Investigation into the circumstances surrounding the death of a man in January 2007 following his release from the custody of HMP Bullingdon

Report by the Prisons and Probation Ombudsman for England and Wales

February 2008

This is a report into the circumstances surrounding the death from natural causes of a man at a local hospital in Oxford, on 5 January 2007. The man had been released from the custody of HMP Bullingdon that morning.

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

I offer my sincere sympathies to the man's family, friends and all those affected by his loss.

The investigation was conducted by one of my senior investigators, on my behalf. A clinical review into the care the man received while he was in prison was undertaken by a clinical manager at Oxfordshire Primary Care Trust (PCT). I am grateful to the clinical reviewer for conducting a very thorough inquiry that contributed greatly to the writing of this report. I am also grateful to the Governor and staff at Bullingdon for their co-operation with this investigation and clinical review process.

The clinical reviewer examined the medical processes in place to manage someone of this man's acute medical needs. She made 16 recommendations, many of which I am pleased to report have already been implemented by the prison. I have made one additional recommendation about the communication of urgent healthcare matters.

Stephen Shaw CBE
Prisons and Probation Ombudsman **February 2008**

CONTENTS

Summary	4
Investigation Process	5
HMP Bullingdon	6
Key Events	7
Issues	12
Recommendations	19

SUMMARY

The man suffered from diabetes. His wife had always helped him manage the disease and, when he came into prison, staff identified that he would need help to learn to manage it by himself. On first reception to HMP Bullingdon in November 2006, the man was admitted to the healthcare centre.

After they had stabilised his blood sugars over a period of around two weeks, healthcare staff discharged the man to ordinary location with an insulin pen in his possession. Each refill for his insulin pen should have lasted only five days. However, in the three and a half weeks that the man was on the residential wing, he only asked for one insulin refill. Prison officers had noticed that he was not eating properly, although he repeatedly told them that he was fine. During this time, the man complained to staff of joint pain and was prescribed ibuprofen. He did not tell staff that he had suffered from chronic gastritis before he arrived in prison.

On 22 December 2006, the man was found by a prison officer in a state of confusion in his cell. At the very moment the officer alerted the healthcare centre that the man needed urgent attention, the Clinical Manager was reviewing his record and noting the failure to manage his diabetes, coupled with the lack of follow up by healthcare staff. The Clinical Manager arrived on the wing within minutes of the officer making the call for assistance. The man was taken to the healthcare centre where he was urgently examined by a doctor. He was transferred to the Intensive Therapy Unit at the local hospital in Oxford.

The man’s blood sugars were effectively stabilised at the hospital over the next few days. However, his condition deteriorated and, following an endoscopy, it was found that he was suffering from a perforated bowel. In keeping with his religious beliefs, he refused a blood transfusion and died on 5 January 2007, just hours after being released having served the requisite part of his sentence.

INVESTIGATION PROCESS

1. Although the man was not in custody at the time of his death on 5 January 2007, I exercised my discretion to investigate his death because it occurred so soon after his release.

2. At the time that he died, Oxfordshire Primary Care Trust (PCT) had already commissioned a 'red' incident investigation into the circumstances surrounding his admission to hospital. (When there is a serious untoward incident, an investigation is launched by the PCT; 'red' is the highest priority and indicates an immediate investigation.) This red investigation was completed by a clinical manager at Oxfordshire PCT.

3. I appointed a senior investigator from my office, to conduct the investigation into the circumstances surrounding the man's death. The senior investigator liaised with Oxfordshire PCT, and agreed that the red incident investigation should proceed as planned and would form the basis of the clinical review for the purposes of this report. I wish to thank the clinical reviewer for the thorough and balanced review that she has produced.

4. This PPO report has been based on the clinical review and supporting documentation, and on a review of the man's prison files.

5. The man's wife contacted the investigator during the course of the investigation and outlined her concerns about her husband's care while he was at Bullingdon. Throughout the investigation process, his wife was in contact with my Senior Family Liaison Officer to whom she also spoke about her concerns. I trust that I have addressed these issues in this investigation report.

