# Investigation into the circumstances surrounding the death of a female prisoner at HMP New Hall, in November 2008

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

**November 2009**

This is the report of an investigation into the death of a woman, who was a prisoner at HMP New Hall. She died in November 2008 at a hospital in Wakefield, where she had been an inpatient for around two months. The cause of death was recorded as a pulmonary infarction (obstruction of the artery supplying blood from the heart to the lungs) caused by a pulmonary thromboembolism (a blood clot blocking the artery) which was due to a deep vein thrombosis caused by an infection of the pelvis. I offer my sincere sympathy and condolences to the woman's son and all who have been affected by her loss.

The investigation was carried out by one of my investigators, An independent review of the woman's medical care in prison was carried out on behalf of the Wakefield District Primary Care Trust and I am most grateful for their assistance with the investigation.

I would also like to thank the Governor and staff of New Hall for their full and ready co-operation during the course of the investigation. My particular thanks go to in the liaison officer and his work with liaising with the investigator.

The woman had a difficult time at New Hall. She struggled both physically and mentally to cope with her numerous medical conditions and regularly refused to undergo recommended procedures. Sadly, this was the case in the last weeks of her life when she refused almost all of the interventions offered to her. I find that staff at New Hall cared for the woman in a respectful manner, and this report commends them for their commitment to helping her.

**Jane Webb**
**Deputy Prisons and Probation Ombudsman** **November 2009**

**CONTENTS**


| | |
|---|---|
| Summary | 4 |
| The investigation process | 5 |
| HMP New Hall | 6 |
| Key findings | 7 |
| Issues | 20 |
| Conclusion | 29 |
| Recommendations and good practice | 30 |

## SUMMARY

In September 2003, the woman underwent emergency surgery for a perforated colon, which required her to wear a colostomy bag as part of her recovery. Around three weeks later, she was remanded in custody to HMP New Hall. As well as her colostomy, the woman had several long standing health problems, including asthma, arthritis and depression. The following year she was sentenced to life imprisonment.

The woman experienced a number of problems with her physical health throughout her time in custody. Wearing the colostomy bag caused her great distress and embarrassment. This was particularly the case following an operation to reverse the procedure in August 2007, after which she had to wear a second bag (for what is known as an ileostomy) as part of her recovery. The woman also had some difficulty understanding when and how to change her bag, which led to her damaging her skin. Despite her dislike of the bag, she initially refused to have the colostomy reversed in 2005, and refused a reversal of the ileostomy in early 2008. She also refused to attend hospital for several other appointments and procedures during her time in prison.

Of further concern to the woman was her level of mobility. She regularly complained to staff that she was unable to walk around the prison and felt she required a wheelchair to go to healthcare, visits or education. A mobility assessment in April 2007 disputed this. Nevertheless, she was persuaded in early 2008 to move from E wing, where she had made several friends, to B wing, which was more centrally located.

The woman's physical health problems tended to exacerbate her depression. She spent a large proportion of her time in prison being monitored under Assessment Care in Custody and Teamwork arrangements (ACCT, the document used by the Prison Service to monitor and support persons deemed to be at risk of suicide or self-harm). On some occasions she indicated that she would rather die than live any longer with her poor health.

Following an admission to hospital in September 2008, the woman's health deteriorated significantly. Although seriously ill, she refused almost all the treatment offered to her and said she did not want to undergo any procedures even if refusal was likely to lead to her death. A psychiatric assessment made at the hospital concluded that the woman was mentally capable of making this decision. She died in her sleep at 3.45pm on 20 November 2008.

Caring for the woman presented staff at New Hall with a number of challenges. Nevertheless I am satisfied that the care she received was respectful and, in the main, appropriate. However, I make a total of six recommendations covering several aspects of her time at New Hall. They include the appointment of a named individual to lead regular case reviews.

## THE INVESTIGATION PROCESS

1. The investigation was opened in November 2008 when the investigator issued notices announcing it to staff and prisoners. The notices included an invitation to those who wished to submit information relating to the woman's death to make themselves known to the investigator. No one came forward as a result.

2. The investigator first visited New Hall at the start of December 2008. He toured the prison including visiting the healthcare centre and the wing on which the woman lived, and was given copies of her prison files. The investigator returned to New Hall in mid March 2009 and interviewed four members of staff.

3. An independent clinical review of the woman's health needs whilst she was in custody was carried out by the Wakefield District Primary Care Trust. The reviewer visited New Hall with my investigator in mid March and contributed to the interviews.

4. The senior family liaison officer telephoned the woman's son in December 2008 to inform him of the investigation. He told the family liaison officer that he had been kept informed of his mother's health and care whilst she was in hospital, and had been allowed to visit her. The family liaison officer and my investigator subsequently met the woman's son at HMP Grendon in January 2009. He said he was anxious to know that his mother received appropriate care whilst at New Hall. The woman's son went on to say that he had been allowed to speak to his mother over the telephone and she had told him that she was in a lot of pain. He visited her in hospital in September 2008 and was able to attend her funeral.

5. The family liaison officer contacted the woman's son for a second time in November 2009 to see if he wished to comment on the Ombudsman's draft report. He told the family liaison officer that he found it very difficult and distressing to read the draft report. His view was that his mother was not treated with any compassion and the staff at New Hall just did what they had to do.

**HMP NEW HALL**

6. New Hall is a local training prison for adult women, young adult women and juvenile girls. The operational capacity (the maximum number of spaces in the prison) is 446.

7. Healthcare is commissioned by the Wakefield District Primary Care Trust, who also provide primary care and substance misuse services. Mental health services are provided by the South West Yorkshire Mental Health Trust. The prison has an inpatient facility consisting of 12 beds, including one cell for disabled prisoners, all in single rooms. Full-time prison doctors are employed and hold clinics during the day and in the evening from Monday to Friday and on Saturday mornings.

8. HM Chief Inspector of Prisons conducted a full announced inspection of New Hall from 10-14 November 2008, around a week before the woman died. HM Chief Inspector reported that New Hall holds a "needy and challenging population" but was a "reasonably safe and purposeful prison". She went on to say:

   > "Few areas were suitable for women with disabilities. Two cells on Willow House had been knocked into one to create a disabled living area with a separate toilet, more space and a wider cell door suitable for wheelchair access [the woman lived in this cell for several months in 2008]. There was no formal system of carers, but other women offered informal assistance."

9. HM Chief Inspector of Prisons also reported on healthcare at New Hall:

   > "Health services were stretched, with a number of vacancies and a reliance on agency staff … Provision of primary care was satisfactory. However, women waited too long for a routine GP appointment. Mental health services appeared generally good, but the social care needs of some women managed on the wings were not well met."

