

**Investigation into the circumstances surrounding the
death of a man in April 2010, at hospital while in the
custody of HMP Cardiff**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

March 2011

This is the report of the investigation into the circumstances surrounding the death of a man at hospital. He was a Cameroon national and was admitted to hospital on 22 March 2009. Hospital staff carried out tests and discovered that he was human immunodeficiency virus (HIV) positive with hepatitis B. (HIV is a serious disease affecting the immune system and hepatitis B is a liver disease.) On 1 April, medical notes record that he had contracted tuberculosis (TB). The following day, he died suddenly at 4.45pm. He was 29 years old. I extend my sincere condolences to his partner, family and friends.

Her Majesty's Coroner for Cardiff held an inquest into the man's death in September 2010. The inquest found that his death was due to natural causes, specifically tuberculosis and HIV.

An investigator was appointed to investigate the circumstances of the man's death on my behalf. Healthcare Inspectorate Wales (HIW) was commissioned to carry out a clinical review of his medical care whilst at Cardiff. I am grateful to HIW for its review, which is the first annex to this investigation report. HIW has identified missed opportunities before he was referred for specialist treatment and also that his care was un-coordinated.

I would like to thank the Governor of HMP Cardiff and his staff for their help and assistance with this investigation. Furthermore, I would like to thank the safer custody manager for his support in the role of liaison officer. Enquiries were made with the United Kingdom Border Agency (UKBA) and I would like to acknowledge their help and that of a caseworker.

I make seven recommendations: six are for the Head of Healthcare and refer to the transfer of prisoners for specialist treatment, nursing and care plans, appointments with healthcare services, tracking secondary care services, secondary healthcare screening and prisoner's medical history. The last recommendation is for the attention of the Governor and relates to the use of restraints which were left in place whilst the man was having invasive medical tests. I acknowledge two areas of good practice and two additional recommendations made in the clinical review.

In this final report one recommendation has not been accepted regarding the secondary health screen, one recommendation has been partially accepted relating to prisoners' previous medical history and the remaining five recommendations have been accepted. The man's family could not be traced therefore a copy of this report will stay on file should they contact my office at a later date.

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

Jane Webb
Acting Prisons and Probation Ombudsman

March 2011

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SUMMARY

The man was remanded to HMP Cardiff following a court appearance for fraud on 14 October 2009. He was a foreign national prisoner from Cameroon and would have been deported at the end of his sentence.

A first reception health screen form to assess the man's current and medical history was completed. He told the nurse that he was not registered with a doctor and had not seen one for some time. He added that he did not have any physical illnesses. His weight was 89 kilograms (14 stone) and he was 1.90 metres (six feet two inches) tall. He was allocated a shared cell on a wing. A routine follow up health screen was not completed and so further medical observations were not taken.

The doctor treated the man for a groin abscess on 20 October, with antibiotics and pain relief. The following day, it was noted that the abscess had reduced in size. He did not attend a follow up appointment on 28 October, as he had a visit from his family.

On 4 December, the man was examined by the doctor after he complained of acne spreading across his face and chest. A further course of antibiotics was prescribed. He did not attend a follow up appointment in January 2010, but was seen on 12 February where his acne was reviewed and the prescription of antibiotics continued.

The man was examined by Prison Doctor A on 15 March. He was unwell with bleeding gums, vomiting, a sore mouth and blood in his urine. He told the doctor that he had lost 19kgs since his arrival at Cardiff. The doctor took a blood test to be sent for analysis. He told the doctor that he had had an HIV test the previous year which was negative. (In fact, it is clear from his immigration file that he was diagnosed with HIV in 2007.)

The following week, the man was examined again by the doctor. He had lost more weight and his symptoms were persistent. The doctor recorded that she rang the hospital for the results of the blood tests taken the previous week, as they had not arrived at Cardiff, and was told that they could not trace a patient of that name or date of birth, so she took a full set of tests and asked for them to be urgently analysed. A second doctor at Cardiff who saw the man later that same day spoke to the hospital and was given the results of the blood tests from 15 March. He was transferred to the healthcare unit that afternoon. Later that evening, he was escorted to hospital, as the blood test results revealed that his condition was cause for urgent concern.