HMP BULLINGDON

6. HMP Bullingdon is a modern prison that can accommodate up to 963 prisoners. There are five wings made up of both single and shared cell accommodation. The majority of prisoners are category C, although some category B prisoners are received from the local courts.

7. Bullingdon has a 22-bed inpatients' healthcare facility, with clinical care available at all times. The outpatients' facility delivers a daily triage system, referring prisoners to a doctor as necessary. Medication is also dispensed from the facility. A General Practitioner (GP) is available for prisoners every week day and there is an on-call system at weekends and out of hours.

8. Her Majesty's Chief Inspector of Prisons carried out an unannounced inspection of Bullingdon in 2004. She found a prison that had "visibly improved" since an inspection that had taken place two years earlier.

9. Many of the recommendations that the Chief Inspector had made regarding healthcare in the earlier inspection had been achieved or partially achieved. Notably, she thought that there were sufficient healthcare staff in reception. She also said that the regime in healthcare had improved, and commented that it offered activities such as art classes and discussion groups about current affairs.

10. However, the Chief Inspector thought that "newly arrived prisoners who have an identified healthcare need should see a doctor as soon as possible". Although the prisoners were seen by a GP on the day following their arrival, they were not routinely offered symptom control before that GP appointment. The Chief Inspector made a further recommendation that "there should be systems to enable healthcare staff to administer symptom relief to new prisoners who require it on arrival".

11. The Chief Inspector expressed concern about the length of the waiting list to see a GP. She recommended an urgent review to address the situation. She thought that triage protocols should be developed to ensure consistency of care. (This investigation found a shorter waiting list for GPs, reduced from the two weeks recorded in the unannounced inspection report to four working days in the man's own experience.)

12. Finally, the Chief Inspector was concerned that healthcare staff did not follow up patients who did not attend their healthcare appointments. This is an area that the clinical reviewer examined in some detail in her clinical review.

KEY EVENTS

13. The man appeared at his local magistrates' court on 7 November 2006. He was convicted of drink driving and driving while disqualified and received a four month custodial sentence. Following his conviction, he was taken to HMP Bullingdon in Oxfordshire, arriving at about 7.00pm. It was noted on the Prisoner Escort Record that the man was a diabetic and his medication was in his property. No information was recorded about his blood sugar levels or whether he had administered insulin during the day or on the journey.

14. Upon reception at the prison, a staff nurse completed the man's first reception health screen. This involves an interview with a healthcare professional to determine if a prisoner has any medical needs that need to be addressed while in custody. During the assessment, the man told the nurse that he was an insulin dependent diabetic who took Mixtard twice daily. He said that he was Christian but did not specify that he was a Jehovah's Witness. He said that he binge drank regularly, but that he had not had a drink since the previous day. The nurse recorded his blood sugars as being 19.9 millimoles (mmols – a measurement of the concentration of chemicals in the body). The normal range is 3.0 – 5.5 mmols. When asked about his elevated blood sugar level, the man said that he had seen a doctor recently about it.

15. The man was admitted to the healthcare centre following the assessment because of his unstable blood sugar level. The night staff were briefed about his diabetic condition but no notes were made in the clinical record about his admission to the healthcare centre or any medication administered that evening.

16. Another nurse carried out a follow-up health screen the next morning (8 November). This screen is intended to explore a prisoner's health in more depth. She recorded the man's blood pressure and found it to be "elevated". His weight was recorded as 52 kilograms. The nurse has said that the man had no symptoms at the time of the screening but that he reported feeling dizzy beforehand. He told her that he had lost his appetite since being diagnosed with diabetes five months previously.

17. Later that morning, a psychiatrist carried out a mental health assessment to determine if the man was at risk of suicide or self-harm. He was not. During the assessment, the psychiatrist identified that the man suffered from Type 1 diabetes mellitus and that he had no history of hypo or hyperglycaemic attacks. Nevertheless, the psychiatrist referred the man to be seen by the prison GP that afternoon for further management of his diabetes. The GP reviewed the man's condition and agreed with the psychiatrist's diagnosis that he suffered from Type 1 diabetes. The psychiatrist took the man's blood pressure (it was 159/113, very high), and prescribed him medication for hypertensive disease.