10. In their annual report for 2008-2009, the prison's Independent Monitoring Board (IMB) commented that "an effective and appropriate level of service is maintained within healthcare at New Hall". The IMB reported that access to a prison doctor "is not a problem".

11. The woman's death was the seventh to have occurred at New Hall since April 2004, when the Ombudsman began investigating all deaths in prison custody in England and Wales. It is the first since May 2006, and the second investigated by this office that was due to natural causes. The previous natural causes investigation considered the care received by a woman with significant physical health needs and found that healthcare staff provided excellent care for the woman in question.

## KEY FINDINGS

12. The woman was remanded to New Hall in July 2003. An F2052SH (the document then used by the Prison Service to monitor and support persons deemed to be at risk of suicide or self-harm) was opened as her solicitor expressed concern that she might kill herself. A first reception health screen (a routine health screen for all new arrivals into prison) was completed the same day. At her health screen the woman said she had been treated for depression in the past and had previously harmed herself. She also said she was asthmatic, had severe arthritis and was noted to be "physically unsteady". In addition, she said she had a collapsed bladder, bowel cancer and epilepsy. Her doctor in the community was contacted and said she had no history of the latter three conditions.

13. In July, she was seen by a psychiatrist instructed by her solicitor. The psychiatrist concluded that there was no evidence that she was suffering from any mental illness, although she did have a learning disability. He considered that the woman was fit to stand trial.

14. After around six weeks in prison, the woman was released on bail. Whilst on bail, she was admitted to a hospital in Liverpool where she received emergency surgery in September. The woman had an ovarian tubal abscess (an infection of the ovaries) and a perforated colon, which required a colostomy. (A surgical procedure in which the colon is cut and brought through the abdominal wall to create an artificial opening. A colostomy bag is attached to this opening as an outlet for the bowel.)

15. It is not clear how long the woman remained in hospital after her surgery. However, in late September, she was again remanded to New Hall. At her reception health screen, the woman was noted to be physically well. Her wound from the recent surgery was said to be healing and she was given a supply of colostomy bags.

16. Apart from experiencing some intermittent depression, the woman settled reasonably well into prison life. She was assessed by a nurse at the start of November, who reported that she was "totally self-caring in all aspects of daily living". The woman also told the nurse that she was able to manage climbing stairs.

17. In April 2004, the woman was convicted and sentenced to life imprisonment with a tariff (the minimum time that must be served) of 15 years. On her return to New Hall an F2052SH was opened, partly in relation to her sentence and also because she had been depressed in recent days. The woman also spent four days under observation as an inpatient in the prison's healthcare centre, before returning to A wing. She was prescribed antidepressant medication for the majority of her time at New Hall.

18. In May the woman was noted to be struggling to care for her stoma (the artificial opening where the colostomy bag was attached). She also spoke of pain in the stoma area and, in early June, of diarrhoea. In a referral letter to the local hospital in June the prison doctor wrote that a large hernia was causing this increased pain.

19. The woman's F2052SH was closed in mid June. However a new document was opened in July, after she wrote a note in which she said she was being shouted at by other prisoners at night and wanted to take her own life. It is not clear whether these allegations of bullying were investigated.

20. Following her referral to hospital, the woman attended an outpatient appointment in early August 2004 with a consultant colorectal surgeon. The consultant thought it would be possible to reverse the colostomy, through a procedure known as a laparotomy (to join the two ends of the bowel back together and therefore remove the need for a colostomy bag), for which the woman would have to join a waiting list.

21. In November, after complaining of chest pains, the woman was admitted to hospital as an inpatient. She was diagnosed with a chest infection, for which she was prescribed an antibiotic and remained in hospital until late November. She had a scan during her stay which showed hydronephrosis (excess water on the kidney, in this case due to swelling in the ureter, the tube that runs from the kidney to the bladder). As a result, a stent (a plastic tube) was surgically inserted to do the job of the ureter until it had healed. The woman was also reviewed by the consultant whilst she was in hospital. He confirmed that she was on the waiting list for a laparotomy but, although in pain, could not be prioritised above people waiting to have a cancerous tumour removed.

22. Throughout the first half of 2005, the woman continued to complain of pain in her abdomen and pain when urinating, due to her swollen ureter. She was prescribed various antibiotics for the infection, some of which she refused to take due to their side effects. The woman was still troubled by the hernia and told prison doctor that it was getting worse. The prison doctor subsequently wrote to the consultant in mid May to ask for his advice on pain relief. The consultant replied a week later, saying that the only way to resolve these issues was by reversing her colostomy, for which the woman was on the waiting list.

23. The woman went to an outpatient appointment in June with a consultant urologist (specialist in the urinary tract). He reported that the woman's latest urine samples showed no sign of an infection, although she continued to complain of pain. He explained that he would arrange for her to undergo a scan and have her stent changed.

24. The F2052SH procedures, under which the woman was being monitored, were converted to an Assessment Care in Custody and Teamwork (ACCT) system in April 2005. This was a new procedure introduced

across the Prison Service to replace the F2052SH. The woman's ACCT was closed on 5 July, as she had recently moved to a different wing and said that she was much happier now.

25. Throughout July and August the woman complained regularly of a chest infection and pain when passing urine. She continued to be treated with antibiotics. In early September she was due to be admitted to the local hospital for the operation to reverse her colostomy. However, despite her recent pain and the consultant's advice, she refused to go and said that she did not wish to undergo the procedure. She gave no reason for her refusal.

26. The stent replacement and scan requested by the consultant urologist were scheduled for October. However, the woman also refused to attend this appointment. The consultant urologist was told of her decision, and asked nursing staff to try to persuade the woman to attend. She did not change her mind, and signed a disclaimer to confirm that she did not wish to attend hospital.

27. A new ACCT document was opened in early November as the woman said she was lonely, depressed and having suicidal thoughts. She also said that her sister had cancer and did not have long to live. The ACCT was closed three weeks later when the woman said she was feeling much better and that an education course she had recently started was taking her mind off her worries.

28. The woman did attend an outpatient appointment with the consultant urologist in early December, at which she said she did not attend for surgery in October because she did not want an anaesthetic. The consultant urologist discussed the risks of her decision with the woman. Although she was not willing to have her stent replaced, she did agree to have it removed. It is not clear why she was willing to have surgery to remove the stent, but not to replace it. An appointment was subsequently made for the procedure to take place later in December. However, the woman changed her mind and again said she did not wish to attend. As previously, she signed a disclaimer to this effect.

