

**Investigation into the circumstances surrounding the  
death of a prisoner in January 2007 in hospital  
and whilst in the custody of HMP Cardiff**

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

**January 2008**

This is the report of an investigation into the death of man who was a prisoner at HMP Cardiff and died in hospital on 6 January 2007. The man had been suffering from the effects of lung cancer for a number of months before his death. He was 50 years of age.

The loss of a loved one is always distressing and I extend my condolences to the man's family for their loss. I know his daughter has raised a number of concerns with regard to the treatment he received in prison. I trust that my report answers her questions.

The investigation into the man's death was carried out by one of my investigators. A clinical review was commissioned from the Health Inspectorate Wales. I extend my thanks to the Inspectorate for the observations and recommendations drawn from their findings.

I would like also to thank the Governor and his staff at HMP Cardiff for their co-operation and assistance during this investigation.

The man who died had suffered from diabetes for many years and was diagnosed with lung cancer in 2006. The clinical review makes seven recommendations with regard to the care that the man received whilst he was in the care of the Prison Service. I concur with the recommendations made by the Health Inspectorate Wales and have, in addition, drawn a number of other matters to the Governor's attention.

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.

**Stephen Shaw CBE**  
**Prisons and Probation Ombudsman**  
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## **SUMMARY**

The man who is the subject of this investigation was received into custody at HMP Shrewsbury in November 2004. He was a diabetic and insulin dependent. Whilst at Shrewsbury, the man was seen by healthcare staff on a number of occasions.

At the beginning of March 2005, the man was transferred to HMP Usk. At Usk, the man continued to be treated for his diabetes and a number of related illnesses, including infections and inflammations.

In April 2006, the man complained of a sore throat and gruff voice. He was diagnosed with laryngitis and prescribed an antibiotic. In May, still complaining of a hoarse throat, he was referred to an ear nose and throat (ENT) consultant.

Whilst at Usk, the man missed a number of hospital appointments. However, he was seen by the ENT consultant on 18 July 2006. The consultant recommended that he have a CT scan. The man attended for a scan on 14 August, seeing another consultant a week later. It was thought by doctors that the man either had an inflammation or lung malignancy. It was decided that he should have a bronchoscopy (a medical test in which a scope is passed into a patient's lungs) to confirm his condition.

On 29 August, the man attended for his bronchoscopy. Unfortunately because of a side effect of the operation, he was required to stay in hospital for a number of days. Whilst the man was in hospital, healthcare staff at Usk discussed the care that he would require on his release. Healthcare staff at HMP Parc were contacted to see if they could take him. (Parc is able to offer 24 hour healthcare and better inpatient facilities.) However, staff at Usk were told that there were no available beds at Parc.

The man who died was discharged from hospital and returned to Usk on 1 September. On 8 September, he was told that he was suffering from cancer in both of his lungs. Over the coming days he attended a number of hospital appointments. On 12 September, staff decided that he would be better cared for at Parc. However, because Parc said that there were no beds available, the man was sent to HMP Cardiff.

Staff at Cardiff put facilities in place to provide the man with his nursing needs. Within days of his arrival, healthcare staff at the prison had contacted the palliative care nurse at the local hospital with regard to his pain relief and chemotherapy.

The man's daughter had contact with him, primarily by letter and telephone, over the coming months. The man's daughter also wrote to the Governor of Cardiff asking that he be moved closer to home. A governor wrote to the man's daughter, as well as speaking with her on the telephone. Enquiries were made about the man being moved to a hospice, should his condition deteriorate.

An application for the man's early release on compassionate grounds was started by staff at the prison. During this time he wrote a letter to the Governor expressing his gratitude for the care and kindness that he had received.

Over the coming weeks, the man who died attended a number of hospital appointments. The palliative care nurse who attended him was reported to have been pleased with the efforts made by staff to make him as comfortable as possible. He was invited to attend a multi agency case conference, and plans were put in place to look at the availability of a local hospice and to assess his pain relief needs.

At the beginning of December, the man was told that his application for early release had been refused. On 22 December, he received a visit from his daughter and grandson. The man's medical records recorded that he was tearful at this time as he was saying "goodbye" to his family.

The man's health deteriorated towards the end of December, and his breathing becoming more laboured. An appointment was made for him to attend hospital so that fluid could be drained from his chest. On 4 January 2007, the man went to hospital for the fluid to be drained and was then returned to Cardiff prison. Later that evening, his breathing worsened and he was admitted to a local hospital. The prison medical record notes that his daughter could not be informed of his admission to hospital as there was no phone available at her address.

The following day the man was transferred to another ward and it was recorded that during the last few hours of his life he was sitting up in bed and sleeping. In the early hours of the next day he complained of shortness of breath and was examined by a doctor. Over the following few hours, the man continued to have breathing difficulties. He was pronounced dead at 5.05am on 6 January 2007.

