REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The Governor of HMP Cardiff, The Chief Executive of the Cardiff and Vale University Health Board, the Chief Executive of the Swansea Bay University Health Board and the Secretary of State for Justice
1	**CORONER** I am David Regan, Assistant Coroner, for the coroner area of South Wales Central.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** A Coronial investigation was commenced on 23rd September 2021 into the death of Alan Richard Miles Davies. The Investigation concluded at the end of the inquest which I conducted with a jury on 26th February – 15th March 2024. The conclusion was a narrative conclusion and the medical cause of death was 1 (a) Cardiac arrest in a setting of starvation and dehydration
4	**CIRCUMSTANCES OF THE DEATH** These were recorded as: Mr Davies was transferred to HMP Cardiff from Caswell Clinic on the 2nd September 2021. 10 days later on 12th September Mr Davies was found in a collapsed state in his cell and following CPR was transferred by ambulance to University Hospital of Wales where he later died. The narrative conclusion which the Jury returned was: Mr Davies died from an equal combination of misadventure, self neglect and neglect. Mr Davies contributed to his death by deliberately refusing food and fluid but he did not intend to end his life. It was an unintended consequence of such refusal. There were missed opportunities regarding the transfer of Mr Davies to hospital. The management, coordination and planning of Mr Davies' care including the handover of information within the prison and healthcare was unsatisfactory. The level and adequacy of observations was insufficient in noticing Mr Davies' signs of deterioration. The events between 10th and 12th September were highly unacceptable. The Inquest focused upon the following: - 1. Mr Davies was transferred to HMP Cardiff from the Caswell Clinic following 16 days of food refusal in a state in which reception nursing

staff felt he was unfit to be admitted to the prison, mobilising by wheelchair and requiring to be physically supported by escort staff.

2. While Mr Davies refused to consent to formal observations, no assessment was made by Caswell Clinic of his physical condition prior to his transfer.

3. No advanced notice was provided to HMP Cardiff that Mr Davies was being transferred to it in an impaired physical condition and refusing food, although the risk that he would refuse food had been communicated

4. Mr Davies was transferred to HMP Cardiff by escort agency staff unfamiliar with his care or needs

5. The majority of the Caswell Clinic discharge paperwork was provided to HMP Cardiff at the time of transfer rather the prior to it, in a format which did not easily identify the concerns related to his transfer

6. At HMP Cardiff there was no systematic care plan put in place to address Mr Davies' food and fluid refusal or the risks of physical deterioration as a result of the same.

7. No policy was in place to guide prison healthcare staff relating to food and fluid refusal.

8. Mr Davies' capacity was not assessed on a planned or formal basis in prison.

9. The prison GP reversed her decision to send Mr Davies to hospital on 10th September 2021 following discussion with a prison Governor, the product of which was that she received an erroneous understanding of the length of time for which he had been refusing food.

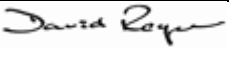
10. No clear plan for escalation of care was put in place for the weekend. A GP was not asked to review Mr Davies over the weekend.

11. The Health care assistant responsible for the care of Mr Davies on the night of his collapse had not been informed that he was refusing fluids and had not been observed to drink fluid since 3rd September 2021.

12. The Nurse and Health care assistant responsible for the care of Mr Davies at the time of his collapse had not been informed that he was at risk of sudden collapse due to food and fluid refusal.

13. The number of healthcare staff working night shifts was insufficient to meet the demands upon them.

	14. Despite being held in a camera call on the Healthcare wing, Mr Davies' focalised requests for "help" while lying on the floor of his cell were not recognised or heeded from 00.19 on 12th September 2021 until it was identified that he was in a collapsed state at about 02.54
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. For your information the **MATTERS OF CONCERN** are as follows: (1) There was limited communication between the Caswell clinic and HMP Cardiff following the s 117 meeting until Mr Davies' discharge. In particular, information that Mr Davies had commenced food refusal following the s 117 meeting and that it had not been possible to assess him physically prior to transfer was not clearly communicated to HMP Cardiff before the transfer occurred (2) Discharge information and assessment was not provided to HMP Cardiff in a clear and easily understandable format to manage the known risks associated with the transfer of Mr Davies to prison (3) Mr Davies was transferred to prison without being accompanied by a member of Caswell Clinic staff. Agency staff did not have sufficient information to be able to assist prison reception staff in an informed manner (4) Insufficient consideration was given to whether Mr Davies' needs were too complex to be met by HMP Cardiff. (5) Mr Davies was transferred to HMP Cardiff with the intention that he be transferred again within a short time to HMP Parc. Insufficient consideration was given as to whether Mr Davies' needs were better met at an alternative specialist institution. (6) No clear plan to promote Mr Davies' engagement with prison medical services, or the assessment of his mental or physical condition was devised or implemented at HMP Cardiff (7) No clear plan for the assessment of Mr Davies' capacity to refuse food or fluid was devised or implemented at HMP Cardiff (8) No food and fluid refusal policy was in place to guide healthcare staff.

	(9) The number of GPs working in HMP Cardiff was insufficient to meet the demands upon them. (10) The Nurse and Health care assistant responsible for Mr Davies on the night of his collapse were working an 11.5 hour night shift without rest breaks, which they identified as being overly fatiguing (11) The Nurse, Health care assistant and Custodial manager responsible for Mr Davies on the night of his collapse were not provided with clear information regarding the duration of his fluid and food refusal or the warning signs to consider in the context of the known risk of sudden collapse (12) The Health care assistant caring for Mr Davies overnight overheard more senior prison staff stating that they would not return to assist Mr Davies in healthcare, and felt unable to challenge this.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 17th May 2024. I, the Coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the following who may find it useful or of interest. Mr Davies's family, HM Prison and Probation Service, the Governor of HMP Parc, the Medical Director of the Cardiff and Vale University Health Board, Medical Director of the Swansea Bay University Health Board. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**21st March 2024** **SIGNED:**  **D Regan** **Assistant Coroner**