29. In mid December, the woman was seen in the gynaecology clinic at the hospital after complaining of post menopausal bleeding for several months. She was assessed by a gynaecologist who recommended she return for a hysteroscopy (an examination of the womb). Although not documented in her notes the woman apparently refused to attend for this procedure. At the start of January 2006 the gynaecologist wrote to say that, on reflection, the woman did not need to undergo the procedure anyway as her symptoms had settled.

30. In early 2006 the woman complained of increased pain and bleeding from her stoma. She also said she had lost weight over the last year although prison records showed that, whilst her weight had fluctuated, it was similar to January 2005. During January 2006, the prison doctor wrote to the

hospital colorectal consultant and asked him to reassess the woman on account of her increased pain and bleeding. There is no response to this letter in the woman's medical record.

31. On the same day the prison doctor also wrote to the hospital consultant urologist to report that, on account of her pain, the woman had now agreed to have her stent removed. An appointment for this procedure was made for March 2006. On this occasion, the woman attended hospital and the stent was successfully removed. She returned in late April for a urogram (a scan of the urinary system) which showed that her kidneys were working well. The woman denied any further abdominal pain and was therefore discharged from consultant urologist's care.

32. Within six weeks however the woman's symptoms had returned. The prison doctor again referred her to the consultant urologist at the start of June, after the woman complained strongly of pain between her ribs and hip bone. She was admitted to hospital a week later after complaining of vomiting for 24 hours and pain in her abdomen and hernia area. She was discharged the same day, having been prescribed a course of antibiotics.

33. In mid July, the woman went for a consultation with the consultant colorectal surgeon. They discussed the benefits of reversing the colostomy and how the surgeon would be able to repair her hernia at the same time. The woman agreed to undergo the procedure and her name was put back on the waiting list.

34. A chartered forensic psychologist at New Hall completed a psychological assessment of the woman in early August. This was a standard report completed for all life sentenced prisoners, with the aim of assessing an individual's intellectual ability and their thinking strengths and weaknesses. The forensic psychologist concluded that the woman had limited ability to think and reason verbally and would find it difficult to process information. She recommended that staff spend time explaining non-routine situations to her and that information should be presented to her in small, manageable amounts.

35. Through the summer the woman continued to complain of pain in her kidneys and when passing urine. In September she submitted a complaint form saying that she needed a wheelchair as she could not walk out of her cell. She also asked healthcare staff to visit her on the wing because she could not walk to the healthcare centre. A prison nurse met the woman in her cell ten days later to discuss these issues. The woman said she needed a wheelchair to leave the wing to go to education or healthcare, but was able to move around the wing without a problem. It is not recorded whether any action was taken following this meeting.

36. A week later the woman complained of feeling hot and dizzy and was seen by the then lead nurse on E wing (who later became lead nurse in primary care at New Hall). She was offered the opportunity to go to healthcare in a wheelchair so that she could see a prison doctor but

declined. In October, a shower chair was delivered to E wing as the woman's reduced mobility meant she had been assessed as needing to sit down in the shower.

37. At the start of December the woman wrote a long letter complaining about the treatment she was receiving at New Hall. She said she was being "neglected by the nursing staff" because they were not giving her colostomy bags and she had been refused a wheelchair. It is not clear to whom this letter was addressed although it is stamped as having been received at the Mid Yorkshire Hospitals Complaints Department. There is no reply to the letter in her medical record.

38. A fast track referral was made to the local hospital in mid December as the woman had reported a tender abdomen and bleeding from her vagina. The referral was for a biopsy to determine whether she had gynaecological cancer. She subsequently attended an outpatient appointment with an oncologist (cancer specialist) towards the end of December. The oncologist saw no abnormalities.

39. Also towards the end of December 2006 the woman submitted a complaint form asking that she be taken to education in a wheelchair. This happened over the following two weeks, although on other occasions she was noted to have walked around the prison by herself.

40. A second referral was made in early January 2007, this time for suspected kidney cancer. In his referral note a locum prison doctor, said his suspicions were raised by an apparent lump on woman's right kidney and because of blood in her urine.

41. In mid January, a meeting was held amongst healthcare staff to determine the best way for the woman to get around the prison without encouraging her to become wheelchair bound. The panel concluded that she should be escorted around the prison by a nurse with whom she could link arms. A wheelchair would be used only if necessary.

42. A few days later the woman attended the local hospital following the prison locum doctor's referral in early January. The consultant was concerned about a lesion on the woman's bladder and arranged for her to return for a cystoscopy (examination of the bladder) and biopsy.

43. In early February, a Senior Officer (SO) reported to healthcare staff that the woman was not coming out of her cell at mealtimes and other prisoners had been fetching her meals for her. At her own request, the woman had recently moved back to the first floor of E wing after a spell on the ground floor. This move was on the condition that she was able to climb the stairs without difficulty. As a result of the SO's report, the woman was warned that if she did not come to collect her own meals she would have to move back to the ground floor. The woman did not agree and threatened to go on hunger strike and refused to attend her hospital appointments. A few days later in February she refused to attend an

appointment with a prison doctor unless she was taken in a wheelchair. Although she was told that the wing's wheelchair was being used by another prisoner, the woman refused to walk or wait for it to be free.

44. The woman was admitted as an inpatient to the local hospital in late February in order to undergo the planned cystoscopy and biopsy. The results showed that she had a fistula (an opening between the bowel and the bladder) which was allowing faecal matter to pass directly from the bowel to the bladder, causing persistent infection. It was decided to treat the woman with antibiotics and refer her to the consultant colorectal surgeon as an outpatient.

45. As part of her follow up treatment, the woman was due to attend the local hospital in March, for a scan similar to an x-ray. In the days leading up to her scan, the woman had said she was concerned about going through a 'tunnel', as happens in other types of scan. It was explained to her that this was not the case for her scan and nursing staff tried to persuade her of the importance of the procedure. However, the woman refused to attend and signed a disclaimer to this effect.

46. In April, a physiotherapist visited New Hall to assess the woman's mobility. He saw the woman walk for 50 metres and descend a staircase without problems. The physiotherapist also felt that she had no balance problems. He concluded that she was "fully able to walk long distances with no obvious limiting factors".

47. The woman attended an outpatient appointment at the local hospital in mid April, and was persuaded to undergo the scan. The consultant also noted that she had not been prescribed a particular antibiotic for the infection diagnosed in February. He arranged for a course to be prescribed.