The man underwent medical investigations and he was confirmed as HIV positive. Following a minor surgical procedure, he was further diagnosed with tuberculosis. On receipt of this information, the restraints were removed and escort staff monitored his security through an adjacent room. On 2 April, he deteriorated and did not respond. Cardio pulmonary resuscitation (CPR) was started by hospital staff but he died at 5.45pm.

I make seven recommendations for the attention of the Governor and Head of Healthcare, particularly regarding delays before specialist treatment was obtained and lack of coordination. I also comment on the use of restraints whilst the man was undergoing an invasive medical procedure. I note two areas of good practice and acknowledge two recommendations made in the clinical review.

THE INVESTIGATION PROCESS

1. The investigation into the man's death was opened on 15 April 2010, when the investigator visited Cardiff. She met the Governor, the Deputy Governor, the Safer Custody Manager, and a representative of the Prison Officer's Association. No member of the Independent Monitoring Board (IMB) asked to see her but her contact details were made available to them. (The IMB are volunteers from the local community who monitor the day to day life of the prison and prisoners.)
2. Notices of the investigation and the Ombudsman's terms of reference were sent in advance of the investigator's visit. (At the time of circulation of this report no responses have been received to those notices.) Later, she informally spoke to the Head of Healthcare and a doctor.
3. The investigator reviewed the man's prison and medical file and asked for copies of those documents to be sent to her. A review of his medical care was commissioned from the Healthcare Inspectorate Wales (HIW).
4. On 20 April, the investigator telephoned a case worker at the UKBA and asked for documents from the man's immigration file to be sent to her. The investigator spoke to a bedwatch officer on the telephone on 17 May to clarify the use of restraints and protective measures taken during a surgical procedure.
5. One of my family liaison officers attempted to contact the man's partner. He eventually spoke to a friend who said that she had gone to France for several months and was not in contact. The friend asked him to contact another friend of the man's. The liaison officer telephoned the number which had been passed to him and left a voicemail message. However, no contact has been forthcoming from the friend. A copy of this report will be retained by the Ombudsman's office should any of the family or friends request it in the future.
6. Another of my investigators and HIW's clinical reviewer spoke to the Head of Healthcare and a doctor.
7. I apologise to the Coroner for the delay in issuing this report which meant that it was not available before the inquest. Unfortunately, the clinical review was not completed until October.

HMP CARDIFF

8. Cardiff is a local prison with a maximum population of 784 adult men. It is located very close to the city centre and was originally built in 1827. As a local prison, the majority of the prisoners have arrived at Cardiff after making court appearances in South East Wales. As well as prisoners remanded into custody and those serving short sentences, a significant number are serving life sentences.
9. The prison has 24 hour nursing cover and 16 inpatient beds. During weekdays the core healthcare staff work until 5.00pm. Four nurses continue to work between 5.00pm and 8.00pm. Two nurses then work between 8.00pm and 9.00pm and from 9.00pm overnight one nurse remains in the healthcare centre with a member of the prison staff. That nurse will respond to emergencies and can contact the healthcare manager out of hours if need be. Using an out of hours' telephone service, the nurse on night duty can obtain medical advice, ask a doctor from a local surgery to attend or summon an ambulance if they have serious concerns about a patient. All prisoners undergo a health screening during the first night reception process upon arrival at Cardiff.
10. HM Chief Inspector of Prisons completed an inspection of Cardiff in January 2008. She found that prisoners were "much more likely to report feeling safe than at other local prisons", in the most part due to "good relationships between staff and prisoners". The support offered to newly arrived prisoners was praised and the healthcare offered to prisoners was thought to generally be of a good standard.
11. The most recent Annual Report by the IMB 2007-2008 noted in its conclusion:

"The Independent Monitoring Board finds that overall, HMP Cardiff is a well-run establishment with good relationships between staff and prisoners. We are aware that financial constraints have affected the profiling and work-loads of both uniformed and administrative staff. Since further savings will be demanded of the prison during the next reporting period, we hope that the effects will not be detrimental to the positive work that is currently being carried out. There is only so much extra commitment that can be expected of the staff who keep the prison running smoothly."
12. There have been five previous deaths at Cardiff from natural causes since the Ombudsman's office took over investigations from the Prison Service in 2004. None of those deaths had any similarities to that of the man's.

KEY EVENTS

13. The man arrived at HMP Cardiff on 14 October 2009, following an appearance at Magistrates' Court. A first reception health screen form was completed and it was noted that he was not registered with a doctor in the community. His weight was 89kgs and he was 1.90 metres tall. He told the nurse that he had been in HMP Hull in 2005 and had harmed himself by scratching his wrists. However, he said that he did not have any feelings of self harm, no physical illnesses and was not taking any medication.
14. A routine follow up health screen was not completed. (This health screening usually takes place up to 72 hours following reception into prison.) On 20 October, the man had an appointment in the healthcare unit because of a large abscess in his groin, which had burst two hours prior to him seeing the nurse practitioner. A doctor prescribed an antibiotic and pain relief medication of paracetamol and ibuprofen.
15. The following day, the doctor examined the abscess and noted that it had decreased in size. An appointment was made for the man to return to the healthcare unit in one weeks' time. However, he failed to attend the appointment because of a family visit.
16. The man was next examined by the doctor on 4 December, with facial acne that was spreading across his chest and back. An antibiotic was prescribed along with Panoxyl, a treatment for acne. A follow up appointment for a month later did not take place. My investigator has seen no record of why he did not attend or if he knew about the appointment. He was prescribed another course of antibiotics for his acne on 12 February 2010, following examination by Prison Doctor B. He was suffering from flu like symptoms but no clinical observations or tests were undertaken at this consultation. He was advised to return for a review of his symptoms in four week's time.
17. On 15 March, Prison Doctor A examined the man in the healthcare unit. She wrote that he was complaining of a loss of taste in his mouth, bleeding gums and a dry tongue. He was weighed and it was noted that he had lost nearly 19 kilograms (three stone) since his reception into Cardiff five months earlier. His blood pressure was recorded as 167/74 (an average reading is 130/80), and there were traces of blood and protein in his urine. He told her that he had an HIV test the previous year which was negative.
18. The doctor prescribed a mouthwash and a steroid paste. She asked for blood, stool and urine tests to be taken for analysis. An urgent appointment was made for him to be seen in the genito-urinary medicine (GUM) clinic, later that day and to be weighed in one weeks' time. (The GUM clinic specialises in sexually transmitted diseases and BBV [blood born viruses, hepatitis] conditions.) It was recorded in his

medical notes that he did not attend his GUM appointment and went to another family visit instead.