18. The GP referred the man to the detoxification team to address his alcohol dependency. He prescribed him Thiamine and Vitamin B compound. There is no further note of contact with the detoxification team in the man's available records. A handwritten note with his name on it, found in his records, reads:

"*needs to see MO, shaking!! Has no detox!! Requires tablets*." No reference is made to this note in his continuous clinical record.

19. The man had a quiet night on the healthcare centre. The following day (9 November), healthcare staff started his insulin regime to stabilise his blood sugars. He was to remain on the healthcare centre until his blood sugars were stabilised. During his time in healthcare, staff observed him to be a quiet but respectful man who would occasionally play pool with other prisoners during association. His medical condition was monitored daily by staff and a record made in his medical notes every night and day. The GP continued to review the man's diabetes every few days.

20. On 24 November, the doctor decided that the man was fit to transfer out of the healthcare centre and onto the residential wing of the prison. A follow-up review was made on 26 November by another GP who recorded that the man had "much better diabetic control" and agreed that he was fit to transfer to ordinary location. The clinical review team spoke with the second GP. He recalled requesting that the man's insulin not be given in possession, although this was not recorded anywhere. This would have meant that he would have to collect his insulin daily and enabled nursing staff to check that he was administering it properly. The second GP's suggestion was never put into practice.

21. On 27 November, the first GP again reviewed the man. He recommended that the treatment for his diabetes continue and prescribed him some thin lancets to make it less painful to test his blood sugar. He was discharged from the healthcare centre and relocated to a residential wing.

22. When a prisoner is discharged from the healthcare centre at Bullingdon, a form is filled out by a member of staff to be sent to the outpatients' department. The form gives a basic overview of the prisoner's health and the medication he is taking. The man's form records that he needed his blood pressure taken weekly (the next date being 3 December), and that he was an "insulin dependent diabetic", who needed medication twice daily and was on medication for his blood pressure. There is in fact no record that the man's blood pressure was checked after his discharge from healthcare to the wing.

23. The man collected a refill for his insulin pen on 7 December, ten days after his discharge from the healthcare centre. An insulin pen should only last five days. This was the only occasion that the man collected a refill. A triage nurse told the clinical reviewer that it was an "oversight" that she did not notice that he had not been collecting his medication.

24. The man's wife spoke with my investigator during the course of the investigation and raised several concerns. Around 9 December, the man told his wife that he was experiencing joint pain, which he associated with exercise that he had been doing. He said that he had been taking paracetamol. The man also told his wife that he was being treated for hypertensive disease. He thought that the joint pain might have been connected to the new medication that he had been prescribed for his blood pressure. His wife advised him to speak to someone about the continued pain and to ask for something stronger than paracetamol.

25. The man had an influenza vaccination on 12 December. The nurse administering the injection said she asked him if he was "fit and well" and he confirmed that he was. She assessed him as fit for vaccination and vaccinated him accordingly. The nurse said that they did not discuss insulin because the man did not raise any concerns.

26. The man's wife had a telephone conversation with her husband on 14 or 15 December. He said that he had gone back to the healthcare centre about his joint pain and had been prescribed Nurofen (a proprietary brand of ibuprofen). He told her that he was suffering abdominal pains that were so bad that he could not eat. His wife told my investigator that her husband had a history of gastric problems and she advised him not to take Nurofen because it would aggravate his gastric condition. On his wife's advice, he stopped taking ibuprofen. There is no record that he spoke to staff about his gastric pain.

27. On Saturday 16 December, the man's wife visited her husband in prison. During her conversation with my investigator, she described his appearance as "emaciated, grey and dehydrated" and said that he kept biting his tongue and slurring his words. She asked two officers in the visits area whether her husband could see a doctor. The officer in the visits area remembered speaking to the man's wife on that occasion and rang the healthcare centre on her behalf. He asked if the man could see a doctor and was told that he would be "put on the list to be seen". Staff told the clinical reviewer that this meant that the man would see a nurse in the triage session the following Monday morning. Although his wife was initially reluctant to leave her husband without medical attention for two days, the man eventually agreed to wait for the triage session. No record was made of the telephone conversation with the officer or the wife's concerns in the clinical records.