48. An appointment was booked for the scan in early May, but had to be cancelled on the day as the scanner was broken. The scan eventually went ahead later in the month, although there is no record of the findings in woman's notes.

49. Prior to the scan the prison doctor wrote to the consultant colorectal surgeon to express concern over rectal bleeding that the woman had developed in the previous two weeks. He also referred to a lump on her abdomen and queried whether she might have a cancerous tumour. The woman subsequently went to an outpatient appointment in mid May, but there is no record of who this was with or the reason for the consultation.

50. A letter was received in healthcare from the woman's solicitor in May. It said that the woman was experiencing great difficulty walking, had been refused medication and that a chair was not provided for her to sit on whilst waiting for her medication. A reply was sent in mid June by a prison nurse. She said there was no medical reason why the woman was unable to attend to her own daily needs and she was being encouraged to be

independent. She went on to say that the woman was prescribed the maximum pain relief and continuous antibiotics, although she sometimes did not take it as advised. A chair was not allocated to the woman when she collected her medication as she did not queue with the other women. Instead, she was allowed to wait for the queue to go before collecting her medication. This also meant that she could spend time talking to a nurse every day, whilst collecting her medication.

51. A referral regarding suspected cancer was made to the local hospital in July. The memo said the woman was still complaining of rectal bleeding and still had a lump on her abdomen. An appointment was made for the woman to see the consultant colorectal surgeon. This was cancelled, however, as there were not enough escort staff available on the day. A second appointment was arranged for the end of July.

52. Also in July, the woman met the services manager of the Wakefield District Primary Care Trust. The purpose of the meeting was to address several issues that had been raised by the woman and her solicitor. Firstly, the woman had said she was not getting enough colostomy bags. It was agreed that she would receive four bags a day and be able to access more if required. A second issue was that she wanted to be taken to education in a wheelchair. She was reminded of the physiotherapist's assessment and that their advice was that she should be encouraged to walk as inactivity would lead to a deterioration in her mobility. It was also recorded that she had been given the opportunity to move to a wing closer to healthcare and education, but refused as she was settled on E wing. Several other issues were discussed, which included encouragement for her to eat healthier food.

53. The woman attended her appointment with the consultant colorectal surgeon at the end of July. At the appointment she denied all of her reported symptoms of bleeding. She said she still wanted to have the colostomy reversed and it was confirmed that she was still on the waiting list.

54. A few days later, a room was found in the hospital for the woman to undergo this procedure. She was admitted as an inpatient and had surgery the following day. She underwent reversal of her colostomy and a partial hemicolectomy (removal of part of the large bowel and adjoining together the remaining pieces of the bowel). To help this heal she had a temporary ileostomy (a procedure similar to a colostomy, whereby the end of the small bowel is brought to the surface of the abdomen, with a bag used as an outlet for the small bowel). The woman's hernia was also repaired during this surgery.

55. In the week following her discharge in late August, the woman's health deteriorated. She ate little and reported vomiting on several occasions. As a result, she was admitted as an inpatient to the local hospital in early September. She was discharged later in September, having been diagnosed with an infection of her surgical wound. On her return from

hospital, an ACCT form was opened as her mood was very low. She said she had nothing to live for and was distressed about having to wear a bag for “the rest of [my] life”.

56. The following day, the woman attended an ACCT assessment in the nurses room on E wing. She said that she “cannot bear the ileostomy” and was “devastated” to wake from her operation in August and find another stoma. Later that day, information was received that she may have been trading her tramadol (a strong painkiller) with other prisoners. It was decided that this should be administered to her directly by a nurse for the time being.

57. The ACCT was closed in early October. The woman said she was feeling much better and had been spending more time on association than previously. The following day it was noted that she was refusing to empty her stoma bags into the toilet and, instead, was putting them in plastic bags which she left in her cell.

58. In mid October, the woman’s solicitor again wrote to the prison. The solicitor said she was having difficulty getting to the visits hall without assistance and requested that a wheelchair be provided. A prison nurse replied a week later. She reiterated that the woman had been independently assessed as fully mobile and there was no physical reason to give her a wheelchair. However, they would ask a healthcare support worker to walk from E wing to visits with her to encourage her to be independent. The nurse also wrote that the woman “remains non compliant and appears unwilling to acknowledge any improvement in her health”.

59. In early November, the woman complained that her wound site was very sore. She told a nurse that she did not like to clean it on a daily basis, and was encouraged to do so. A few days later she attended an outpatient appointment with the consultant colorectal surgeon. It was noted that her wound had now virtually healed but she “hates the ileostomy”.

60. An appointment was subsequently made for her to be admitted to the local hospital to have the ileostomy reversed. However, the procedure did not go ahead as the woman had developed a chest infection and the join in her bowel had not healed properly. The consultant wrote to New Hall to say that the procedure would be re-arranged once it had healed fully.

61. Another ACCT form was opened at the end of November, following the woman’s return from hospital. She said that not having the operation was getting her down and she did not want to have to wait for several months to have the procedure.

62. Following a review of her risk assessment, the woman was allowed to keep her own medication again from the start of December. Over the following two months, the woman continued to complain that she needed a wheelchair to go to the visits hall. In January 2008, she moved to the

disabled cell on B wing (now part of the renamed Willow House). This is a more central location and meant that she did not have to walk as far to get to visits or healthcare. Although she was not formally classed as disabled, use of this cell meant that healthcare staff had more room to work when they visited her. The woman was not happy about this move. She was again advised that she did not require a wheelchair and that walking would help her to retain her independence.

63. The ACCT form was closed at the end of January. On the same day, the prison doctor wrote a referral to the consultant colorectal surgeon as the woman appeared to have developed a hernia at the site of her ileostomy. An outpatient appointment was booked.

64. In the weeks leading up to her appointment, the woman complained of tiredness and pain in her abdomen. However, on the day of the appointment, she refused to attend. An ACCT form was opened by a member of the prison's chaplaincy team. The woman told the chaplain that she "wants to kill herself and that she is better off dead". She threatened to cut the hernia out herself and said she was depressed on B wing and would be happier on E wing. She also complained of diarrhoea and said this was why she did not attend her hospital appointment.

65. The following day, information was again received that the woman was trading her tramadol with other prisoners. As a result, she was no longer allowed to keep this medication in her possession. A senior officer (SO) had received information that the woman was being bullied by other women who were taking her medication from her. Although she denied this was the case, the SO initiated anti-bullying strategies on some women on B wing. This initially involved monitoring the activities of the suspected bullies on the wing. The SO told the investigator that they had to take further action regarding some women and restrict their movements until the situation had resolved.