## THE INVESTIGATION PROCESS

1. One of my investigators carried out the investigation into the man's death. Notices were issued to staff and prisoners informing them of the investigation and its terms of reference, and inviting them to contact the investigator should they wish to do so.
2. My investigator visited HMP Cardiff. He spoke informally with staff and visited the healthcare centre where the man spent the last few months of his life. This report is based upon a review of all relevant paperwork, including the man's clinical records, and a number of informal telephone calls with staff.
3. My investigator passed all of the man's healthcare records to the Health Inspectorate Wales, who undertook an independent clinical review of the man's healthcare whilst in custody. A number of staff at both HMP Cardiff and Usk were interviewed by my investigator and the Health Inspectorate Wales.
4. My investigator also contacted the Coroner's office, and a copy of this report will be sent to the Coroner to assist with her enquiries into the man's death.
5. One of my family liaison officers has had continuing contact with the man's daughter. The man's daughter told my family liaison officer of a number of concerns she had about the healthcare her father had received whilst in custody.
6. The daughter of the man who died said her father had written a number of letters to her about the difficulty he was having in getting timely medical attention. In one letter he told her that he was refused medical attention due to the lack of healthcare staff, and in another that it took three to four months to receive some test results.
7. The daughter said her father was due to have a flu jab in September 2006, but did not receive one until two months later. She said it was her understanding that, as a diabetic, her father should have been considered 'high-risk' and she questioned the delay.
8. The daughter wondered whether her father's cancer could have been diagnosed earlier had the Prison Service reacted more quickly to his requests for medical attention. She also said that, on a visit to her father on 22 December, she found him to be having difficulty breathing and awaiting a procedure to drain his lungs. The man's daughter asked whether the thrombosis from which her father died would have been detected and treated had this procedure been administered more quickly.
9. She enquired why her father could not have been moved to a prison nearer his family and said some of his property had gone missing

during his transfer.

## **HMP CARDIFF**

10. HMP Cardiff is a category B local/training prison which first opened in 1827 and which has accommodation for just under 800 prisoners. It accepts people remanded into custody from the courts in its catchment area, some category C prisoners and stage 1 and 2 life prisoners.
11. Cardiff's regime includes full time education, employment in the prison workshops and training courses.
12. The prison's healthcare centre provides 24 hour primary care and contains 16 in-patient beds located in single cells. Attached to the healthcare centre is a day centre. This includes an association room for inpatients as well as consultation rooms. A new healthcare centre is being built at Cardiff and is expected to open fully in autumn 2007.
13. Healthcare is provided by a wide range of professionals who are employed by the Prison Service. Staff comprise two general practitioners, a senior nurse and Healthcare Manager, and 19 nurses and healthcare officers. Specialist mental health services are provided by Cardiff and Vale NHS Trust.
14. Cardiff was last inspected by HM Chief Inspector of Prisons, Ms Anne Owers, in January 2005. She identified that good healthcare for prisoners continued, with most staff being very well motivated, caring and professional.

## KEY FINDINGS

15. The man who is the subject of this investigation was first received into custody at HMP Shrewsbury on 22 November 2004. He told healthcare staff at the prison that he suffered from diabetes and was insulin dependent. He explained that he also suffered from high blood pressure, had poor eyesight and experienced mobility problems due to painful joints.
16. At Shrewsbury, the man had contact with the diabetic nurse at the local hospital. The nurses discussed with him how to manage his diabetes and liaised with prison healthcare staff.
17. On 28 November, the man complained of pains in his joints. As he was unable to use the stairs, staff ensured that he was given a cell on the ground floor. The man saw the medical officer a month later and rheumatology outpatient appointments were made. An appointment for 24 February 2005 was eventually made. However, a handwritten note on the appointment letter says that he refused to attend. It is also noted in his medical record that he did not wish to attend a urology clinic appointment on 21 June 2006.
18. During December 2004, the man became distressed on a number of occasions and was concerned for the welfare of his daughter. He was seen by a mental health nurse. During this assessment, the man denied all thoughts of self harm and no further action was taken.
19. The man received a flu jab on 6 January 2005.
20. On 8 March, the man was transferred to HMP Usk. During his assessment by healthcare staff there, it was recorded on his medical notes that he smoked and had been diagnosed with hypertension, diabetes and depression. During the assessment, he denied any thoughts of self harm.
21. At Usk, the man continued to monitor his blood glucose levels himself, ensuring that the levels of insulin he took were correct. During this period his sugar levels were slightly higher than usual and, as a consequence, he was referred to the diabetes consultant at hospital in Abergavenny. He attended the clinic on 4 April, less than a month after the appointment had been made.
22. During May, the man was seen by a chiropodist who believed he was suffering from neuropathy in his feet. (Neuropathy is the degeneration of nerves. It can be caused by diabetes and is very painful.) Appointments were made at Neville Hall Hospital in order for him to be fitted with insoles and special shoes. (Several of these appointments were changed. The Head of Healthcare at Usk said that this could have been because the prison was not able to release discipline staff to attend the clinics with the man. A number of further appointments were

made, with some being rescheduled throughout the remainder of the year. In a letter dated 19 January 2006, the man told his daughter that he had received his new shoes.)

