

**Investigation into the circumstances surrounding the  
death of a man in hospital in April 2007, whilst a prisoner  
at HMP Wayland**

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

**December 2007**

This is the report of an investigation into the death of a man who died in April 2007 in hospital, whilst a prisoner at HMP Wayland. The man had been admitted to hospital in April after being taken ill at the prison. He had been in poor health for sometime.

The man had been convicted of serious sexual offences and was sentenced to nine year's imprisonment in 2002. This was his first time in prison.

The Coroner for Norwich made the decision not to hold a post mortem into the man's death. His death was noted as one from natural causes resulting from acute pneumonia.

I extend my sincere condolences to his family and friends.

This investigation was undertaken by one of my investigators. I would like to thank the Governor of Wayland and his staff for their help and assistance in this investigation. I am also grateful to Norfolk Primary Care Trust who was commissioned to undertake a clinical review into the man's medical care.

I make 16 recommendations in total. Three recommendations are for the attention of Offender Health, three for Norfolk PCT, one for Prison Service Eastern Area Manager, five for Wayland's Healthcare, and four for the Governor of Wayland. I make one general commendation that I hope the Governor will share with relevant staff. Eleven recommendations have been accepted, two recommendations partially accepted and three recommendations relating to Norfolk PCT have also been accepted.

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

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

**December 2007**

## **CONTENTS**

Summary

The Investigation Process

HMP Wayland

Key Findings

Issues

Recommendations

## SUMMARY

The man died in April 2007 in hospital. He had been sentenced to nine years imprisonment in 2002 for serious sexual offences. On his reception into custody at HMP Bedford, the man was noted to have several chronic diseases, including diabetes, chronic lymphatic leukaemia, ischemic heart disease, peripheral vascular disease, hypertension, and a small aneurysm of the distal abdominal aorta.

During his first year in custody, he underwent several operations. Two of his toes were amputated followed by an amputation of his right leg just above the knee. The man did not use his artificial limb, preferring to use a wheelchair for mobility.

In December 2003, the man was transferred to HMP Wayland and located on the ground floor of a wing. His cell was not designed for a disabled prisoner but he was able to manoeuvre himself around within its confined space. It was also possible to have his wheelchair in his cell. He was self medicating, but failed to take his medication for his diabetes on a regular basis. He did not monitor his blood sugar levels frequently.

The location of the man in Wayland was assessed as being unsuitable because they only offered limited healthcare provision. Prison staff raised this issue on several occasions. The Governor wrote to the Head of Healthcare also outlining his concerns over the inappropriateness of the man's location. Unfortunately, there were no other establishments in the area able to provide the necessary resources and accommodation for his needs.

In April 2007, the man was seen by a nurse as he was complaining of abdominal pain. He was prescribed appropriate medication. A few days later, the man was seen again by a nurse from healthcare. His symptoms had persisted and he had a painful right shoulder. It was also noted that he had not been taking his insulin or monitoring his blood sugar levels. On the morning of 10 April, the wing senior officer noticed that the man seemed very unwell. A member of staff from healthcare was contacted and visited him in his cell. The staff member referred the man to the doctor, who was due to be in the prison that afternoon. The doctor saw the man several hours later, and after examination requested an ambulance. The man was admitted to hospital later that day.

His condition continued to deteriorate and he died the following day. The man had been escorted by two officers. Restraints were removed just prior to his death. He was asked if he wished his family to be notified of his admission to hospital but he declined this offer.

My investigation found that the man's location at Wayland was inappropriate. The lack of resources to support his disability and medical conditions did not offer him the help that was essential for his day to day living. His medical conditions were such that he was in need of 24 hour healthcare. Whilst prison staff raised the issue of the inappropriateness of the man's location, neither healthcare or prison management seemed able to find alternative accommodation for him.

The clinical review has pointed to many areas where the lack of dedicated healthcare for prisoners with disabilities and serious medical conditions needs to be addressed.

The man was restrained up to ten minutes before his death. A risk assessment about this was not carried out after his admission to hospital. As his mobility was greatly impaired and his health extremely poor, I consider the use of restraints to have been unnecessary in the circumstances.

The family of the man did not raise any specific issues in relation to his death. They wished to express their appreciation of the prison for the support offered to them. Nevertheless, I think it was unfortunate that the prison informed the family of the man's death by telephone rather than a face to face visit and I make a recommendation about this.