66. At an ACCT review in February, the woman said she was not looking forward to going to hospital for the reversal of ileostomy and was feeling low because of her medical condition.

67. At her own request, she returned to E wing at the end of February. Prior to the move, she told staff she was able to walk and did not require assistance. However, the following day she told a prison nurse that she could not go to healthcare without assistance. The prison nurse made the following entry in the woman's medical record:

> "The woman will try and manipulate the situation and use her health problems as a means to get her own way. This is a pattern she appears to have used in the past in association with her non compliance of healthcare advice."

68. In early March the woman was assessed by the prison nurse after telling night staff that she had used up her supply of colostomy bags. The prison

nurse established that the woman was changing her bags much more frequently than necessary. The woman said the bags had burst, but the prison nurse found no evidence of this after looking at the used bags. By frequently changing her bag, the woman was causing damage to her skin. The prison nurse reminded her that she had previously been shown how to change her bags correctly. On the same day the woman returned to the disabled cell on B wing, having been persuaded to do so by prison staff.

69. Nursing staff spoke to the woman about her use of colostomy bags on a further three occasions in the next ten days. She continued to use many more bags than necessary and claimed that they kept bursting, despite there being no sign of this in the used bags. It was reported that she had used 30 bags in eight days. She was advised that she should change the bag once every three days, to avoid damaging her skin.

70. The woman went back to the local hospital for an ultrasound in mid March, which showed that her kidneys appeared normal. However, the scan showed that the lining of her uterus was thicker than it should be. As a result, an urgent gynaecological referral was made. On her return from hospital, an ACCT review was held at which the woman said she was still feeling low and felt like self-harming at times. However, she said she was now happier on B wing and the staff were "lovely".

71. In late March, the woman was admitted as an inpatient to the local hospital for further tests. An x-ray showed that the join in her bowel had still not healed from November 2008, and an ultrasound confirmed the findings of a week earlier. The consultant advised that an appointment be booked for a hysteroscopy.

72. Three appointments were made in April for the woman to have the planned hysteroscopy. On the first occasion, she went to hospital but the procedure did not go ahead because she had a chest infection. On the other two occasions, she chose not to attend as she did not feel well enough. The hospital contacted New Hall to say that the woman would not be offered another appointment without a new referral, as she had refused to attend on three occasions. (This appears to contradict the reason behind the cancellation of the first appointment.)

73. Several ACCT reviews took place in April, and the woman continued to say that she felt down because of her medical condition. She said she worried about her treatment and was depressed because she did not think she would ever get better. On a more positive note, the woman said she felt supported by her friends on B wing.

74. In May, the woman attended a review with a prison doctor. She was persuaded of the importance of the hysteroscopy and agreed to undergo the procedure. The prison doctor also wrote to the consultant colorectal surgeon to ask that the woman be re-listed for reversal of ileostomy, as

she was “now asking again if she could have her operation”. It is not clear when she had asked to be removed from the waiting list.

75. A week later, the woman said she was experiencing pain in the night because she was not allowed to keep her medication in her own possession and take it when it best suited her. After discussion, it was agreed to give her ibuprofen to take at night.

76. The hysteroscopy went ahead in June, with nothing significant found. A week later the woman returned to the hospital for tests on her stoma site. The tests showed there was still a small leak in the join in the bowel, although the consultant colorectal surgeon felt it was at the stage where they could plan to reverse the ileostomy. Although there was some risk of further problems, the woman was happy to go ahead.

77. An ACCT review was held at the end of June, at which the woman said she was feeling depressed and was worried about her upcoming surgery, which had been scheduled for July. She said she would kill herself if they could not reverse the ileostomy, as she could not cope with it anymore.

78. The woman was admitted to the local hospital in preparation for surgery. The procedure was a success and, by the time of her discharge in August, she was able to open her bowels and had no additional problems.

79. In the week following her return from hospital, the woman had to be encouraged by nursing staff to walk to collect her medication, as a means of helping with her recovery. At the end of August, the woman was sick in her cell and said she could not eat solid food. Since her discharge from hospital she had been taking Fortisip (a nutritional supplement). However, she said that this also made her feel sick. She was allowed to have soup for each meal for a week instead.

80. On three occasions in the next week, the woman refused to get out of bed to collect her medication. She said she was unable to walk because she was too ill. Concern was also raised that she was not looking after her personal hygiene or keeping her cell clean. She was encouraged to do so. Nursing staff helped her clean her cell and walk down the corridor to collect her medication.

81. Despite her reluctance to come out of her cell, the woman’s ACCT form was closed in September. She was noted to be “more positive of late”. Over the following days, she complained of pain in her kidneys and lower back. She also said that she vomited on several occasions.

82. In mid September, the woman was admitted to hospital by emergency ambulance as she had a fast heartbeat and was short of breath. As at her previous admissions, she was accompanied by one officer and cuffed to him by means of an escort chain (a long chain with a handcuff at each end). Within two days of her admission, the escort chain was removed because of her weak physical condition and lack of mobility. It was not

reapplied. Over the next few days the possibility of sepsis (a blood stream infection) was considered. Some faecal fluid was drained and the medical team planned to do an IVU (a specialist diagnostic test that assists in the diagnosis of kidney and bladder disorders) and cystoscopy (scan of the urinary bladder via the urethra). The woman refused the IVU as she said she was not feeling well enough. Over the next few days her blood pressure repeatedly fell and her urine output was low. She continued to refuse both the IVU and a scan of her abdomen.

83. The woman refused to have a central line (a soft plastic type of catheter that is a means of giving medication, fluids, nutrition and taking blood samples) inserted despite it being explained that this and the scan of her abdomen might be necessary to save her life. The next day, her condition had deteriorated significantly. She was said to be "gravely ill" and slipping in and out of consciousness. The escorting officer felt that he needed support and a second officer was therefore sent out to join the bedwatch. The woman's son was contacted at HMP Frankland the following day and told of his mother's condition. The woman was moved into the intensive care unit.

84. Another ACCT form was opened by the head of security at New Hall. The woman had asked that she not be resuscitated were she to stop breathing and had signed the relevant 'do not resuscitate' form to this effect. The head of security at New Hall made the following entry in the ACCT document:

> "[The woman] has effectively refused medical intervention but her condition has deteriorated to the extent that she is no longer able to make a rational decision as to the interventions. The hospital has therefore started an aggressive treatment for her condition."

85. The woman was visited by her son towards the end of September, but was unconscious throughout. Her condition had improved by the end of September, and over the following days she was noted to be "argumentative" with nursing staff and said she was going to die. The woman was spoken to by the medical team. She said that she did want treatment and did not want to die.