19. According to his medical records, the man's blood sugar levels were tested on 20 March. It is unclear why this was done and nothing else is noted in his records relating to this test.
20. Two days later, on 22 March, he was examined by Prison Doctor A who noted that he had lost another five kilograms in weight and there were still traces of blood and protein in his urine. A blood pressure reading of 105/77 was recorded and his temperature was normal at 36 degrees. He told the doctor he was not in pain or experiencing any new symptoms. She recorded that she made contact with the hospital to track down the whereabouts of the test results from the previous week but was told that the hospital was unable to trace the results. The doctor repeated the tests, which were immediately sent for analysis.
21. The man was transferred from his wing cell to the healthcare unit for observation at 4.30pm. His medical notes recorded that he was feeling lethargic and had a poor appetite. A short while later, healthcare staff received the results from the hospital, taken the previous week, which had been untraceable a few hours earlier. The result of the tests indicated an abnormality. Another doctor arranged for him to be transferred to UHW for further investigations. He left the prison at 6.00pm, escorted by two officers and restrained by an escort chain. (An escort chain is a 1.8 metre length of chain with one cuff attached to an officer and the other cuff to the prisoner.)
22. The man was admitted to an assessment ward for tests and observations. On 23 March, it was recorded in the bedwatch notes that he asked for money from his prison account to be sent to him at the hospital so that he could telephone his partner. He was given intravenous fluids (fluid passed into the body via a drip in the arm) and observation checks by doctors and nursing staff.
23. The following day, a hospital doctor told the escorting officers that they should wear a protective apron and gloves when entering the man's room. The doctor explained that his blood tests indicated that he had HIV. This advice was also extended to his visitors. At 4.10pm, he was visited by his partner and four hours later, he was moved to a general ward.
24. On 26 March, the man's partner visited him for two hours during the afternoon and visited again with a friend the following day. At another visit two days later, his friend and partner brought some food for him to eat. Prison regulations do not allow visitors to bring in food and so the bedwatch officers told them that it was not permitted. The officers noted that the man, his partner and friend then became hostile. The officer telephoned the prison to confirm this regulation and was told that under no circumstances should he be allowed to accept the food. The

bedwatch officer offered details of the prison's complaints procedure should the visitors wish to challenge the decision. (There are no documents in his prison file to indicate whether a complaint was made.)

25. Three days later, on 29 March, the bedwatch notes record that the man's condition was deteriorating and he was weak, with poor mobility.
26. During the morning of 30 March, the bedwatch officers were told by hospital staff that he would be taken to another hospital the following day, for an endoscopy. (An endoscopy is a procedure where a camera is inserted down the throat to examine the chest and lungs.) One of the officers, Officer A, telephoned the prison to inform them of this procedure and that an ambulance would transfer the man to the other hospital.
27. A governor carried out a management check later that day at 1.25pm. (Management checks are daily visits by senior prison staff to ensure the welfare and security of both the prisoner and officers.) No reference was made to the man's transfer to the other hospital or the need to review his security risk assessment. (A risk assessment is a form completed by a manager to assess the prisoner's risk to the public whilst away from the prison. The assessment should be reviewed when the prisoner's circumstances or the location changes.)
28. At 9.15am the following day, the man and the bedwatch officers were taken as planned by ambulance to the other hospital for the endoscopy. His bedwatch notes said that whilst he was weak, he was still mobile. The escort chain was used during the journey. It was not removed during the endoscopy, and remained attached to Officer B, who had to stay in the room, whilst the procedure was carried out. The second officer stayed outside the room.
29. Officer B said that the man was lightly sedated during the procedure. The officer was given full protective clothing to wear (a matter of routine during surgical procedures). Hospital staff asked him if the escort chain was essential and he explained that the man was still a prisoner in custody. The officer was not authorised to remove the chain without permission and he did not seek advice from prison managers. The man's security risk assessment had not been updated since he was first admitted to hospital one week earlier. The hospital staff expressed no further concerns about the restraints remaining in place. The man and the officers returned to the first hospital at 3.30pm.