23. On 15 July 2005, the man was diagnosed with sleep apnoea syndrome and was referred to hospital for tests and sleep studies. He was given an appointment for 16 January 2006. (The clinical reviewer says that the man did not wait any longer for his appointment than any other NHS patient would have). The clinical reviewer notes that the subsequent letter to the prison medical officer said that, "... an examination of his hypopharynx [throat] was normal". The clinical reviewer said that this was significant, as it indicated that the lung cancer was not yet detectable on examination."
24. During 2005, the man suffered from a number of infections and inflammations for which blood tests were taken and antibiotics given. On 25 November, his medical records indicate that he was suffering from cellulitis (a deep skin infection). On 2 December, he was seen by the medical officer for a swollen leg. The man was given an antibiotic used to treat skin infections.
25. On 18 January 2006, the man received his flu jab.
26. On 18 April, the man complained to healthcare staff that he had a sore throat. He was advised to gargle salt water. On 20 April, he vomited and complained of a gruff voice. The medical officer diagnosed laryngitis and prescribed an antibiotic. On 19 May, the man still complained of a hoarse voice and was referred to an ear nose and throat (ENT) consultant at a local hospital.
27. On 28 June, the man complained to staff of being short of breath at night. The medical officer noted that he had some fluid on his chest, and thought that he may have had mild heart failure. He was treated for this and weekly blood tests were taken.
28. An entry on the man's medical records, dated 28 June, records that he had been offered two appointments for the ENT clinic but that these were not met as discipline staff were unable to attend. During his interview with the clinical reviewer, the medical officer at Usk said that he had to push discipline staff to take the urgency of the man's appointment seriously as he already suspected that the man had cancer.
29. On 13 July, the man wrote to his home probation officer about his removal from a course at the prison. He explained that he had lost his voice approximately 17 weeks previously and had still not got it back. He advised his probation officer that he hoped to be going to hospital for tests soon.

30. On 14 July, the man once again complained of being short of breath. He was sent to hospital immediately for an emergency assessment. Tests were conducted and results indicated normal levels of liver and kidney functioning. The tests also confirmed that he had not suffered from a heart attack. However, his chest X-ray was abnormal so he was referred to the respiratory consultant and for a CT scan.
31. On 18 July, the man attended the ENT clinic. The man's consultant felt that something was pressing on his vocal cord and that he required a CT scan in order to exclude malignancy. The scan had already been arranged. On 26 July, a doctor recorded that an investigation into lung malignancy was to be undertaken and confirmed that the man should be moved to a more appropriate healthcare facility. In her clinical review, the clinical reviewer notes that no discussions with the healthcare centres at Cardiff or Parc were started at this time. The clinical reviewer also says that this was the first time that cancer was mentioned in the man's prison medical record.
32. An appointment for the CT scan was made for 14 August, the first available slot. The clinical reviewer points out that HMP Cardiff's medical officer, thought that a month was about an average length of time to wait given the number of patients within the NHS requiring such an investigation.
33. The man attended for his scan at hospital on 14 August, and saw another consultant from the rapid access chest clinic on 18 August. It was thought that the man either had inflammation of the lungs or lung malignancy. It was decided that he should have a bronchoscopy. The clinical reviewer notes that on 21 August healthcare staff discussed the possible diagnosis with the man.
34. On 29 August, the man attended hospital for the bronchoscopy. However, due to a side effect of the operation he was required to stay in the hospital, unexpectedly, for several more days.
35. On 1 September, whilst the man was still in hospital, healthcare staff at Usk discussed his nursing care needs in preparation for his discharge. Staff had decided that he would need more care than they were able to provide. The healthcare centre at Parc was contacted with regard to a possible transfer. However, staff at Usk were advised that there were no beds available at the prison.
36. On 1 September, the man returned to Usk. On 8 September, he was told by the hospital consultant during his clinic appointment and in the presence of a Macmillan lung cancer nurse that he had widespread cancer in both of his lungs.
37. On 12 September, the man was seen by a consultant at an oncology clinic in hospital. His diagnosis was discussed and he was provided with information about chemotherapy, which he was advised might

prolong his life for a short period. During the consultation, the man took the decision that he would start chemotherapy. Plans were made for him to receive his first treatment a week later.

38. Healthcare staff at Usk determined that arrangements should be made to transfer the man to Parc. Staff at Usk believed Parc would be able to provide the man with 24 hour healthcare cover and was better able to deal with vulnerable prisoners. However, the Healthcare Manager at Usk said during interview with the clinical reviewer that the man had to be sent to HMP Cardiff since he understood that Parc had no beds available.