## **THE INVESTIGATION PROCESS**

The investigation into the man's death was opened by one of my investigators on 20 April 2007, when she visited HMP Wayland. She met with the Governor and the Deputy Governor. My investigator also met with a member of the Independent Monitoring Board (IMB) and a representative of the Prison Officers' Association (POA). Notices and terms of reference had already been sent to the prison by post.

My investigator received the man's prison file and medical record. She requested copies of other documents to be forwarded to her. My investigator later visited the wing and the cell where the man had been located.

On 11 May, my investigator returned to Wayland and interviewed prison staff and prisoners.

One of my Family Liaison Officers spoke to the man's daughter. His daughter did not raise any issues the family wished my investigator to look at with regard to her father's care whilst at Wayland. She was very grateful for the support and assistance shown to her and her family by the prison.

## **HMP WAYLAND**

Wayland is a category C training prison located in Norfolk near to the town of Thetford. It opened in 1985 and has an operational capacity of 709 prisoners. E wing can hold 90 prisoners in single cells and all prisoners on the wing are encouraged to participate in the national sex offender treatment programme.

There is no in-patient 24 hour healthcare unit at Wayland. Staff in healthcare work from 8.00am to 8.30pm Tuesday to Friday, and from 8.00am to 5.30pm Saturday to Monday. Clinical staff comprise four full-time Registered General Nurses employed by the Primary Care Trust (PCT), with three healthcare officers (HCOs). A general practitioner (GP) from a local practice provides cover. A qualified pharmacy technician and an assistant are employed by the PCT. Nurse practitioner appointments are generally arranged within 48 hours and where necessary prisoners are referred to the GP.

An announced inspection of Wayland was carried out by Ms Anne Owers, Her Majesty's Chief Inspector of Prisons, in June 2006. Ms Owers's inspection report commented: 'The healthcare service provided a good range of nurse-led clinics and chronic disease management services. The PCT gave good leadership and support to staff in the prison. Mental health in-reach services had only recently started and needed further links with core services in the establishment. Wayland had found it difficult to manage some inappropriate allocations, and had received little support from local prisons that had the inpatient accommodation that it lacked.'

Overall, Ms Owers said: 'The healthcare department provided a high level of care to prisoners. Wayland is an impressive training prison, and rightly one of the Prison Service's best-performing establishments.'

## KEY FINDINGS

The man was received into HMP Bedford in 2002. He was later sentenced to nine years imprisonment in July. During his reception into HMP Bedford, his first reception health screen document noted he had several serious illnesses. These were type two diabetes, chronic lymphatic leukaemia, vascular disease, a myocardial infarction (heart attack) in 2000, hypertension, asthma and osteoarthritis. The man was prescribed appropriate medication.

In September 2002, shortly after his conviction, the man was taken to hospital for amputation of a toe on his right foot. He had developed gangrene in the toe as a result of his diabetes. Six months later, a second toe was amputated from the same foot. In April 2003, the man underwent an operation to amputate his right leg just above his knee. Following this he was fitted with an artificial limb. He did not use this prosthetic, preferring instead to use a wheelchair. Following the man's discharge from hospital, he was admitted to the healthcare unit at Bedford and a care plan was activated for his post operative care.

In December 2003, the man transferred to Wayland. His medication was given to him to keep in his possession. He thereby became self medicating. This was in line with the general self medication policy at Wayland. The man was located on a wing, the vulnerable prisoner unit, and allocated a cell on the ground floor. His cell was not specifically designed for a disabled prisoner. However, the doorway was wide enough for his wheelchair to pass through, and his bed and cell furniture were rearranged to allow the man the best access around his cell.

In December 2003, following a mobility assessment, the man received a letter from an Acting Principal Officer (APO) in the healthcare unit, encouraging him to utilise his artificial limb. The APO also offered advice on moving around his cell, and said the prison was looking into providing him with a glide chair and a shower chair.

In January 2004, a memo from the Therapy Unit at a hospital to the healthcare unit at Bedford was forwarded to Wayland. The memo noted that the man had been fitted with a new artificial limb in September 2003. At subsequent physiotherapy sessions in October 2003, the man had failed to take his new limb with him. He was instructed at these sessions to use his walking frame in prison.

In April 2004, the man was again seen for a risk assessment in his cell by the APO. The APO noted that the man still did not use his artificial limb. The assessment indicated several areas where he was at risk. This included his limited mobility and lack of disabled resources. The APO noted that Wayland did not have the necessary amenities to meet the man's needs.