2 April

30. On 2 April at 1.50am, a nurse visited the man in his room. She was wearing a surgical mask, as well as gloves and an apron. The nurse told the bedwatch officers that he was moving to an acute ward for closer observation, as his condition had deteriorated. She also instructed that all the prison staff should wear face masks when in his presence as he was being tested for tuberculosis.
31. The Head of Healthcare started an application for the man to be released on compassionate grounds. (This application was not completed before his death.)
32. Officer C telephoned the prison to speak to the night orderly officer, Senior Officer (SO) A. The officer told the SO that both officers on bedwatch were uncomfortable about being so close to the man as an airborne infection, thought to be tuberculosis, had been diagnosed. The SO agreed that the restraints should be removed and he should be observed from outside his room by looking through the window.
33. At 5.30am, the man was moved to an isolation room on ward A7. (An isolation room is designed to protect the spread of infection.) Both officers continued their bedwatch duties from outside this room and they wrote on the bedwatch notes that a new risk assessment should be completed. This was done by Senior Officer (SO) B who noted that he should only have three visitors at a time, they must be escorted and should wear masks and protective clothing provided by the hospital. The SO also noted that the consultant had told him that a review of security arrangements should be undertaken in a week by which time the man should have responded to treatment.
34. A governor visited the hospital at 12.45pm to make a management check with the next set of bedwatch officers.
35. Officer D wrote in the bedwatch notes that at 4.22pm, the man went into cardiac arrest and an emergency response hospital team treated him. A short time later, hospital staff told the officer that he had died. His death was certified at 4.45pm.
36. At about 6.00pm, the family liaison officer from the prison's chaplaincy and the safer custody manager visited the man's partner at her home. Many of his friends were present and his partner declined to speak in private with them. They left their contact telephone numbers with one of the friends after breaking the news of the death.
37. Four days later, the family liaison officer left a voice message for the man's partner asking her to make contact. On 7 April, the liaison officer telephoned again. The man's partner did not wish to talk to her but did pass on the number of one of his friends. The liaison officer telephoned the friend and left a message. The friend returned the

telephone call and spoke to her, who told him of the prison's responsibility to offer assistance with funeral expenses. The friend told her that the man's body would be flown back to the Cameroon. She asked for the name of the funeral directors dealing with his body so that any financial arrangements could be made directly through them. As yet this information has not been provided.

38. On 8 April, a meeting was held at the prison between prison staff, public health officers, hospital staff and other National Health Service personnel. The purpose of the meeting was to assess whether there were any public health issues following the man's diagnosis of tuberculosis, particularly for prisoners and prison staff. Arrangements were made for his cellmates and bedwatch officers to be screened for the disease. It was agreed there was minimal risk to the public but precautionary measures should be taken.
39. The family liaison officer met the man's friend at the prison gate on 13 April and handed him the man's personal possessions. No further contact has been made by prison staff with any of his relatives or friends.

ISSUES

Clinical care

40. A review of the man's medical care while in Cardiff was commissioned with the Healthcare Inspectorate Wales (HIW). For the review, HIW considered the following points:
- Was the level of care provided to the man appropriate and timely?
 - Was the man provided with adequate information about his illness, diagnosis and care options?
 - Were appropriate care pathways and pain management arrangements put in place?

Was the level of care provided to the man appropriate and timely?

41. HIW evaluated the information held in the man's clinical notes whilst he was in custody at Cardiff. He had told healthcare staff, on his reception into prison, that he was not registered with a doctor nor had he seen one for sometime. No medical records were available for healthcare staff to trace any of his medical history. He had said he had been a prisoner in Hull. However, their healthcare unit have no record of him being in custody. A full medical assessment was not undertaken following his arrival at Cardiff.
42. The man denied suffering from any physical illness when his first reception health screen was opened by healthcare staff. Prisoners with underlying medical conditions, such as tuberculosis, HIV or other potentially serious illness may be reluctant to reveal them. The letter confirming his diagnosis of HIV in 2007 was held in his UKBA immigration file which did not contain any other medical notes. The prison did not have access to the immigration file and therefore accepted his account that he did not have any contagious medical conditions.
43. I am careful not to apply hindsight in my investigations and there is no evidence to suggest the nurse completing the healthscreen should have doubted the man's account. I accept that it can be difficult to balance patient confidentiality with effective controls of contagious diseases. I therefore acknowledge the recommendation in the clinical review regarding routine screening of prisoners for tuberculosis and HIV. However, I am aware that this cannot be enforced because prisoners cannot be tested against their will.
44. A routine secondary health assessment was not completed and this should be undertaken as a matter of course for every prisoner. It is particularly important when a prisoner has not seen a doctor for sometime and/or his medical history is unavailable. A routine follow up health screen normally takes place up to 72 hours after the prisoner

has arrived in prison. The Head of Healthcare explained to my investigator that Cardiff does not routinely undertake these assessments. She described them as “voluntary” and said that most prisoners, especially younger men, often refuse. HIW’s report notes that there was no evidence in his medical notes that the man was offered a secondary health assessment