39. The Healthcare Manager at Cardiff, said that on 12 September she received a phone call from the head of Healthcare at Usk, asking for the urgent transfer of a patient who required 24 hour nursing care. The Healthcare Manager at Cardiff said that she:

“... expressed concern. No case conference had taken place and it was extremely poor practice to transfer a patient late in the day for obvious reasons. He [the head of healthcare at Usk] informed me that HMP Parc were over their operational capacity and had refused the man.”

When asked who had ordered that Cardiff should take the man, the Healthcare Manager at Cardiff said:

“... the Area Manager had said that this patient had to come here because of the need for 24 hour nursing care and that HMP Parc did not have the space to facilitate this.”

40. The clinical reviewer notes that:

“Discussions between both prisons at around 4.00pm on the afternoon of the 12<sup>th</sup> resulted in the transfer being ordered and nursing staff at HMP Cardiff prepared by ordering an extension lead to supply electricity to the cell to power the oxygen compressor.”

The man was transferred to Cardiff at 7.00pm and facilities were put in place for the care required by him to be delivered. One of the healthcare cells had to be adapted. The clinical reviewer says that healthcare staff at Cardiff recorded that the man was suffering from terminal lung cancer as well as diabetes, cellulites, sleep apnoea and high blood pressure.

41. My investigator contacted Parc about availability of beds in their healthcare centre on the day that the man was transferred to Cardiff (Parc have a capacity of 18 in-patient beds in their healthcare centre). On 12 September, Parc had eight patients in their healthcare centre

and over the following three days the centre held seven in-patients.

42. The Healthcare Manager at Cardiff told the clinical reviewer and my investigator that in the days after the man's transfer to Cardiff she asked Parc if they would be able to take him because of his vulnerable prisoner status. The Healthcare Manager at Cardiff was told that Parc were unable to accommodate the man.
43. On 13 September, healthcare staff at Cardiff contacted the palliative care nurse at a local hospital to arrange the man's ongoing palliative chemotherapy and pain relief. The palliative care nurse informed them of the man's need for pain relief and oxygen. During this time, the man's chemotherapy sessions were also in the process of being transferred to another hospital.
44. The man attended the chemotherapy clinic at hospital on 18 September and received his first chemotherapy treatment on 21 September. He spoke with his daughter later that day. It was noted by prison staff that the following day the man appeared to be in a 'flat' mood. A note in the wing record records that the man called his daughter from the wing office.
45. Throughout the period of the man's treatment, his glucose levels were monitored more closely. This was to ensure that his insulin levels were at the correct dose.
46. On 21 September, the man's daughter wrote to Cardiff prison. In her letter, she asked if her father could be moved closer to her home. She explained how, as a single parent, it was difficult for her to afford the travel to Cardiff. At the bottom of the letter, she provided the prison with her telephone number. Within a couple of days of receiving the letter, the residential governor at Cardiff, telephoned the man's daughter. He reassured her that everything was being done to make her father's life more comfortable. The residential governor explained to my investigator that, during the period leading to the man's death, he had numerous telephone conversations with his daughter, as did staff from the chaplaincy. However, it is unfortunate that no record of this contact with the man's daughter was kept by Cardiff.
47. Staff at Cardiff confirmed that, during his time in healthcare, the man was given access to a telephone and his daughter phoned him on a number of occasions. On 21 September, he spoke to his daughter on her mobile phone, after which it was recorded that he was tearful. However, a note on the man's medical record on 28 September records that he was refused a telephone call with his daughter because of a lack of authorisation.
48. The man's early release on compassionate grounds had been discussed on 8 September by staff at Usk. (Early release on compassionate grounds may be considered on the basis of a prisoner's

medical condition or as a result of tragic family circumstances. It is granted in only the most exceptional circumstances.) Staff at Cardiff submitted an application for his early release shortly after his arrival there.

49. The man's doctor at the prison completed the medical section of the early release documentation on 22 September. In the report the doctor concluded that:

"It is to be anticipated that his physical condition will gradually deteriorate over the next few months and he is likely to become increasingly breathless, weak and generally debilitated."

50. On 26 September, the probation officer at Cardiff, contacted the man's home probation officer requesting a risk assessment report on him. On 2 October, the home probation officer spoke with the prison probation officer again. The prison probation officer explained that the man had talked of possibly entering a hospice rather than going back to any of his family. The man's home probation officer said that there was a local hospice and that she would make further enquiries. Contact was made with a hospice near the man's home. However, they advised that any referral would need to be made by a GP and that each case would be judged on its own merits.

51. On 3 October, the prison probation officer provided a probation report with regard to the man's early release. He concluded that:

"While it is appropriate to look sympathetically at his current circumstances, I feel the risk is too high with regard to early release at this time."

52. The man wrote a letter, dated 3 October, to the Governor of Cardiff in which he expressed his gratitude for the care and kindness he had received from healthcare staff and other prisoners within the healthcare centre.