86. In early October, the woman was transferred back to a ward. She refused several aspects of her care and experienced several panic attacks. She again refused to have a scan of her abdomen and, despite vomiting on several occasions, was very reluctant to allow nursing staff to wash her.

87. Through the remainder of the month, the woman intermittently refused treatment and medication. A consultant psychiatrist was asked to assess whether she had the capacity to make such decisions. His conclusion was that she had full mental capacity and that any decisions she made should be upheld.

88. In early November, the woman told the hospital chaplain that she did not want any further treatment. She was eating little and, in mid November, a doctor offered to insert a tube into her nose which would feed her. The woman said she would "rather be dead than have a tube put in her". In the following days, she continued to intermittently refuse medication and eat little.

89. By mid November, the woman was assessed as being towards the end of her life and a referral was made to the palliative care team at the hospital. Hospital staff asked how she would like them to respond if her condition continued to deteriorate. The woman said she did not want any procedures to take place even if it meant she would die.

90. The woman died in her sleep at around 3.45pm on 20 November. A post mortem report gave the cause of death as a pulmonary infarction (obstruction of the artery supplying blood from the heart to the lungs) caused by a pulmonary thromboembolism (a blood clot blocking the artery) which was due to an ileofemoral venous thrombosis from chronic pelvic inflammation with enterovesical fistula (a deep vein thrombosis caused by an infection of the pelvis). Her son was informed of his mother's death by staff at HMP Grendon, where he had recently transferred. The woman's funeral was held in December and was attended by her son. The funeral was arranged and paid for by New Hall.

## ISSUES

### Clinical care

91. The woman experienced a number of problems with her health throughout her time in custody. Following an operation for a perforated colon in 2003, she was required to wear a colostomy bag for several years. After further surgery to reverse the colostomy, she wore a second bag, for an ileostomy, for a further year as part of the recovery process.

92. During this time, she also experienced a recurrent urinary infection and other physical health problems, including asthma and arthritis. She experienced significant pain, although it was thought that she might exaggerate this on occasions. In the paragraphs below I discuss the clinical care provided to her at New Hall. This care was respectful and, in the main, appropriate.

### Managing the woman's colostomy and ileostomy

93. The woman had surgery for a perforated colon in September 2003, which required a colostomy. It is clear both from her records and from conversations with staff who knew her that the colostomy troubled her significantly. She seemed to have great difficulty understanding when and how to change her bag. In addition the experience of wearing the bag reportedly intensified her depression. This was exacerbated further following her ileostomy in August 2007, when the woman was said to be "devastated" to find that she still had to wear a bag.

94. The Roman Catholic chaplain at New Hall, told the investigator that the woman was "very conscious of her physical appearance and found her colostomy bag embarrassing". The chaplain went on to say that the woman was "frustrated by her ailments and saw it as her way of being in life that she was a sick woman".

95. The lead nurse in primary care at New Hall spoke to the woman on a number of occasions about her misuse of colostomy bags. The woman had been changing her bags much more frequently than necessary, which caused damage to her skin. She told staff that the bags kept bursting, although when her used bags were examined there was no evidence that this was the case.

96. A senior officer on B wing, said she thought the woman tampered with her bags "as an element of self-harm". She went on to say that the woman was able to care for her colostomy herself but preferred nursing staff to come to her cell and do it for her.

97. Given her dislike of the colostomy, it is surprising that she initially refused to undergo the reversal procedure in September 2005 and could not be persuaded to have her name put back on the waiting list for nearly a year.

She later refused to have her ileostomy reversed, in early 2008, despite having said she “cannot bear” and “hates” the ileostomy.

98. The lead nurse in primary care at New Hall thought the woman refused the surgery because of her mental state at time:

> “You have got to be mentally prepared for surgery and I think she probably was a bit depressed and she [had] kind of got used to it and did enjoy the attention. She did have a regular relationship with the nursing staff and the officers used to help her out as well … I suppose [she may have preferred] being an unwell person to getting better. I think she was hanging on to her illness, she seemed to be scared of getting better.”

99. In her clinical review, the clinical reviewer makes the following comment about the management of woman’s colostomy:

> “[There were] several challenges for the management of [the woman’s] colostomy. Her lack of concordance, abuse of the colostomy bags and frequency of changing, resulting in tissue damage around the stoma site … [the woman] was assessed as able to be independent, but again reluctant to manage her own stoma and cut colostomy bags to appropriate size, which could have resulted in further damage around the stoma due to faecal contamination … [the woman] throughout her time in prison refused nursing/medical intervention and surgical interventions, prolonging her time with the colostomy.”

100. The clinical reviewer went on to say that there was a “lack of comprehensive nursing action/treatment plan to facilitate consistent approach”. She also made the following comments about the management of the woman’s abdominal wound following her colostomy:

> “[the woman] had an abdominal wound following reversal of colostomy [with] very little documented intervention … [there was] inconsistency in wound management in part due to [the woman] refusing to attend for treatment interventions. No evidence of robust wound care documentation in which measurable outcomes could be monitored.”

**The head of healthcare should seek to improve the documentation of nursing interventions. This should specifically involve action and treatment plans for patients with long term physical conditions.**

**Pain relief**

101. The woman's son told the Ombudsman's senior family liaison officer that when he spoke to his mother on the telephone she said she was in a lot of pain. The lead nurse also told the investigator that the woman "had pain every single day". However she went on to indicate that the woman might play on her pain to get attention from staff, particularly if they told her she was looking well.

102. On some occasions, the woman was suspected of trading her tramadol with other prisoners. For the majority of her time in prison, she was given her medication by what is known as 'daily in possession'. This meant she collected a day's supply of medication each morning, with the intention that she then took it during the day as prescribed. There were suspicions that she was being bullied by other prisoners who wanted her tramadol. When she was suspected of trading tramadol, the woman was required to collect this particular medication four times a day and take it in the presence of a nurse. An SO initiated anti-bullying measures against those individuals who were under suspicion.

103. In the clinical review, the prison doctor makes the following comment on the management of the woman's medication:

> "Medication misuse continued to be well monitored and the usage of opiate drugs [tramadol] in particular was monitored, with some suspicion that she was not taking her medication but passing it onto others."

104. The clinical reviewer comments on the management of woman's pain:

> "[The woman] consistently complained of pain around the stoma, abdomen, loin and back. Each time she complained of pain she was referred to a [prison doctor] who reviewed and prescribed medication in accordance to the symptoms. [Prison doctors] made appropriate and timely referrals to secondary care … on occasions there was duplication due to [the woman] consulting different [prison doctors] within a short time line."