45. Prison Service Order 3050, continuity of healthcare for prisoners says,

“In the week following first reception, every prisoner must be offered a general health assessment. This assessment is equivalent to a primary care assessment when registering with a new practise in the community.”

46. Furthermore, the man’s medical records from his sentence at Hull were unavailable, with their healthcare unit saying that they had no record of him being there, despite him telling the reception nurse that he had harmed himself whilst in their custody. I therefore endorse the following recommendations by HIW:

The Head of Healthcare should ensure that secondary health assessments or general health assessments are undertaken for all prisoners.

The Head of Healthcare should ensure that every effort is made to trace a prisoner’s medical and mental health history.

47. On 15 March, after five months in prison, the man told Prison Doctor A that he had had an HIV test the previous year but it had proved to be negative. (As I have reported, this information was not correct.) Whilst he was not seen regularly, he was treated for infections, which could have indicated a poor immune system, including an abscess and infected rash (acne). People with HIV are vulnerable to infections, which are known as ‘opportunistic infections’ as they weaken the immune system. (Opportunistic infections are caused by bacteria, viral or fungal. Tuberculosis is a common HIV opportunistic infection.)

48. HIW concludes that the man’s symptoms should have raised suspicion and he should have been referred earlier for the appropriate tests. The tests might well have established whether any serious underlying illness was causing his infections.

49. In October 2009, he was treated for a scrotal abscess. Neither a blood or urine test was carried out. I understand from HIW’s report that it would have been good practice to complete a blood count. HIW writes that “a swab of the infected area of his abscess would have indicated bacteria” and therefore “highlighted his serious health status”. I agree with HIW’s recommendation:

The Head of Healthcare should introduce mechanisms for the timely follow up and tracking to secondary care and specialist services (including diagnostic and microbiology services).

50. Nursing plans for his abscess were not identified in the man's medical notes. He did not attend a healthcare appointment after receiving treatment for his abscess, preferring to have a visit, and there is no evidence that a follow up appointment was offered or if he had asked for an alternative appointment. Visits are an important part of prison life and it is understandable that he wanted to see his family. At that time, healthcare staff were unaware of the seriousness of his condition. If a nursing care plan had been in place, it would have recorded the treatment he received and whether any was outstanding. I endorse HIW's recommendation:

In liaison with Cardiff and Vale University Health Board, the Head of Healthcare should develop appropriate referral pathways to ensure timely access to specialist services and second opinions. This should include 'fast track' referral processes for prisoners with suspected serious/terminal illness.

51. The man's serious weight loss was not noticed until 15 March 2010 when he was examined by Prison Doctor A. He had only been seen once between December 2009 and March 2010, when he did not tell the doctor of his weight loss, and neither was he weighed. However, I believe that losing 19 kgs in five months is excessive given he was so tall and was not overweight when he came into prison. I acknowledge that imprisonment can cause stress, which might lead to weight loss. However, the extent of his weight loss over such a short time was a clear indication that he was in need of medical attention.

52. I therefore endorse the recommendation made by HIW.

The Head of Healthcare should ensure that plans are in place for prisoners with on-going health problems to ensure that holistic care is provided. These plans should include tools for monitoring weight loss, nutrition and other symptoms such as pain.