In May, the then Governor of Wayland wrote to the Head of Healthcare. The Governor attached the risk assessment report by the APO. The Governor commented that Wayland was unable to provide either the environment, or level of health care necessary to meet the man's needs. The Governor sought advice from the Head of Healthcare with regard to the man's medical needs and his appropriate location. There is no record of a reply from the Head of Healthcare.

In July 2004, a discipline officer on the wing wrote to the Governor. The letter outlined the risks posed for the man, being a disabled prisoner on the wing. The letter further noted issues relating to his hygiene needs and the collection of food from the servery. The officer said that the assistance the man required to attend the healthcare unit for appointments was down to the goodwill of staff and prisoners on the wing. There is no record of any action being taken as a result of this letter.

In October, the man was admitted to hospital. His BM count was noted as high and he had a possible urine tract infection. It was recorded that the man had poor diabetes control. Whilst an in-patient, he was also reviewed by the Department of Haematology in relation to his chronic lymphocytic leukaemia. He was discharged back to Wayland on 8 October. The urine infection culture proved to be negative and his leukaemia did not require any further treatment. The hospital advised that six monthly blood tests be taken to check his diabetes and leukaemia.

In January 2005, the man was issued with a Notice of Formal IEP Warning for failing to comply with the current regime. He had failed to keep his cell clean to the required level of hygiene. This was not the first warning the man had been issued in relation to his hygiene, both personal and in his cell.

In February 2005, the man fell off his bed during the late evening. When he was discovered by staff the following morning on his cell floor, he was fully conscious. Healthcare staff attended his cell, checked his physical condition and returned him to bed.

The accident was discussed at the Senior Management Team meeting on 21 February. A note on the Accident Record Form recorded that there did not seem to be an appropriate prison where the man could be accommodated. Nevertheless, the prison would endeavour to continue trying for alternative accommodation for him. Night staff on the wing were instructed to keep a 'regular eye' on the man during their shift. Further enquiries would be made about the possibility of making arrangements to meet his needs at Wayland. However, there is no record of any formal attempts in his file to get him transferred from Wayland to another establishment with more appropriate resources.

In September, the man was admitted to hospital for cataract surgery. Following the surgery, he was discharged to HMP Norwich's healthcare unit for post operative care. He transferred back to Wayland on 22 September.

In November, the man was assessed by two registered mental nurses for any signs of dementia. The nurses found no evidence of long term memory deterioration, though short term memory was deemed to be a little poor. With regard to his medication compliance, it was noted that he often forgot to take his medicines, but appeared to be nonchalant and care-free about this. The nurses suggested that a chart pinned to his cell wall to act as an aide memoire would be useful. There is no information that this was done or if the man was willing to participate with this suggestion.

The man was seen in the healthcare unit in January 2006. The medical notes record that he was unable to establish the frequency and amount of insulin he had been

using. He was advised to continue with his regime but to monitor his blood sugar levels more frequently. He said he had not used his insulin that morning. The entry ended with a note for wing staff to observe for any signs of alteration in consciousness. The following day, the man was seen again in the healthcare unit. His notes record his blood sugar levels were still too high, and he had not provided a urine sample. However, he remained unconcerned about his health and general diabetes control.

On 20 January, the man saw the general practitioner (GP). The GP reviewed the man's diabetes control and noted that some days he did not use insulin and was erratic in his medication regime. The man had still not provided a urine sample and was apparently unconcerned about his medication. He told the GP he had no relatives and failed to see the point of living. The GP felt the man was not depressed, but did prescribe metformin to help brighten his mood. The GP noted that it was difficult to care for someone who did not want to be cared for.

On 24 January, the man's medical record noted that he seemed more motivated and was regularly testing his blood sugar levels. In May, the man was seen in the healthcare unit with a lesion behind his left ear. This was an ongoing problem and diagnosed as a fungal infection. Lamisil cream was prescribed. No other examination of him was carried out and his blood sugar level was not recorded.

In July, the man attended the healthcare unit. His medical record noted that he looked unkempt, his clothing was soiled, his dentures were not in place, he was unshaven, and body odour was evident. The man was advised that he needed to shower daily and wear clean clothing. His personal hygiene was discussed with wing staff. The man was to be prompted to shower and change his clothing through the Incentives and Earned Privileges Scheme. It is noted in his prison file that he received several formal warnings in relation to his personal hygiene and cleanliness of his cell. The man was prescribed a hydrocortisone cream for his skin infection. Again, no examination or investigations such as temperature, blood pressure or blood sugar monitoring were recorded.

