop had told one of the cleaners that he had swallowed a package.
48. Nurse A said she did limited clinical observations of Mr Allsop's pulse rate and oxygen saturation at some time between 9.00 and 10.00pm, but did not record them. She said Mr Allsop was standing at his cell door engaging in conversation at the time.
49. On 25 February at 12.23am, Nurse A checked on Mr Allsop. His pupils were dilated, and he was cold to the touch. She was unable to feel a radial (wrist) pulse, and she noted that his oxygen saturation had fallen to 80%. Mr Allsop described his pain as '15 out of 10'. She rang the GP, who advised her to call an emergency ambulance. She did so and administered oxygen through a breathing mask.
50. Mr Allsop was still responding verbally when she called the ambulance and strenuously denied that he had swallowed a heroin package, but due to the conflicting information, Nurse A administered naloxone (an emergency antidote for opioid overdoses) in case he had overdosed. She inserted an airway to assist with breathing as Mr Allsop's condition was deteriorating.

51. At 1.03am, paramedics arrived. Mr Allsop went into respiratory arrest, so they moved him to the floor and began cardio-pulmonary resuscitation (CPR). At 1.35am he went into cardiac arrest. Paramedics continued with CPR but were unable to resuscitate him and, at 2.27am, Mr Allsop was pronounced dead.

Contact with Mr Allsop's family

52. As Mr Allsop's mother and sister lived in Yorkshire, Cardiff asked HMP Holme House for assistance in breaking the news of Mr Allsop's death. Two family liaison officers from Holme House visited Mr Allsop's mother at her home to break the news of her son's death and offer condolences. In the days that followed, a family liaison officer from Cardiff maintained contact with Mr Allsop's mother.
53. In line with Prison Service instructions, the prison contributed to the costs of the funeral.

Support for prisoners and staff

54. The Head of Residence and Services held a debrief for staff, including healthcare staff, involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and for managers to offer support. The staff care team also offered support.
55. All the staff interviewed said that they had felt supported. However, during the interview with Nurse B, it was evident that she had not been part of the hot debrief and had not been offered support.
56. The prison posted notices informing staff and prisoners of Mr Allsop's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Allsop's death.

Cause of death

57. The Coroner held an inquest on 23 January 2023 and concluded that Mr Allsop died from acute peritonitis (an infection of the inner lining of the stomach) caused by a perforated gastric adenocarcinoma.

Findings

Clinical care

Record keeping

58. The clinical reviewer concluded that some of the care that Mr Allsop received had been appropriate and timely. This included the management of his epilepsy medication; the prompt request for community medical records; Nurse A's return to review Mr Allsop ten minutes after she first saw him complaining of stomach pain; moving him to healthcare and setting up a care plan. It was also good practice to have prison officers present in the cell after the ambulance was called, to facilitate a speedy transfer to hospital if necessary.
59. However, the clinical reviewer found that conclusions had been reached and decisions made about Mr Allsop's care that were not documented in the medical records. As a result, there was a series of misunderstandings and a breakdown in communication between healthcare staff in the 24 hours leading to Mr Allsop's death. These included:
- The GP saying that she was not aware that Mr Allsop was in pain, despite there being numerous entries in the medical records to this effect.
 - The GP deciding that the most likely diagnosis was drug withdrawal, despite there being nothing in the records to support this.
 - The GP gaining the impression that Mr Allsop's whole history of pain had been fabricated in order to access healthcare, despite there being nothing in the medical records to support this.
 - No record that clinical observations were taken hourly after 9.39am.
 - No action being taken when Mr Allsop's pulse rate showed a considerable rise at 7.54pm.
 - The potential, and ultimately correct, diagnosis of a perforated ulcer being disregarded early on in the process, despite Mr Allsop's past history of a perforated ulcer and his continued complaint of pain and insistence that he needed to go to hospital in view of his past history.
60. No notes were made of the telephone calls with Nurse A and Nurse C on which the GP based her diagnosis. The nurses' recollections of their discussions were different to the GP's and, without records, it is impossible to say which account is correct.
61. During interview, the GP said that, after speaking to Nurse A, her working diagnosis was one of 'withdrawal'. She also said that when she spoke to Nurse C, they jointly assumed that he had fabricated the pain in order to access healthcare because he was anxious about having swallowed heroin.
62. The clinical reviewer said that both the GP's conclusions that Mr Allsop's initial symptoms were due to drug withdrawal, and that the whole history of pain had been fabricated were, unfortunately, incorrect.

63. The clinical reviewer is concerned that the records and accounts given by staff give no indication of a process of differential diagnosis for the cause of Mr Allsop's pain and that the past history of a perforated ulcer was disregarded following the GP's conversation with Nurse C. She said:

'If a potential diagnosis is not thought at the time to be the most likely cause of an illness, it should still not be completely disregarded until a definite diagnosis is established. If one of the possible diagnoses, even if it is thought unlikely, has potentially life-threatening consequences [as is the case with a perforated ulcer], it would be normal procedure to take steps to make sure that it was not indeed the cause of the illness before excluding the diagnosis. If the potential threat to life is considered to be possibly imminent, then these steps should be taken as a matter of urgency.'