53. The man was in denial of his HIV status when he arrived at Cardiff and still when he saw Prison Doctor A on 15 March 2010. It is evident that he was treated for seemingly minor illnesses following his reception into Cardiff. However, he did not report his serious medical problems to healthcare staff until he experienced severe symptoms. Once it was noted that he had lost a large amount of weight and was obviously unwell, like the clinical reviewer I believe that actions should have been taken to ensure that he attended clinical appointments, or they should have been re-arranged. I therefore endorse the following recommendation.

The Head of Healthcare should put in place a mechanism for flagging prisoners with serious and deteriorating health, so that priority is given to their attendance at clinics and healthcare related appointments.

54. HIW considered that there were unnecessary delays referring the man for a specialist review and treatment for his presenting symptoms of severe weight loss, bleeding gums and dry tongue. The delay getting the results of his blood tests should have been explored before 22 March when they were found missing. An earlier enquiry should have been a priority, given his poor physical health when Prison Doctor A saw him the previous week. Additionally, HIW said:

“It is concerning that the prison doctor leading on the man’s care appeared not to have noticed the seriousness of his condition earlier. Investigations undertaken on his admission to hospital showed that he had advanced HIV/AIDS and he was also considered to have disseminated tuberculosis.”

55. In the clinical review, HIW said:

“If blood tests had been ordered earlier when the man presented with abscesses and wide spread acne, his HIV status and immune system issues would have been known earlier. Admission to the hospital for specialist assessment and investigations would have been timelier.”

56. The clinical review raises serious concerns about Prison Doctor A’s approach to the man’s care. While I do not repeat it, I acknowledge HIW’s recommendation that the doctor undertakes further training.

Was the man provided with adequate information about his illness, diagnosis and care options?

57. The man knew about his diagnosis long before he came into Cardiff prison but he chose not to share the information with the medical practitioners. He was not told of the seriousness of his medical condition and the care options until he was admitted to hospital. It then became quickly apparent that he was extremely ill. In these particular circumstances I do not believe that more information could have been shared with him or with his family.

Was there appropriate follow up after the man’s transfer to hospital?

58. There was little proof of care pathways and care plans in the man’s medical notes. HIW commented:

“The absence of any evidence of nursing input and care plans is of serious concern, as is the lack of any sense of urgency with

regard to seeking a specialist opinion of hospital referral, up until the afternoon of 22 March 2010.”

59. The transfer of a prisoner to hospital for in patient care should be regularly followed up by healthcare staff to record their treatments and ongoing medical care. There is a gap in the medical notes from 23 to 31 March, where no information is recorded as to the man’s condition in hospital. HIW noted that there was no explanation as to why the medical notes show no contact between hospital and healthcare staff. However, it is evident that the bedwatch notes indicate that there were five points of contact between the healthcare unit and the hospital. Therefore it would have been appropriate for those points of contact to have been noted in his medical record.

60. HIW concludes the review by saying:

“There are many aspects of the man’s care that we (Healthcare Inspectorate Wales) consider to have been questionable and flawed. Opportunities were missed that would have helped to achieve an earlier diagnosis and more timely treatment. Further we consider his care to be fragmented and un-coordinated with no evidence of care planning or nursing input.”

Use of restraints on 31 March 2009

61. The man was transferred from the first hospital to another for an endoscopy on 31 March. This is an invasive procedure which is conducted in sterile conditions. Throughout the procedure, the escort chain remained in place and was attached to one bedwatch officer who had to wear protective clothing and stay in the same room. The officer wrote on the bedwatch notes that although hospital staff asked if the chain was essential, they did not express any issues about it remaining. The previous day, Officer A had informed the prison of the appointment at another hospital. A management visit had taken place after the information was passed on and before the procedure took place. Nevertheless, the security risk assessment was not updated to reflect that an endoscopy was to be carried out.

62. Whilst the security of the public and hospital staff is fundamental, I believe that using an escort chain during a medical procedure such as an endoscopy is inappropriate. The man was weak and his mobility was poor. The risk assessment should have been reviewed and considered the removal of the restraint during the procedure. The escort chain could have been removed, then re-applied after the endoscopy. I do not criticise Officer B who was obliged to keep the restraint on although either bedwatch officer could have alerted their managers.