On 26 July, at the request of wing staff, a member of the healthcare unit saw the man in his cell. Wing staff reported that the man was not eating or administering his medication. He was observed sitting in his wheelchair without clothes. He agreed to dress and attend the wing treatment room. The man said he had diarrhoea and had not eaten or been drinking that day. The healthcare nurse was unable to establish whether he had taken his insulin. The man was inconsistent and contradictory in response to questions. He was advised to eat a small tea meal, take fluids and his insulin. His physical and mental state appeared to be as normal.

In August, the man saw the GP. His medical record noted he had a cold and a bit of a cough. His bowels were now normal and he was drinking fluids, though had a lack of appetite. The man told the GP he was using insulin every day.

In October, the man attended the healthcare unit. His skin infection had not improved and it was noted he had athlete's foot. He was prescribed anti fungal cream and advised on good foot hygiene.

On 17 October 2006, the man was refused release on licence by the Parole Board. The refusal was based on his denial of the offences, victim issues and the potential high risk to children. The man did not actively contribute to his release plan. In December, he was prescribed ointment for a 'sticky eye'.

In April 2007, the man was seen in the healthcare unit with abdominal pain, bloating and some diarrhoea. There were no signs of blood in his stools. He was prescribed a laxative. On 8 April, he was seen again in his cell by a member of healthcare. The man's personal officer was also present. The man said he still felt unwell with stomach ache. He also complained of pain in his shoulder. He had not taken his medication or eaten. His various medications were seen in a large bag on top of his cupboard. The officer and the member of healthcare decanted the medication into small plastic bags and labelled the bags with the time and date when the man should take his medication. Arrangements were made with wing staff for the man's meals to be collected for him from the servery and handed to him in his cell. It was observed that his mouth seemed dry and some orange squash was made for him to drink. The pharmacy was contacted to ensure the man collected his medication.

During the morning of 10 April, a senior officer (SO) saw the man in his cell. He spoke with him and noticed that he was unwell and seemed a little confused. The SO made contact with the Clinical Nurse Manager who was in the wing dispensary with the pharmacist. The SO asked the nurse manager to come and look at the man.

At 12.00 midday, the nurse manager saw the man in his cell. The nurse manager noted the syringe and insulin in the cell and asked the man if he had tested his blood sugar levels. He appeared to be confused and did not seem able to do his own blood sugar level testing. The man told the nurse manager he had not been eating. The nurse manager was unable to obtain sufficient blood from a finger prick sample to test the man's blood sugar levels. The nurse manager decided that the man should see the doctor as an urgent referral.

The nurse manager returned to the healthcare centre and wrote an entry into the man's medical notes. He then informed the incoming doctor that the man needed to be seen on the wing. The nurse manager also told a nurse that the man was unwell and that he had been referred to the doctor.

Between 2.00 and 3.00pm, the nurse visited the man in his cell. The nurse asked him to get dressed so she could examine him in the treatment room. An officer was present with the nurse in the man's cell.

The man was struggling to dress and move out of his cell. He managed to put on a pair of boxer shorts. After 20 minutes, the nurse decided that it was becoming too difficult for the man to leave his cell. The man was experiencing great difficulty in manoeuvring himself. A prisoner saw the man, the officer and the nurse. The prisoner and the officer held blankets around the man to preserve his dignity as he was half in his cell door way and half on the landing in a state of partial undress. It was agreed to assist the man back into his cell and on to his bed in preparation for the nurse and doctor to examine him. The officer and the prisoner helped the man

back into the cell. The man asked to use the toilet and the prisoner supported him to do this.

The nurse then examined the man. She took his blood sugar level and noted that it was too high to register. She tried to take his blood pressure, but this was too low to record. The nurse thought that the man seemed confused. She started him on oxygen, and then went to the medication room on the wing to telephone the GP who had arrived at the prison by this time.

The nurse suggested to the GP that they telephone for an ambulance straight away but the GP decided to review the man first. The nurse had intended to write up an entry in his medical notes later that afternoon, but forgot to do so as she was very busy.

The doctor examined the man at 4.00pm. The GP found him to be acutely ill. The man was confused and not able to speak, his temperature was 35.5, his blood sugar levels too high to record, his blood pressure was 100/60 and respiratory rate 28 per min. There were signs of parts of his body being cyanosed (turning blue in colour) and there was some slight swelling to his right leg but no sign of infection. The doctor then called an ambulance for the man to be taken to hospital as an emergency admission.