53. On 5 October, the head of custody at Cardiff completed the governor's section of the early release paperwork, concluding that the man's release at that time would be a high risk.

54. The man attended an out patient clinic at hospital on 9 October, and a further chest X-ray was requested. It is recorded on the man's medical records that he did not wish to receive any cardiopulmonary resuscitation (CPR) should it be needed. This note was written and signed by the man himself. The man was assessed as being capable of making such a decision by a prison psychiatrist.

55. On 10 October, the man received a response from his home probation officer to his letter of 13 July. The probation officer said that staff at the

prison had been in contact with her about his early release and that provisional enquiries had been made with regard to him being transferred to a hospice. On 16 October, the man wrote back confirming that he would be happy to take early release. In his letter the man also said:

“The healthcare staff here are great some of them can’t do enough for you and some go out of the way to help me.”

56. On 19 October, the medical notes say that the man:

“... appears bright in mood no problems to report. 12.36 contacted governor ref TV that works, pillows and access to DVDs, pillows now arrived Governor looking in to other issues. IMB also aware of requests. 15.15 hrs – TV and “X-Box” being fitted into the man’s room, seems happy that this is being done.”

57. On 19 October, a governor at Cardiff responded formally to the man’s daughter’s letter of 21 September. The governor wrote that the possibility of transferring the man to HMP Shrewsbury had been considered. However, he explained that Shrewsbury did not have a dedicated healthcare centre for inpatients. He said that the man’s daughter and her son could visit her father and that the chaplain would help with this. The governor’s response to the man’s daughter took the form of a memorandum. Although his intentions were kindly, I believe this to have been an inappropriate way to communicate with a relative. I suggest that in future any correspondence with prisoners’ families is simply in the form of a letter.

58. The documentation for consideration of early release was posted to the Release and Recall Section (RRS) of the National Offender Management Service (NOMS) on 19 October.

59. On 20 October, the palliative care nurse attended the man at the prison and was very pleased with the efforts by staff to make him as comfortable as possible. It was also noted that the man wished to see his daughter and grandson. However, on 28 October, staff refused the man permission to speak with his daughter on the phone because of a lack of authorisation. This was despite the man’s daughter informing them that the governor had given authorisation for such calls. (I would remind the Governor that staff working with terminally ill patients must be fully briefed with regard to what family contact has been permitted and how it is to be made, ensuring that instances like this do not recur.)

60. On 30 October, the man’s chemotherapy was postponed as he was not well enough to attend. On 3 November, the palliative care nurse requested a case conference to discuss his future. On 9 November, the man attended for chemotherapy for the third time. He received his

final dose of chemotherapy on 30 November.

61. Because of an incorrectly addressed envelope, the man's early release paperwork was returned to the prison by the Royal Mail on 13 November.
62. The man was seen by a prison medical officer on 16 November when he complained of further breathlessness. The doctor noted that the man's cell was full of cigarette smoke as he "was trying to smoke as much as he could".
63. On 17 November, a multi agency case conference was held. The man was asked if he wanted to attend, but declined. It was decided that plans would be put in place to look into the availability of a local hospice and to further assess needs for pain relief.
64. The man's compassionate release paperwork was eventually received by the RRS on 22 November. The following day, the RRS wrote to the Governor of Cardiff advising him that the man's early release had been refused. Enclosed with the letter was a memorandum, addressed to the Governor, which outlined the reasons for refusal and which asked that its contents be relayed to the man.
65. On 1 December, the man was told that his early release application had been refused. However, it is unclear how this news was broken. The man was also seen by the palliative care nurse that day.
66. On 14 December, the man suffered from a high temperature and blood samples were sent for analysis. These showed that he continued to suffer from anaemia.
67. On 22 December, the man received a visit from his family. His medical records say that he felt tearful as he was going to be saying "goodbye" to them. The clinical reviewer comments that there was no entry on 23 December about the effect that this visit had upon the man. However, an entry on 26 December records that the man mentioned to the wing cleaner that he had "given up after seeing his daughter." He expressed this sentiment again the following day.
68. On 26 December, the man complained of more breathlessness and pain. The palliative care nurse visited him on 29 December. She said that he had stopped eating and that his mood was very low. She advised the prescription of antidepressants and further pain relief. A special mattress and back rest were ordered for him.
69. The prison medical officer felt that the man's chest was filling with fluid and contacted the hospital. She made an appointment for early January 2007 for the fluid to be drained from his chest. The medical officer also expressed concern about the prison's capacity to provide

24 hour nursing care.