64. The clinical reviewer noted that poor medical record keeping may have been a factor in another death at Cardiff five weeks before Mr Allsop's. We share the clinical reviewer's view that the issue of record keeping should now be escalated and dealt with as a matter of extreme urgency.

65. We make the following recommendation:

The lead GP/Clinical Director and Head of Healthcare at Cardiff should ensure that immediate steps are taken to assess, monitor and improve the standard of note keeping in the medical records. (This should include, but need not be restricted to, the actions set out in paragraph 6.1 of the Clinical Review report.)

Observations

66. At 4.00am on 24 February, the GP requested hourly observations to monitor Mr Allsop's vital signs and to look for 'signs of shock'. Observations were carried out hourly until 9.39am. Nurse C then took Mr Allsop's observations at 1.55pm, 5.19pm and 7.54pm, although she said she may have taken observations at other times without recording them. Nurse A said she then took his observations sometime between 9.00pm and 10.00pm without recording them, and then at 12.23am on 25 February (when she called an emergency ambulance).

67. The clinical reviewer is concerned that Mr Allsop's observations were not taken hourly and that some observations may have been taken without being recorded.

68. The clinical reviewer is also concerned that 'there was an overreliance on the clinical observations and a complete disregard for the history [of a perforated ulcer]'. She said that Mr Allsop's documented clinical observations were usually within the normal range (although there is no way of knowing what the undocumented observations showed) and Nurse B recorded that he did not respond in a way that suggested he was in pain when she examined him. However, this did not take into account that a minority of patients react to pain in an atypical way.

69. The clinical reviewer is also concerned about the GP's instructions to admit Mr Allsop to hospital if he was showing 'signs of shock'. She said that the GP did not provide details of what signs to look for. She said that clinical 'shock', even if mild, can very quickly turn into a potentially life-threatening condition. The GP's instructions could therefore have led to Mr Allsop being admitted to hospital when the clinical situation had already deteriorated to a dangerous level.

70. The clinical reviewer also noted that when Mr Allsop's observations could have indicated shock at 7.54pm, no action was taken, although she noted that Mr Allsop was apparently showing no outward signs of shock either then or later when Nurse A said she took Mr Allsop's observations between 9.00 and 10.00pm.
71. The clinical reviewer concluded that the care Mr Allsop received at Cardiff was not equivalent to that he would have received in the community. She said that Mr Allsop's death might have been preventable if he had been admitted to hospital earlier. And that it seems reasonable to assume that the earlier he had been seen, the more likely he would have been to survive. She goes on to say, however, that Mr Allsop may not have survived even if he had been admitted to hospital.
72. We make the following recommendation:
- HM Prison and Probation Service should discuss with the Welsh Government and the Local Health Board and NHS England and NHS Improvement whether a protocol for the management of prisoners with abdominal pain should be introduced in all prisons in England and Wales (see section 6.4 of the Clinical Reviewer's report).**
73. We recommended to the Head of Healthcare that they should ensure that a protocol is produced to formalise the management of prisoners with abdominal pain. NHS England and The Welsh Government and Public Health Wales told us that management of prisoners with abdominal pain is aligned across England and Wales and is covered by NICE guidelines. They said that our recommendation had been discussed with the Clinical Director at the time; and they advised that it would not be possible to develop a specific protocol for Management of Abdominal Pain. It would not be feasible to write protocols in respect of all eventualities in the treatment of abdominal pain or any other 'general symptom'. The management of abdominal pain is a heterogenous group of conditions, some of which may have NICE guidelines, but others may not.

Reception screening

74. The clinical reviewer is concerned that the routine questions used during the reception screening did not identify that Mr Allsop had a history of a perforated ulcer. She has made recommendations designed to ensure that details of serious but acute health issues are documented in the medical records for new and existing prisoners at Cardiff. We recommend:
- HM Prison and Probation Service should discuss with the NHS England and NHS Improvement, the Welsh Government likewise with Public Health Wales whether the measures recommended by the Clinical Reviewer to ensure that details of serious but acute health issues are documented in prisoners' medical records, should be introduced in all prisons in England and Wales (see sections 6.2 and 6.3 of the Clinical Reviewer's report).**

Support for staff

75. We are concerned that Nurse B said she had not been involved in the de-brief and had not been offered support, apparently because of her working pattern. We recommend:

The Governor and Head of Healthcare should ensure that all members of staff involved in the care of the prisoner and the emergency response are offered support after a death in custody, including offering support when staff return to work.

Inquest

76. The inquest heard on 23 January 2023, concluded that Mr Allsop died from acute peritonitis caused by a perforated gastric adenocarcinoma.

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