At 5.35pm, the man was transferred from Wayland with a two officer escort to hospital. The man was handcuffed to an officer. At 7.15pm, he was formally admitted to hospital after a medical examination in the medical assessment unit. The man was asked by one of the escorting officers if he wished the prison to contact any next of kin and inform them of his admittance to hospital. The man could not think of any immediate contact but said he would inform the officers if he wished the prison to do so.

On 11 April at 8.15am, the man was seen by a hospital doctor. The bed watch notes record that he was confused and not responding to the doctor's questions. At 9.45am, the notes record that he had gone into renal and cardiac failure. The escort officer made contact with the duty governor and gained authorisation for the restraints to be removed.

The man died at 9.55am. He had had very little contact with family members during his time in custody. His next of kin was recorded as his brother in law. The duty governor phoned the man's brother in law who told the governor that the man had a daughter and that he would convey the message to her. The man's daughter made contact with the prison later that day.

The man's funeral was held on 3 May. The prison offered expenses towards funeral costs and this was appreciated by his family.

## ISSUES

### **Clinical Review**

A review of the man's medical care was commissioned from Norfolk Primary Care Trust (PCT). The Professional Development and Clinical Governance Manager for the PCT, undertook the review. The manager examined the man's prison medical record and interviewed two members of the healthcare staff, the nurse manager and the nurse. The reviewer also made contact with the prison GP who admitted the man to hospital on 10 April 2007. I summarise her views below.

### ***Routine Care***

The man's long standing history of poor self care, non-compliance in managing self medication and in following medical advice meant that he required significant health care support. His medical records support this, with repeated medical intervention being required due to his behaviour.

The man was prescribed appropriate medication for his conditions, but there is evidence throughout his medical records that he was not compliant with taking his own medication or testing his own blood sugar level. The reviewer was unable to find any evidence of a formal assessment for the use of self-possession medication, despite it being of concern and a major contributing factor to his poor diabetic control. Health care staff were able to confirm that an assessment process was being developed at the prison, but was not yet in place.

**A process for assessing a patient's ability to take responsibility for their own medication should be introduced as a matter of urgency. This should include a process for training, guidance and support for those prisoners who experience difficulty and, if required, onward referral.**

Another area of concern surrounds the practice of nurse triage for prisoners wishing to seek medical advice or treatment to ensure that they receive care from an appropriate level of staff. Nurses working at HMP Wayland reported that they had not received any training or clinical support in developing triage skills. It was the reviewer's opinion that on 8 April, the man might have benefited from consulting with a GP when he was assessed by a nurse and showed signs of becoming dehydrated.

**Training and supervision in triage for all nurses within healthcare should be implemented and include a process for planning and receiving care.**

The reviewer judged that the man appeared to have received care, attention and support by both the healthcare staff and prison officers which clearly at times exceeded that expected from a type 2 healthcare establishment.

### ***Acute care***

However, there are some aspects of the care that the man received in the two consultations on 4 and 8 of April leading up to his death which appear to fall below

the standard that a patient in the community might receive from a medical practice. The symptoms of diarrhoea on 4 April and that of dehydration, together with not eating or taking medication, on 8 April do not appear to have been investigated or referred on to a doctor at an early stage. There was no reference to blood sugar levels having been taken at either of these consultations.

It was noted that there were no specific review arrangements recorded in the man's notes, and requests for a review of the man appeared to be initiated by prison officers who became concerned for his deteriorating health. During interview, some medical staff stated that they did not currently have clinical supervision.

It was commendable that the GP reviewing the man on 10 April undertook a thorough examination and referred him appropriately to emergency care facilities. There was concern expressed by some staff that the GP decided to commence surgery prior to reviewing the man's condition which delayed his attendance on the wing.

### ***Mental Health Assessment***

The man's mental health needs do not seem to have been recognised and yet may have been a contributing factor in his behaviour and non-compliance in taking medication.

Given his significant long term health problems and above knee amputation, his reluctance to participate in group work within the prison, his non-compliance in taking his medication and reluctance to ensure personal hygiene, plus references within his medical records to having no relatives and that he 'failed to see the point of life', the man may have been suffering from depression. He was referred to the mental health team and assessed for a possible dementing illness but no reference was made to a specific assessment for depression. The reviewer says it seems likely that the man's mental health needs may have contributed to his lack of self-care and lack of diabetic control.

**Prisoners with long terms conditions should receive an annual assessment for depression in line with the national indicators within the Quality and Outcome Framework for general practices. This could be undertaken by the GP or Mental Health Team.**

The reviewer says the man posed particular complications to the health care team in terms of his care. His medical notes show that staff noted that they were not able to deliver the level of care that they felt appropriate for him, but had tried their best to support him. It is to the credit of nursing staff and prison officers that they were able to offer sufficient care to the man to enable him to maintain a level of medical independence within the prison.