**A more robust system for monitoring referrals to outside hospital should be developed.**

105. However, the clinical reviewer also notes:

> "No validated pain assessment tool was implemented so [it was] difficult to monitor site, type, duration and intensity and quantify how much pain she was actually in … and was it acute, chronic or neuropathic."

106. The woman clearly experienced some considerable pain during her time in prison. Although she was, on occasions, suspected of trading her

strong painkillers, this was dealt with sensitively by prison staff. Whilst it has been suggested that she might have used her pain to get attention from staff, I am satisfied that her complaints of pain were dealt with appropriately. However, as the clinical reviewer indicates, the use of a pain assessment tool might have been beneficial to the woman and to staff.

**Nursing staff should implement pain assessment tools for those patients who experience pain on a long term basis.**

**Managing the woman's urinary tract infection**

107. On account of swelling in her ureter (the tube that connects the kidney to the bladder), the woman had a stent inserted in November 2004. In 2005, she continued to experience pain when urinating and was prescribed various antibiotics. The woman did not always take her medication, complaining of the side effects some caused. By June 2005, urine samples showed no sign of infection, although the woman continued to complain of pain. She initially refused to have her stent changed in October 2005, but agreed to have it removed five months later.

108. A scan in February 2007 showed the woman had a fistula (opening) between her bowel and bladder, causing a persistent infection. She was again prescribed a course of antibiotics, although there was apparently some delay to her receiving the course.

109. A doctor makes the following comment about the management of woman's urinary tract infection in the clinical review:

> "The treatment of her ureteric problems seems perfectly appropriate as does the treatment for her bowel bladder fistula which would have needed major surgery to repair and which was left under the care of the consultant colorectal surgeon to supervise. Treatment of urinary infections in the meantime seems to have been appropriate albeit with the possible delay of long term [preventative] antibiotic cover. Again her gynaecological assessments seem to have been appropriate given the compliance issues here."

110. The clinical reviewer also comments on the management of the urinary tract infection:

> "Nurses did undertake frequent [tests] … and made appropriate and timely referrals to the [prison doctor] … at times when [the woman's] urine output was diminished it would have been appropriate to monitor input/output and more robustly document findings."

111. The previous recommendation, regarding improvements to the documentation of nursing interventions, applies here as well.

**Mental health**

112. Prior to coming to prison, the woman suffered from depression for many years and was treated by the psychiatric services in her home area. Around a week after being remanded into custody in July 2003, she was assessed by a psychiatrist instructed by her solicitor. Although he considered that she had a learning disability, the psychiatrist concluded that she did not suffer from a mental illness and was fit to stand trial.

113. Three years later, she was assessed by a psychologist at New Hall who concluded that she had difficulty thinking, reasoning and processing information. The psychologist recommended that information be presented to her in small chunks and staff should take time to explain things clearly to her.

114. The woman spent a large proportion of her time in custody being monitored on ACCT documents. She was depressed by her medical condition and spoke strongly about her dislike of her colostomy and constant pain. On several occasions she spoke of wanting her life to end because of frustration at her condition. At one stage she told a prison chaplain she "wants to kill herself and that she is better off dead". In addition, a SO spoke of the woman sometimes "fiddling" with her hernia and inserting her fingers into her open wounds. As I have noted previously, despite her frustration, the woman did not always comply with her treatment plan, which was considered to be a form of self-harm.

115. Within ten days of her admission to hospital in September 2008, an ACCT document was opened because the woman was refusing all medical intervention. Other than intermittently taking her medication, she continued to refuse medical intervention for the remainder of her life, and told hospital staff she did not want them to treat her even if she was likely to die. The woman was assessed by a consultant psychiatrist at this stage, who concluded that she had full mental capacity to make these decisions and her wishes should be upheld.

116. The doctor comments in the clinical review:

> "Unfortunately no psychiatric assessment seems to have taken place [at New Hall] between her first assessment in 2003 until her death. During that time she received persistent antidepressant medication and it would seem from the fact that her compliance seemed to vary, that her mood may well have swung at times. I think it may have been helpful to have had a psychiatric opinion … The mental health issues would probably not have been resolved by psychiatric or psychological intervention but an assessment may have clarified some of the issues involved."

**Annual psychiatric assessments should be considered for women who take antidepressant medication on a long term basis and who continue to express suicidal feelings.**

## Mobility

117. Throughout her time at New Hall, the woman regularly raised concerns about her level of mobility. In autumn 2006, she complained that she needed a wheelchair to get around the prison from E wing and was being "neglected" by nursing staff as they refused to supply one. There were occasions during this time that she was offered a wheelchair to go to healthcare for a doctor's appointment, but declined. A prison nurse told the investigator:

> "She was quite happy [on E wing] despite the fact that she couldn't see the doctor, so you were kind of in a 'no win' situation. She wanted to come over to healthcare but physically wasn't able to so missed appointments."

118. The nurse went on to describe how this was addressed:

> "Essentially we accommodated her and we went over to see her in her cell … which wasn't ideal because you haven't got the equipment, the beds in the cells are very low so if you are trying to examine somebody it is quite difficult … it is not the same as having the facilities you have got within healthcare, occasionally we did bring her over in a wheelchair but sometimes she just didn't want to come."

119. A physiotherapist visited New Hall in April 2007 to assess the woman's mobility. He concluded that she was "fully able to walk long distances with no obvious limiting factors". It had been agreed at a meeting three months earlier that, if she had to walk around the prison, she would be escorted by a nurse with whom she could link arms if necessary.

120. Although the woman was concerned about her own mobility, she preferred to live on E wing where she was with her friends, rather than the more central B wing. In early 2007, she requested a move to the first floor of E wing, despite having recently moved to the ground floor on account of her mobility problems. She was then persuaded to move to B wing in January 2008, but returned to E wing for a week at her own request a month later. Prior to her return, she told staff she could walk without assistance and did not need to be on B wing. However, after her return to E wing, she refused to go to healthcare unless she was given some assistance. A prison nurse thought she was "manipulating the situation and using her health problems to get her own way".

121. The nurse's own view of the woman's mobility was as follows:

> "She was actually quite mobile if I am honest, she could walk … but [the woman] did walk very slowly and she was reluctant to walk long distances. There was no physical reason that we could ascertain why [this was] and I did encourage her to mobilise."