28. At Bullingdon, triage sessions are held every weekday morning for prisoners who have medical problems. Prisoners present themselves at the triage clinic and, after examination, the triage nurse refers them to see a doctor if there is a medical need. Any prisoner can request an emergency medical appointment with a doctor if they are experiencing difficulties that require urgent attention. The man presented himself at the triage clinic on Monday 18 December. He was assessed and put on the routine waiting list to see a doctor. The next available appointment was Friday 22 December. The man did not request an emergency medical appointment. In her response to the draft report, the man's wife expressed her concern that he was not properly assessed on this occasion. It is her view that a health professional should have picked up the symptoms of a serious medical problem that she had observed on her visit two days before. She does not accept that her husband did not ask for an urgent medical appointment at that time.

29. The man spoke to his wife on Tuesday 19 December and told her that he was not going to see a doctor until the following Friday. During their conversation, he told her that he had asked to see a doctor before then. His wife said that she telephoned the prison straight after their conversation and spoke to a male officer. She told my investigator that she explained the situation to the officer,

who advised her that she should contact the man's solicitor to liaise with the prison on her behalf. She told my investigator that she was "outraged" by the tone of the conversation. She faxed a letter to the Governor that day, asking that her husband be seen by a doctor as a matter of priority. The letter also referred to her concerns about the prescription of Nurofen in light of his gastritis, and suggested that the medication for her husband's hypertension might have been causing him joint pain. She also contacted the man's Probation Officer who said that she would try and get through to the prison, but she did not hear back from her. The man's wife also did not hear from the prison.

30. The man's wife told my investigator that she tried to telephone the prison on Thursday 21 December and spoke to a female member of staff. She asked to speak to the healthcare centre but the officer refused to put her through. She was told that she would be contacted when there was a problem with her husband. The officer would not tell her whether her husband was in the healthcare centre or on ordinary location. There is no record of this conversation and no member of staff remembered speaking to the man's wife on this day.

31. The man was still located on a residential wing. He shared a cell with another prisoner whose condition meant that staff had to monitor him closely. They would chat to the man at the same time, and asked him if he was eating okay. He confirmed that he was. He routinely told staff that he was okay when they asked, and commented that he slept a lot in his cell.

32. On the morning of 22 December, the man failed to attend his doctor's appointment. A wing officer was working the late shift, starting at around 1:30pm. When he started his shift, he was told that healthcare had been called to see the man but they had yet to attend the wing. The clinical manager received a copy of his wife's letter at around the same time. She took the letter with her from the healthcare centre and collected his drug chart to review it. Upon review, the clinical manager realised that the man had not been collecting the medication required to manage his diabetes. The clinical manager immediately became so concerned that she made her way directly to the wing. At about the same time, the wing officer went into the man's cell to see if he was okay. Although he replied that he was fine, the officer was sufficiently concerned by his appearance to call for assistance from the healthcare centre. The officer's telephone call and the clinical manager's visit overlapped and she arrived at the man's cell within 15 minutes. The clinical manager made the following entry in the man's medical record:

    "Seen on wing, concerned that [the man] has not collected medication or attended GP appointment. Very concerned that he has not collected meals and that his cell mate has been worried about him. Could not tell me when he last checked his bm [blood sugar level] or took insulin. Appears emaciated, very weak. Blood sugar 26.7 ? reliability of meter. Admit to hcc [healthcare centre] immediately for further investigation. Dr informed and asked to see on admission."

33. This entry was made at 4:25pm. The GP assessed the man as being in a "collapsed state" when he got to the healthcare centre and immediately

requested that he be transferred to the Accident and Emergency Unit at the local hospital. He administered actrapid insulin (a form of insulin that is injected under the skin and works rapidly, lasting for up to 8 hours). Attempts to cannulate the man failed due to his dehydrated condition. Paramedics arrived and took over his care. He was transported to the hospital, where he was admitted to the Intensive Treatment Unit (ITU) with very high blood sugars.