70. The man's condition worsened at the end of December. Supplementary drinks were given and, because he was not eating, his insulin dose was lowered. The man's breathing became more laboured and his oxygen therapy was increased. Nursing staff described his condition as deteriorating.
71. In a letter dated 2 January, the prison medical officer wrote to the consultant at the hospital to confirm the man's urgent appointment for early January. The letter referred to the man's visit from his daughter and grandchild and how he had become more withdrawn since then.
72. The man went to hospital to have the fluid drained from his chest. X-rays were taken and the man was returned to prison. However, during the remainder of the day his breathing became worse. Staff at the prison contacted the hospital at 8.00pm. They advised that the man should be admitted to the accident and emergency unit immediately. The man was accompanied by two officers and was not restrained. The prison medical notes record that the man's daughter could not be contacted as there was no telephone number recorded at her address.
73. At 2.25pm, on 5 January, healthcare staff at Cardiff sent a fax to the hospital indicating that he did not wish to be resuscitated. The bed watch record indicates that the man transferred wards. However, he could not be transferred because of a shortage of beds. The man refused a meal at 5.00pm and was described as quiet, using his oxygen frequently.
74. The bed watch entries indicate that, at 8.15pm, the man was sitting up in bed and that he was asleep from 11.45pm through to 2.30am the following morning. It was at this time that the man was examined by a doctor after complaining of feeling short of breath. It was recorded that he continued to have breathing difficulties over the following few hours. At 5.05am, the man was pronounced dead by hospital staff.
75. The Duty Governor informed the local police of the man's death at 6.50am. The Duty Governor's Death in Custody Checklist notes that:
- "Local police informed 06.50 and also helped to contact next of kin.                   Advised we need to phone Derbyshire police ... 06.55 advised phone                   Staffordshire police, spoken to, faxed details reference informing next                   of kin ..."
- The police informed the man's daughter of her father's death at 8.10am and she was asked to contact the prison.
76. When asked why the police had been asked to break the news of the man's death to his daughter, the Duty Governor said:

“The reason for asking the police to break the news to the man's daughter was that I had phoned her on numerous occasions without response I had no option ... In normal circumstances I would have visited and informed the family accordingly but as the man's daughter lived in Staffordshire this was out of the question. The contingency plans are quite clear that in the first instance you should visit. If this is not possible you should phone and if there is no response and the distance is too far you should ask the police to inform.”

77. A member of the chaplaincy team at Cardiff spoke to the man's daughter later that day. She informed the daughter of the chaplaincy phone number and advised her of their continuing support.
78. The principal officer (PO) who had been appointed Family Liaison Officer (FLO), first made contact with the man's daughter two days after her father's death. Unfortunately the log of the FLOs contact with the man's daughter has been lost. However, the FLO was able to provide my investigator with a short summary of his contact with her. He said that during his conversation with her he provided his contact details, explaining that she could contact him at any time. The FLO also advised the man's daughter that the prison would pay for the man's funeral arrangements. The FLO said that he had problems contacting the man's daughter because she only had a mobile phone. This would often not accept incoming calls. After some delay by the prison, the man's possessions were returned to his daughter.
79. No post mortem was available during the writing of this report and the clinical review.

## ISSUES

### Healthcare provision at HMP Shrewsbury and HMP Cardiff

80. The clinical reviewer concludes that the primary medical care in Shrewsbury and Cardiff appeared good. She highlights that both prisons endeavoured to keep relevant parties informed with regard to the man's health and followed up his appointments.

### Healthcare provision at HMP Usk

81. The man's daughter told my family liaison officer that her father had written a number of letters about the difficulty he had in getting medical attention. In particular, she said that he had been refused attention due to the lack of staff available, and that test results took a number of months to process.

82. My investigation has established that the man underwent many tests during his time in prison, and his letters are not clear about the particular test to which he is referring. The letters to his daughter also said that he had missed a number of medical appointments and was not told in advance when he would be attending hospital. (Due to security requirements, the Prison Service does not tell prisoners when appointments in outside hospitals are made.) However, my investigator and the clinical reviewer did establish that the man missed a number of medical appointments whilst at Usk. Two of these were appointments which he himself refused to attend (24 February 2005 and 21 June 2006). However, due to the unavailability of staff to carry out escort duties at Usk, some of the man's other hospital appointments were cancelled.

83. In her review, the clinical reviewer observes that:

"The MO in HMP Usk had no hesitation about referring the man for specialist opinions for treatment of complications relating to his diabetes. However, more thought should have been given to allowing him to attend outpatient appointments on days requested by the hospital and prison clinical staff."

The clinical reviewer concludes:

"It would help to improve the learning from these incidents if a reason why an appointment has been missed could be recorded on a prisoner's medical record. Although it is recognised that on occasions a prisoner's hospital appointments may be missed, the Governor in conjunction with the prison Medical Officer should ensure that urgent appointments are met."

84. I understand that on occasions it might be necessary to cancel a prisoner's appointments at hospital. This may be for a number of operational reasons. However, there are occasions when it is equally important for a prisoner to attend a hospital appointment. In such circumstances, the Governor should ensure that all necessary steps are taken. I therefore concur with the findings of the clinical reviewer in her clinical review and the following recommendations.