The Governor should satisfy himself that risk assessments are reviewed when invasive medical procedures are planned.

Release on compassionate grounds

63. The Head of Healthcare began the application process for the man to be released on compassionate grounds once the severity of his medical condition was known. I acknowledge that her consideration for his release was good practice.

Actions following the man's death

64. Following the man's death from tuberculosis, a multi agency meeting, of public health officers, prison and hospital staff, was held to ensure that all prisoners and staff who had been in contact with him and with their consent, would be screened for the disease. These actions ensured that the disease was monitored and the health and well being of staff and prisoners was not compromised.

CONCLUSION

65. The clinical reviewer comments that the man's healthcare was "flawed with missed opportunities". When he was seen by the doctor on 15 March, he was obviously very unwell having lost 19kgs in five months. Although medical tests were taken and sent for analysis there was no follow up by healthcare staff for seven days as to whether his health was improving or declining. When he was finally admitted to hospital, he was seriously ill and his HIV status was identified. Following further medical investigations he was diagnosed with tuberculosis.
66. The escort chain was not removed when the man underwent a surgical procedure whilst temporarily transferred to another hospital, despite the security department being informed of this planned procedure. I believe that arrangements should have been made to review his risk and whether it was necessary to use the escort chain.
67. I acknowledge the start of an application for a compassionate release and I am also pleased to note the multi disciplinary approach to ensure the well being of prisoners and staff following the man's death from tuberculosis. However, I make one recommendation for the attention of the Governor and six for the attention of the Head of Healthcare.

RECOMMENDATIONS

For the Head of Healthcare

1. The Head of Healthcare should ensure that secondary health assessments or general health assessments are undertaken for all prisoners.

Not Accepted – “A routine health secondary screen should be offered to prisoners but it is not mandatory (PSO 3050 2.12.) This assessment is equivalent to a primary care assessment when registering with a new practice in the community.”

2. The Head of Healthcare should ensure that every effort is made to trace a prisoner’s medical and mental health history.

Partially Accepted – “A full medical reception screen was completed by a Registered Nurse. It is noteworthy that the man stated he had been a prisoner at HMP Hull. Their medical record department have no record of him. HMP Cardiff do attempt to obtain relevant medical information which includes confirmation of medication. He was not registered with a GP.”

3. The Head of Healthcare should introduce mechanisms for the timely follow up and tracking to secondary care and specialist services (including diagnostic and microbiology services).

Accepted – “HMP Cardiff has appropriate referral pathways to ensure timely access to specialist services and second opinion. The man was not suspected as having a serious terminal illness. He hid his diagnosis from the GP and other healthcare professionals. There are fast referral processes for suspected serious or terminal illness.”

4. In liaison with Cardiff and Vale University Board, the Head of Healthcare should develop appropriate referral pathways to ensure timely access to specialist services and second opinions. This should include ‘fast track’ referral processes for prisoners with suspected serious/terminal illness.

Accepted – “HMP Cardiff does have appropriate referral pathways. However, we will check our systems to ensure robust systems in place.”

5. The Head of Healthcare should ensure that plans are in place for prisoners with on-going health problems to ensure that holistic care is provided. These plans should include tools for monitoring weight loss, nutrition and other symptoms such as pain.

Accepted – “Care plans, tools for monitoring weight loss, nutrition and pain are in place.”

6. The Head of Healthcare should put in place a mechanism for flagging prisoners with serious and deteriorating health, so that priority is given to their attendance at clinics and healthcare related appointments.

Accepted – “We have a comprehensive palliative care policy and risk register in place. There are fast track referral processes for suspected serious or terminal illness in place.”

For the Governor

The Governor should satisfy himself that risk assessments are reviewed when invasive medical procedures are planned.

Accepted – “Risk assessments are in place and reviewed prior to invasive procedures.”