### ***Location and services available to the man***

HMP Wayland prison offers Type 2 Healthcare. This means that there is no 24-hour facility. The medical service commenced with nurse triage daily. It appeared from the man's records that risk assessments had been undertaken by the prison and

health care staff, and prison officers had highlighted to the governor and health care managers the need for him to be transferred to more appropriate facilities. This unfortunately had not happened. Staff do not appear to have been given any feedback regarding this issue.

The man needed a level of intervention greater than that available at HMP Wayland but was assessed by HMP Norwich as being less than the criteria required for transfer to their healthcare unit.

The nature of the man's offence meant that he was accommodated in the wing. This wing does not have suitable facilities for disabled patients and offers an inappropriate level of accommodation for people like him. It is also a considerable distance from the health care facilities, making clinical reviews difficult to undertake without the assistance of prison staff. While the prison did have a wheelchair policy, which included the requirement to ensure that prisoners were able to access health care, it was not always possible for the man to attend at specific times due to staff availability.

**Offender Health should use the man's case as the basis for a review of the care pathway and provision of accommodation suitable for patients with long term conditions who require a level of supervision in meeting their health needs which is greater than that available through Type 2 health care but is not dependent on 24 hour nursing care.**

**Offender Health should standardise the acceptance criteria and admissions process for prisoners in order to support appropriate placement at a particular establishment. This would also reduce the likelihood of inappropriate movement of prisoners with complex medical problems around the prison system.**

**The above standards should be used to audit successful placement of patients with long term conditions to assure good practice.**

**The Head of Healthcare and Governor must determine who the responsible authority is in making decisions regarding the placement of patients who have particular medical needs. This should be clearly recorded in the appropriate records, as should the steps taken to facilitate transfer to a different establishment where that is required.**

### ***Record Keeping***

The reviewer found that the standard of record keeping within the health care centre is not routinely of an adequate standard. Electronic records were in place to capture dates of intervention, but in 117 recorded consultations there are only 35 entries where comment / narrative or text is entered. This meant that in 82 cases there was no clear indication of the purpose of the consultation, although some resulted in medication being issued. Records in written patient notes prior to the computerised records and between 4 and 10 of April 2007 when the computers were not working, have a fuller record of the consultations with narrative. Although these were signed it was difficult to interpret the name in some cases.

The record of a consultation that took place on the afternoon of the man's admission by the nurse is not recorded in his medical records, but came to light through interviewing prison officers and prisoners on the Wing. The reviewer spoke to the nurse and concluded that this omission was not usual practice.

### ***Emergency medication and equipment***

The reviewer found that emergency equipment such as portable oxygen and defibrillators are available within the health care centre.

Drugs which may have been useful in treating the man such as Actrapid Insulin and intravenous fluids are not usual in a GP surgery. But it was the reviewer's opinion that it would have been of assistance to have a supply of emergency drugs in keeping with potential requirements of current patients.

**The Head of Healthcare should review the current practice and develop a policy on the minimum acceptable level of recording within patients' electronic records. Training should be made available to support this policy.**

**The PCT should consider providing a method of remote access to patients' medical records through portable PCs for staff visiting patients outside the health care centre.**

### ***Post Incident care of medical staff***

During interviews, staff were asked what immediate support they were given after the man's acute hospital admission and subsequent death and what processes were in place to share learning with HMP Norwich. When healthcare was managed by the prison, a debrief followed a death in custody and they were invited to attend this. They were not aware of any support or shared learning opportunity post significant events since management of healthcare transferred to the PCT.

**Healthcare staff should be offered support from PCT healthcare within 72 hours of a death in custody occurring.**

**The Governor should ensure that medical staff are invited to attend the prison's 'hot debrief' after a death in custody has occurred so that shared learning opportunities are not lost.**

**Norfolk PCT and the Governors of Wayland and Norwich prisons should consider whether it is appropriate to share death in custody investigation reports so that learning opportunities are available to both prisons and the medical teams that work within them.**

The findings and recommendations of the clinical review have been discussed with the Assistant Director of Specialist Services – Prison Service, Head of Health Care within the prison and will be monitored through Norfolk PCT's Health Care Governance structure.

## **The man's location in prison**

On his reception into prison it was noted that the man was unwell with several chronic illnesses. The amputation of two toes, followed by his right leg in 2003, added to his already poor health. The man did not use his artificial limb, and instead relied on his wheelchair for mobility.