**I recommend that the Governor and Healthcare Manager at Usk ensure that the reason for a prisoner's hospital appointments being missed is recorded in full in his clinical record.**

**I recommend that the Governor at Usk in conjunction with the Healthcare Manager and Medical Officer ensures that urgent prisoner hospital appointments are met.**

#### **Transfer from Usk to Cardiff**

85. The man was transferred from Usk to Cardiff on 12 September 2006. The clinical reviewer points out that the primary reason for the transfer to Cardiff was that the man required 24 hour nursing care and there were no beds available at Parc. The clinical reviewer says that staff at Cardiff believed that the transfer there was only to be temporary and comments that:

“The nursing staff at HMP Cardiff communicated appropriately with the staff at HMP Usk and with the St David's Nurse, but had little opportunity to prepare fully for his admission, having had insufficient time to gain information about his diagnosis, treatment, nursing needs and mental state.”

86. The clinical reviewer says that staff at Cardiff raised a number of concerns about the transfer arrangements. No case conference had taken place and Cardiff did not have the facilities to administer the continuous oxygen therapy that the man required. The clinical reviewer also says that it was poor practice to arrange a transfer so late in the day. The clinical reviewer concludes that:

“It appears that the man's social and health needs were not fully considered in arranging this transfer and transfer of care arrangements were reactive. The rushed transfer may have impacted on the man's physical and mental well being at a time when he was having to come to terms with his diagnosis.”

The clinical reviewer makes the following recommendation:

**I recommend that healthcare staff at Usk should plan and organise transfers in a timely way, after full discussion between all those**

### **involved in the prisoner's care.**

87. On and around 12 September 2006, staff at both Usk and Cardiff were told that the man could not transfer to Parc as the healthcare centre there was full. However, my investigator has established that on 12 September only eight prisoners occupied 18 of the available healthcare centre beds at Parc.

In response to my draft report Parc prison maintained that the reason that the man was not transferred to Parc was because he was being treated at hospitals, both of which were considerably nearer to Cardiff and Usk, than Parc.

### **Palliative Care**

88. The clinical reviewer says that the man's pain control appears to have been good throughout his illness. She reports that there is no reference in the nursing notes to uncontrolled pain, and points out that specialist palliative nursing advice was regularly provided by the George Thomas nurse.
89. In her review the clinical reviewer says that healthcare staff took time to talk to the man about his feelings, but comments that there was no formal assessment of his mental state or evaluation made of his reaction to his daughter's final visit. The clinical reviewer cites an emotional outburst at the end of December in which the man stated that he had not properly said goodbye to his daughter.
90. The clinical reviewer draws attention to the fact that the man had written a letter commending staff for the treatment he had received whilst in the care of the prison. She says that, during interview, healthcare staff had said that the man wished to see out his life in prison, surrounded by people he knew. The clinical reviewer says:

"The option of a hospice was available for the man and he would have been transferred there when healthcare staff in HMP Cardiff felt it necessary for him. However, the man's illness overtook him and he became suddenly very unwell, was transferred appropriately to hospital and died."

91. With regard to the palliative care that the man received at Cardiff, the clinical reviewer concludes that:

"Palliative and general physical care appears to have been satisfactory throughout the man's illness, although the environment of care in the prison healthcare facility is not ideally suited to the purpose of caring for patients with complex needs during the last days of life."

92. I concur with the clinical reviewer's observations. Given limited resources and the inadequate facilities of the healthcare centre at Cardiff, healthcare staff did their utmost to ensure that the man was as comfortable as possible. Staff also invited the man to participate in the decision making process.

### **Clinical Records**

93. Reviewing the man's clinical records, the clinical reviewer finds that they were sparse, out of chronological order and in some cases unreadable. I agree with her observations and recommend that:

**Healthcare staff at Usk and Cardiff should take steps to ensure they adhere to the guidance on records and record keeping issued variously by the General Medical Council, the Nursing and Midwifery Council and the Royal Pharmaceutical Society of Great Britain.**

### **Release on Compassionate Grounds**

94. The man's early release paperwork was incorrectly addressed to the Release and Recall Section (RRS) and returned to HMP Cardiff. It is plainly unsatisfactory that important documentation sent to the RRS should be addressed incorrectly. (On this occasion the delay had no effect upon whether the man would have been released early, and it would appear that proper consideration of his release was taken by staff in the RRS.) I do not make a formal recommendation about this error, but I would ask the Governor to review how it may have occurred and to remind staff of the importance of such paperwork.

95. According to the clinical review, it was unclear how the man was told that his release on compassionate grounds had been refused. The clinical reviewer observes that the sensitivities of a prisoner's illness should be considered when informing him about matters of early release. When prisoners are given such news the prison authorities should be:

“... aware of the need to respect and protect the sensitivities surrounding diagnosis of terminal illnesses with poor prognosis.”