122. The SO said staff on B wing were also concerned about the woman's mobility:

> "There was a constant debate raised by the officers [and] myself about whether [the woman] was fit to walk to the dining hall, because she was telling us she wasn't. We must have asked that question more than ten times to the medical staff and the answer that kept being returned to us was that she was fit, that there was nothing restricting her movement.
>
> "We tried to get [the woman] as active as possible … she enjoyed it actually. Once she was out of her cell she was fine. The medical staff seemed to be right once she was more active she did move more freely."

123. Both the prison nurse and the SO thought the woman's mobility declined after her assessment of April 2007. The prison nurse thought it declined after her surgery in August 2007, saying that whilst the woman could still walk, she was "even slower" than previously. The SO said there was a "significant deterioration" following the woman's move to B wing in January 2008.

124. The clinical reviewer makes the following comment about the woman's mobility in the clinical review:

> "[The woman] appeared to adopt the role of a physically disabled individual and was reluctant to walk from an early stage of her admission to the prison environment. Nurses and other prison staff actively encouraged her to move. This on occasions resulted in conflict and formal complaints. A written action plan would have supported a universal approach to this problem."

125. It is clear from the woman's notes and from interviews carried out with staff that there was a discrepancy between what she thought she was capable of and what was expected of her by prison officers and healthcare staff. Although a mobility assessment was carried out in April 2007, it appears that her physical capabilities deteriorated over the course of the following year. Although I cannot be certain, it is possible that a second assessment might have come to a different conclusion.

**The disability liaison officer should arrange for an annual mobility assessment to be carried out for all women who have mobility problems.**

## Coordination of medical issues

126. The doctor makes the following comments in the clinical review about the overall standard of care received by the woman at New Hall:

> "From the evidence I have seen I feel [the woman] was well supported by a team of dedicated, helpful and supportive [staff] that got to know her over a considerable period of time and were therefore able to engage with her to whichever extent she wished.
>
> "However there does seem to be a lack of a dedicated team leader or indeed team meeting and discussion regards her individual problems and needs, along with the prison's needs in looking after her, and feel that this might be addressed."

127. Caring for the woman's numerous medical conditions was difficult and challenging for staff at New Hall. Her depression and reluctance to comply with recommended treatment only exacerbated these difficulties. The doctor suggests that a team approach might have helped to resolve some of the difficulties encountered. He recommends that this would be led by a named individual and involve multi-disciplinary case conferences with individuals assigned specific areas of responsibility. All decisions should be minuted and justified. The doctor also suggests that such a panel might involve medical representatives from outside the prison healthcare team.

**For women with complex health needs, a named individual should be assigned to lead regular case reviews involving a multi-disciplinary panel.**

## Commitment of staff at New Hall

128. As I have noted in the above paragraphs, the doctor considers the woman was well supported by staff at New Hall. She made regular demands regarding her care, her mobility and her location within the prison. I agree with the doctor's opinion in the clinical review that staff use of "persistent persuasion and encouragement" in dealing with these demands was appropriate.

129. The SO gave the example of the woman refusing to clean her cell when her colostomy bags burst and the contents went over the floor:

> "My personal approach was to go and negotiate with her, I didn't feel it was helpful to go down the disciplinary side … I don't feel [she] was the sort of woman that approach needed to be employed with because she would communicate with me … we would speak to her and [try to provide] a little bit of motivation and [show] understanding and empathy."

130. The clinical reviewer makes the following comment about the work of staff:

> “[The woman] presented several challenges with regards to refusing treatment [and] interventions.  The staff are to be commended for their persistence in trying to address [her] health needs when she lacked the motivation to do so.”

131. The Mid Yorkshire Hospitals NHS Trust commissioned a report into the clinical care afforded to the woman during her inpatient stay at the prison’s local hospital from September 2008 until her death.  I concur with their view that staff from New Hall who escorted the woman at the hospital “showed great empathy and kindness” towards her.

**Staff at New Hall should be commended for their commitment to helping the woman manage her complex health needs.**

## CONCLUSION

132. The woman's time at New Hall was dominated by her numerous physical health problems. Although she was in pain most days and said she "hated" her colostomy and ileostomy, she often refused to accept procedures or interventions that might have helped to resolve her problems. Her medical condition exacerbated her depression and she spent a lot of time being monitored on ACCT documents. Sadly, in the last months of her life, she became determined to refuse nearly all medical help, even though she was warned that this might lead to her premature death.

133. It is apparent that caring for the woman was particularly challenging for staff at New Hall. Her struggles, both physically and mentally, demanded a great deal of time and attention from both wing and healthcare staff. I am pleased to commend the commitment of staff at New Hall in this report. Nevertheless, there are some areas in which more could have been done to establish her needs. I hope the final recommendation, suggesting that a named individual lead regular case reviews for women with complex health needs, might resolve these issues in future.

**RECOMMENDATIONS**

1. The head of healthcare should seek to improve the documentation of nursing interventions. This should specifically involve action and treatment plans for patients with long term physical conditions.

   Accepted – System one [an electronic system of recording patients' medical details] now fully installed into all clinical areas in the establishment. System one user groups take place monthly with ongoing training. Chronic disease clinic now leads on action/treatment plans. Action/treatment plans are available for all residents with the clinical need.

2. A more robust system for monitoring referrals to outside hospital should be developed.

   Accepted – new management system and staff team in place, providing swift referrals to the appropriate services. Tele health has been installed to provide extra support to clinicians and offers an alternative referral source. PCT partnership working has provided new IT based solutions to the referral and monitoring workload. Robust management information is provided by HMPS to the commissioning board for assessment.

3. Nursing staff should implement pain assessment tools for those patients who experience pain on a long term basis.

   Accepted – lead GP now heads up the pain management service. Pharmacy/lead nurses and the GP team monitor individual cases through this service and the medicines management group.

4. Annual psychiatric assessments should be considered for women who take antidepressant medication on a long term basis and who continue to express suicidal feelings.

   Accepted – OPA process will identify the required system adjustments. Chronic disease clinic now in place.

5. The disability liaison officer should arrange for an annual mobility assessment to be carried out for all women who have mobility problems.

   Accepted – disability liaison officer has conducted a full site survey and needs assessment of the residents.

6. For women with complex health needs, a named individual should be assigned to lead regular case reviews involving a multi-disciplinary panel.

   Accepted – this approach is now in place and has recently tested on a very complex case. The results have proved positive with multi-agency working providing excellent care and effective results. Head of healthcare

now nominates a lead nurse, who will report to the multi-disciplinary panel (health operational forum).

## GOOD PRACTICE

1. Staff at New Hall should be commended for their commitment to helping the woman manage her complex health needs.