34. The man's wife was informed at 9:27pm by the prison chaplain that her husband had been taken into hospital. She was told that her husband had collapsed. She made her way to the hospital as quickly as she could. When she got to the hospital, she found that he was disorientated and believed that he was still in his cell.

35. Over the next couple of days, the man's blood sugars were brought under control and his condition slowly improved. Staff at the hospital planned to transfer him out of the Intensive Treatment Unit and onto a ward. He complained of severe abdominal pain on 23 December, although he told staff that he thought it felt better the next day.

36. On 24 December, he was transferred to the surgical ward. The decision was taken to remove the man's restraints, although two officers remained with him. He was monitored closely by hospital staff and his condition was described as "stable but very unwell".

37. On 28 December, the man underwent a laparotomy (a surgical procedure to gain access through the abdominal wall to determine the cause of an unknown condition). The procedure revealed that he had a hole in his bowel and was suffering from peritonitis. His wife informed hospital staff that the man could not have the necessary blood transfusion because he was a Jehovah's Witness.

38. A governor at Bullingdon was informed of this development and arranged for duty governors to ring the hospital every six hours for an update. (Escort staff were present throughout the man's time in hospital.) A member of the chaplaincy team went to the hospital when the man was first admitted and offered to pray for him. The chaplain visited the hospital on three more occasions and liaised with the Jehovah's Witness pastoral team who supported the man and his wife during his last days.

39. The man's release date was 5 January 2007. A prison governor went to the hospital that morning with his property which he gave to the man's wife. The governor signed the release papers but noted that the man was unable to sign the paperwork because he was on a ventilator. Nevertheless, he was released from custody at around 10.00am on the morning of 5 January. Prison staff withdrew from the hospital and the man was surrounded by his family and people from his community church for the rest of the day. He died at 11:05pm that night.

ISSUES

Clinical Review

40. The clinical review was undertaken by a clinical manager for Oxfordshire PCT. She was assisted in her investigation by a governor at Bullingdon.

41. Oxfordshire PCT had been informed of a 'red' incident on 3 January 2007 and had commissioned a serious incident investigation. (In other words, an investigation into the care that the man received while he was at Bullingdon was already underway before he died.) Following his death, it was agreed between my investigator and the PCT that the serious incident investigation would form the clinical review for the purposes of my own investigation. This was explained to the man's family, who had no objection.

42. The clinical reviewer examined the man's prison records, including his medical records. She also interviewed a number of staff. (She kindly provided my investigator with notes for all of the interviews undertaken.) After conducting what I judge to be a very thorough review, the clinical reviewer has made 16 recommendations. She also made several interim recommendations at the beginning of the investigation process.

Was the man's diabetes effectively managed at Bullingdon?

43. The man arrived at Bullingdon with extremely high blood sugar levels. The Prisoner Escort Record recorded that he had diabetes and that he had "medication in property". There is no indication of blood sugars having been measured during transit and no mention of what medication he had. I agree with the clinical reviewer that more precise information should be recorded on the Prisoner Escort Record to inform prison staff about a prisoner's condition upon their arrival.

    The transit history record from custody/court to prison should include all health information on insulin dependent diabetics.

    For all insulin dependent diabetic prisoners arriving at the prison, staff should record details of any equipment or insulin accompanying them, recent food intake, blood sugar results and insulin details if staff or self-administered. Prisoners should see a GP at 9.00am the next morning for insulin prescription.

44. Upon arrival at Bullingdon, the man underwent the First Reception health screen. This is an opportunity for staff to identify all health concerns that might need attention while the prisoner is in their care. Unfortunately, the man did not tell staff that he had suffered from gastric problems or that he was a Jehovah's Witness. The seriousness of his diabetes was not effectively recorded on the first reception health screen. Again, I agree with the clinical reviewer's recommendations:

Staff conducting the first reception health screen should ensure that significant health conditions mentioned on the transit history record, especially insulin dependent diabetics, should be entered in prison healthcare records.

For insulin dependent diabetics, the first reception health screen should gather details of the prisoner's current diabetes management. All insulin dependent diabetics should go to healthcare inpatients for their first night and should see a GP straightaway or on the morning following their arrival.