I concur with the clinical reviewer's findings and her recommendation that:

**Prison authorities should ensure that staff are aware of the need to respect and protect the sensitivities surrounding diagnoses of terminal illnesses with poor prognosis.**

### **Matters raised by the man's daughter**

96. The man's daughter asked whether her father had received timely medical attention. In her review, the clinical reviewer confirms that the waiting time for treatment and diagnosis of the man's condition was the same as he would have experienced had he not been in prison. The clinical reviewer says:

"It appears that the man's cancer diagnosis and care was carried out promptly and was comparable to that given to the general public in the community."

97. The man's daughter asked my family liaison officer if the delay in draining her father's lungs at the end of December would have had any effect upon his health. The clinical reviewer says that, shortly before his death, the man appeared to develop a 'pleural effusion' (fluid on his chest) and that this was due to his lung cancer. She says that the fluid on the man's chest would have made him feel short of breath. She says that the prison medical officer arranged for his chest to be drained in order to help his breathlessness. The procedure would have had no effect on his cancer, as his cancer was not curable. The clinical reviewer's opinion is that carrying out the procedure earlier would not have prolonged his life.
98. The man's daughter mentioned that her father was due to have a flu jab in September 2006 but did not receive one until two months later. My investigation has established that the man received flu jabs on 6 January 2005 and 18 January 2006. At the time of his death, he had not yet received his flu jab for the period 2006/2007.

### **Family Liaison Issues**

99. In her clinical review, the clinical reviewer says that there was no information to suggest whether or how the man's daughter was informed about his admission to hospital in early January 2007. Staff did make a record in the man's medical records that they were unable to contact his daughter as there was no phone number recorded at her address. I appreciate the difficulty that staff in healthcare, and indeed in the prison as a whole, had in contacting the man's daughter, but concur with the clinical reviewer's observation and recommendation that:

**The prison should have next of kin contact details clearly recorded in all sets of notes and develop processes for family liaison in cases where prisoners are terminally ill.**

100. The man's daughter was notified of her father's death within 90 minutes by a police officer from Staffordshire Police. The Duty Governor said that he did not visit because of the distance involved, adding that if a visit was not possible the next of kin should be contacted by phone. He said that if there was no response, and the distance was too far, then

the police should be asked to inform the next of kin.

101. Cardiff's guidance on Handling A Death In Custody, Part E, Duty Governor's Responsibilities says that:

"Decide who will inform the next-of-kin. (Normally the Duty Governor and Chaplain will break the news.) However if the next-of-kin resides some distance away, remember to try the nearest [prison] to them, requesting the Chaplain to assist. Otherwise use the local police, but this should be the last resort."

This guidance reflects the good practice laid out in the Prison Service's Guidance for Prison Family Liaison Officers contained in Prison Service Order PSO 2710. Although not mandatory, the guidance sets out good practice. It suggests that a prison located near the next of kin be contacted to assist in breaking the news of a death.

**Cardiff should adhere to the guidance published in PSO 2710, Follow up to Deaths in Custody, when breaking the news of a prisoner's death to the next of kin.**

102. During the investigation, the man's daughter enquired about a number of her father's possessions that had not been returned to her. These included an X box, prisoner monies and his passport. My investigator raised these issues with the FLO at Cardiff. Unfortunately, the man's daughter had to wait several months before these were returned, despite promises to the contrary from the prison. I understand that all of the man's property has now been returned to his daughter. Again I make no formal recommendation but there are obvious lessons that the Governor will wish to take on board.
103. At the time of issuing this report there has been no response from Usk to the recommendations made.

## RECOMMENDATIONS

**I recommend that the Governor and Healthcare Manager at Usk ensure that the reason for a prisoner's hospital appointments being missed is recorded in full in his clinical record.**

No response from HMP Usk

**I recommend that the Governor at Usk in conjunction with the Healthcare Manager and Medical Officer ensures that urgent prisoner hospital appointments are met.**

No response from HMP Usk

**I recommend that healthcare staff at Usk should plan and organise transfers in a timely way, after full discussion between all those involved in the prisoner's care.**

No response from HMP Usk

**Healthcare staff at Usk and Cardiff should take steps to ensure they adhere to the guidance on records and record keeping issued variously by the General Medical Council, the Nursing and Midwifery Council and the Royal Pharmaceutical Society of Great Britain.**

Accepted by HMP Cardiff  
No response from HMP Usk

**Prison authorities should ensure that staff are aware of the need to respect and protect the sensitivities surrounding diagnoses of terminal illnesses with poor prognosis.**

Accepted by HMP Cardiff

**The prison should have next of kin contact details clearly recorded in all sets of notes and develop processes for family liaison in cases where prisoners are terminally ill.**

**Partially Accepted** by National Offender Management Service – Safer Custody Group are planning to review PSO 2710 Follow up to Deaths in Custody. Review to consider inclusion of above recommendation as good practise in the revised PSO

**Cardiff should adhere to the guidance published in PSO 2710, Follow up to Deaths in Custody, when breaking the news of a prisoner's death to the next of kin.**

Accepted by HMP Cardiff