The man was given his medication, including his insulin, to administer himself. Throughout his medical records it appears he was inconsistent in testing his blood sugar levels and not taking his insulin. All other medication he took regularly himself.

In Ms Owers's inspection report of Wayland in June 2006, under diversity and equal opportunities, she commented that, 'there were three prisoners in wheelchairs for whom daily life was very difficult. It was almost impossible for them to negotiate their wheelchairs into their cells, and grab bars to assist them in the in-cell toilet were poorly sited. Wing staff were not clear of any arrangements to assist wheelchair-users to use the showers, which had not been converted for their use.' Ms Owers further observed that, 'There was no specific reference to the needs of older prisoners or those with disabilities.'

The diversity and equal opportunities policy at Wayland was due for review in January 2007, but this work has been put back until July 2007.

A risk assessment and a memo from the Governor indicated that the facilities on the wing and within Wayland itself did not provide satisfactory medical care or accommodation for the man. In May 2004, the then Governor asked for advice from the Head of Healthcare about the fact that Wayland could not meet the man's needs. There is no record of a reply or what follow up action was taken.

Wing staff at Wayland tried also to get the man's location changed in July 2004. Again, no record of any action taken can be found. Ms Owers commented that, 'Wayland had found it difficult to manage some inappropriate allocations, and had received little support from local prisons that had the inpatient accommodation that it lacked.' With a growing older prisoner population at Wayland, some of whom have disabilities, the placement of such prisoners on a normal landing is difficult to manage. The goodwill of prison staff and prisoners supported the man.

There are three recommendations within the clinical review which comment on the location of prisoners with long term conditions who require a level of supervision in meeting their health needs which is greater than that available through type 2 healthcare. Bearing in mind, the comments from the Chief Inspector's report, I judge that some direction is needed from the Prison Service's Eastern Area.

**The Prison Service Area Manager for the Eastern Area should review the location of older, disabled prisoners at Wayland and the appropriateness of them being accommodated in cells not designed for their complex medical needs. Transfers to more suitable establishments should be arranged where necessary.**

## **Wing Staff**

The staff of the wing were supportive towards the man and tried to ensure that he was assisted where possible to live on the wing in circumstances that were not really suitable for a disabled prisoner. In particular, an officer as the man's personal officer, offered continued help and kindness. The officer was empathetic to the man's disabilities and age. This was evidenced in his support for the man when formal warnings were being issued in relation to his personal hygiene standards.

**I note the support of the wing staff towards the man.**

**I commend the officer for his empathetic approach as the man's personal officer.**

## **Notification of the man's death to his next of kin**

The man's family were notified of his death by a telephone call to his brother-in-law who was his nominated next of kin. Prison Service Order 2710, Family Liaison Officer Guidance section, offers advice on breaking the news of a death to a family. A telephone call is not deemed usually appropriate and alternatives are detailed in the guidance. Whilst appreciating that the man had little contact with his family, and accepting the sensitivities relating to the nature of his convictions, a visit to his brother-in-law would have been more appropriate. One option would have been for Wayland to have contacted the prison nearest to the family home and have asked them to visit to break the sad news.

**In future when a death in custody occurs, the guidance for breaking news of a death to a prisoner's family should be implemented in line with PSO 2710.**

## **Hospital bedwatch**

The man was restrained in hospital up to 10 minutes before his death. On his escort to hospital, he was handcuffed to an officer on a two officer escort. When the man was admitted to the ward the restraints were not removed. Taking into consideration the man's poor state of health and his very limited mobility, the retention of restraints was inappropriate. It must also have been difficult for the escort staff to be handcuffed to such an ill man.

A risk assessment on his prison escort form indicated that the man might be able to escape from the toilet or shower facilities.

A risk assessment should have been reviewed following the man's admission to the hospital ward. A two officer bed watch at his bedside would have ensured security without the restraints.

**A full risk assessment, with frequent reviews, should be carried out by the duty governor on all prisoners in outside hospital whilst under escort.**

## RECOMMENDATIONS

### National recommendations

1. **Offender Health should use the man's case as the basis for a review of the care pathway and provision of accommodation suitable for patients with long term conditions who require a level of supervision in meeting their health needs which is greater than that available through Type 2 health care but is not dependent on 24-hour nursing care.**

**Accepted** - This case will be used by offender health by Offender Health as an example case. Offender Health are considering a review into the utilisation of health centre beds in prisons. Offender care pathways are also being developed to support the primary and social care work stream. The issues raised by this case will be addressed in the older peoples and chronic disease management pathways.