45. The man was admitted to the inpatients' department because he had high blood sugar levels. He told staff that he had seen a doctor about it in recent months. Staff wanted to stabilise his blood sugars but he said that he did not normally manage his own diabetes as his wife usually looked after him. The clinical reviewer found that it was appropriate that the man was admitted to the inpatients' unit in order to stabilise his diabetes. I share the clinical reviewer's concerns that there is no record that observations were made or that he was given insulin to stabilise his blood sugar that evening.

On admission to healthcare inpatients, all patients should have baseline observations recorded, as well as care plans, and at least one night and one day observation.

46. The nurse covering inpatients during the night shift told the clinical reviewer that, during the handover, she was made aware that the man was a diabetic but that he did not require insulin. The clinical review goes on to say:

"His blood sugar the following morning was 3.1 mmols, so there is a general assumption that he must have had a dose of insulin the previous evening."

I note what HM Chief Inspector of Prisons said in her inspection report on Bullingdon: "A policy should be developed for record-keeping; it should emphasise the need for contemporaneous documentation and include a guide to filing medical notes." Accordingly, I endorse the clinical reviewer's recommendation:

There should be a general review of all record-keeping across the whole prison.

47. The man's admission to healthcare was an opportunity to ensure that he was competent to manage his diabetes himself. It was an opportunity missed. The clinical reviewer has noted that "there was no record that staff were confident that he could manage his own diabetes". Staff had not ensured that the man had the necessary training to use the insulin pen. They had not ensured that he had signed the compact to confirm that he had a blood sugar record book, and that he would produce the record book each time he collected medication. And despite identifying that he needed instruction as to how to manage his diabetes, staff did not take steps to ensure that he was capable of managing his condition before discharging him from the healthcare centre. I agree with the clinical

reviewer about the importance of ensuring a diabetic prisoner understands that he has some responsibility for the management of his condition.

A compact between individual diabetics and the healthcare team should be implemented, ensuring that the prisoner has signed the compact and has a blood sugar record book. Staff should be reminded that a blood sugar record book must be produced at every occasion that the prisoner attends healthcare, including when he collects medication.

48. Staff managed to stabilise the man's blood sugar and he was discharged to a residential wing on 27 November. A GP reviewed him before he was discharged and felt that he had "much better diabetic control". Nevertheless, the GP suggested that he should not be given his insulin pen in possession but be seen by a member of healthcare staff every day to ensure that insulin was being administered appropriately. Again, this was not recorded in the medical notes. The discharge procedure was followed and staff on the wing were alerted to the fact that the man was an insulin dependent diabetic who had medication in his possession (despite the GP's suggestion). Staff from the wing did not follow up how the man was managing his health condition. Officers told the clinical reviewer that they noticed that he did not eat regularly but, when they asked him, he reassured them that he was okay. Although the clinical manager confirmed that staff should have identified that the man was not collecting insulin regularly, no healthcare staff followed up how the man was managing his condition. I endorse the clinical reviewer's recommendations:

Before discharge from the healthcare inpatients, an assessment of the prisoner's competency to manage his own diabetes should be made. It should include assessing whether the prisoner understands his dietary needs and that the prisoner has been observed checking and administering his own insulin and been assessed as competent.

A policy should be developed setting out guidelines to determine whether an insulin dependent diabetic is fit to be transferred from healthcare inpatients to ordinary location.

49. The man was given an insulin pen when he was discharged from the healthcare centre. One pen should last a patient five days. He did not collect a refill for his insulin pen until 7 December, ten days after he received his first. In addition, there is no record that he was asked to present his blood sugar book when collecting his refill on 7 December. The nurse who gave the man his refill described it as an "oversight". He did not collect another refill. It was a further 15 days before he was discovered in a collapsed state in his cell. No action was taken by healthcare staff or wing staff during this time to address his failure to collect medication. The man was asked how he was by wing staff on a number of occasions and he assured them that he was fine. He did not proactively seek medical help or advice himself. The clinical reviewer has suggested the following checks be implemented:

A daily wing well-being record sheet should be developed for use by prison officers on ordinary location to ensure that all insulin diabetic prisoners are effectively monitored.