2. **Offender Health should standardise the acceptance criteria and admissions process for prisoners in order to support appropriate placement at a particular establishment. This would also reduce the likelihood of inappropriate movement of prisoners with complex medical problems around the prison system.**

**Partially accepted** - One part of the proposed bed utilisation review would be to ensure that facilities for health and social care in all establishments be published to enable clinically appropriate transfer decisions to be made.

3. **These standards should be used to audit successful placement of patients with long term conditions to assure good practice.**

**Partially accepted** - One part of the proposed bed utilisation review would be to ensure that facilities for health and social care in all establishments be published to enable clinically appropriate transfer decisions to be made.

### Recommendations for Norfolk PCT

4. **The PCT should consider providing a method of remote access to patients' medical records through portable PCs for staff visiting patients outside the health care centre.**

**Accepted** – A number of terminals in locations other than the main healthcare centre are being installed within the prison for the new clinical information system (electronic patient records) which will go 'live' January 2008.

5. **Norfolk PCT and the Governors of Wayland and Norwich prisons should consider whether it is appropriate to share death in custody investigation reports so that learning opportunities are available to both prisons and the medical teams that work within them.**

**Accepted** – Learning from clinical reviews is shared through clinical governance mechanisms across both prisons within the PCT. The Commissioner will discuss with the Governors of both prisons in order to agree a process for this to happen.

**6. Healthcare staff should be offered support from PCT healthcare within 72 hours of a death in custody occurring.**

**Accepted** – The procedure has been reviewed to ensure that staff involved in any future similar incidents are supported through a debrief. Additionally, staff can access Occupational Health for any personal and ongoing support.

**Recommendations for the Prison Service Area Manager for the Eastern Area**

**7. The Prison Service Area Manager for the Eastern Area should review the location of older, disabled prisoners at Wayland and the appropriateness of them being accommodated in cells not designed for their complex medical needs. Transfers to more suitable establishments should be arranged where necessary.**

**Accepted** - All prisoner health care needs are assessed on reception at the establishment. Any prisoner requiring specific accommodation identified as part of the assessment process will be met at the earliest opportunity. If this requires a transfer to an establishment with a health care facility this will be arranged under the existing medical transfer protocol.

**Recommendations for HMP Wayland**

**Healthcare**

**8. A process for assessing a patient's ability to take responsibility for their own medication should be introduced as a matter of urgency. This should include a process for training, guidance and support for those prisoners who experience difficulty and, if required, onward referral.**

**Accepted** - Protocol to be reviewed

**9. Training and supervision in triage for all nurses within healthcare should be implemented and include a process for planning and receiving care.**

**Accepted** – Training programme for triage and recording to be devised

**10. Prisoners with long terms conditions should receive an annual assessment for depression in line with the national indicators within the Quality and Outcome Framework for general practices. This could be undertaken by the GP or Mental Health Team.**

**Accepted** – Mental Health referral/assessment pathway to be reviewed

**11. The Head of Healthcare should review the current practice and develop a policy on the minimum acceptable level of recording within patients' electronic records. Training should be made available to support this policy.**

**Accepted** – NPCT core record keeping policy to be fully implemented.

**12. The Head of Healthcare and Governor must determine who the responsible authority is in making decisions regarding the placement of patients who have particular medical needs. This should be clearly recorded in the appropriate records, as should the steps taken to facilitate transfer to a different establishment where that is required.**

**Accepted** – Protocol to be devised

**The Governor**

**13. The Governor should ensure that medical staff are invited to attend the prison's 'hot debrief' after a death in custody has occurred so that shared learning opportunities are not lost.**

**Accepted** – Review contingency plans to ensure that all staff involved in a death in custody are identified and attend the hot debrief.

**14. I commend the officer for his empathetic approach as the man's personal officer.**

**Accepted** – Formally write to the officer and include a copy of letter into personal file.

**15. In future when a death in custody occurs, the guidance for breaking news of a death to a prisoners family should be implemented in line with PSO 2710.**

**Accepted** – Review contingency plan to ensure that guidance on how to inform the next of kin is included

**16. A full risk assessment, with frequent reviews, should be carried out by the duty governor on all prisoners in outside hospital whilst under escort.**

**Accepted** - Review guidance on Bedwatch Escorts to ensure guidance is included on the need to carry out regular reviews on security and restraint instructions/assessments

**General Commendation**

**I note the support of the wing staff towards the man.**