All insulin diabetic prisoners should have a weekly appointment with a Registered Nurse in healthcare outpatients to discuss how they are.

I am very pleased to note that these checks have been introduced at Bullingdon since the clinical review took place.

50. I also agree with the clinical reviewer that healthcare staff could have taken more steps to ensure that the man was prepared to manage his own condition on the wing. It seems that his condition was not monitored at all after he had been discharged from the healthcare centre. I understand that existing policies and procedures are being strengthened to ensure that healthcare staff monitor a prisoner's wellbeing on the wing. I also commend the idea of a daily well-being record sheet for prison officers to monitor the condition of insulin dependent diabetics. Such prisoners should also be seen by healthcare staff on a weekly basis. I understand and am pleased to note that many of these processes are now in place following the man's death.

Was the man's alcohol detoxification managed appropriately?

51. The man told staff that he was a binge drinker when he first arrived at Bullingdon. On 8 November, he was seen by a GP and a psychiatrist who concluded that "binge drinking rarely requires a detoxification regime". They prescribed him Thiamine and Vitamin B, which was in line with normal treatment for someone who is recovering from a binge drinking problem. Due to his reported weight loss, the GP decided to refer the man to the detoxification team in case the drinking was more than binge drinking.

52. There was an undated note in the man's medical file that said he needed to see a doctor because he was shaking and required detoxification. During interview, the clinical manager told the clinical reviewer that the man had completed the detoxification process.

53. The clinical reviewer found that the detoxification the man received was appropriate for his needs as a binge drinker. However, I agree with her recommendation that the healthcare referral system should be reviewed to ensure that all prisoners who are referred to other services by healthcare staff receive the services they need:

Generic referral forms should be developed.

Family issues

54. The man's wife raised a number of concerns about her husband's care at Bullingdon. She was concerned that he had a history of chronic gastritis and yet was still prescribed Nurofen, which she understood should not be taken by someone with stomach problems. However, the man did not tell staff at

Bullingdon that he had suffered gastritis or had a stomach condition. The clinical reviewer found that it was inappropriate to give non steroidal anti-inflammatory drugs (such as Nurofen) to patients with gastric problems. She recommended that all prisoners are explicitly asked during the reception process whether or not they have experienced any stomach problems. The clinical reviewer also suggested that a prescription flowchart should be followed every time that Ibuprofen was prescribed:

An Ibuprofen prescription flowchart should be implemented.

The first reception health screen should record all beliefs that might affect health treatment and record any stomach problems. Where stomach problems are indicated, this should be recorded on the drug chart and the prisoner should be referred to the GP for a full assessment.

A Patient Group Directive template (PGD) for the prescription of Ibuprofen should be introduced to the prison. ***(A PGD is a written instruction for the administration of named medicines in an identified clinical situations.)***

55. His wife was concerned that the man had been given medication to treat hypertension after such a short time in prison. The clinical reviewer found: "[the man] was being monitored and treated appropriately."

56. The clinical review concluded that joint pain is not a commonly recognised side effect of the medication that the man was given.

57. The man's wife understood that insulin had to be kept in a refrigerator and yet her husband had been given insulin to keep in his cell. The clinical review noted that insulin must be refrigerated until it is used and then should be kept at room temperature. The man was issued only one pen or refill at a time and had no need to keep the insulin refrigerated.

58. During her visit on 16 December, the man's wife was so worried by his appearance that she requested an officer call healthcare to secure him a doctor's appointment. Despite his wife's concern, the man did not have a doctor's appointment scheduled until six days after her visit. The clinical reviewer looked into this matter and discovered that the man would have had the opportunity to ask for an emergency appointment when he saw the triage nurse, two days after the visit. He did not ask for an emergency appointment and was put on the ordinary waiting list. The length of the waiting list was such that the man had to wait for four working days after his triage to be seen by a GP.

59. The man spoke to his wife on 19 December and she discovered that he had still not seen a doctor. She was worried about her husband's condition and wrote a letter which she faxed to the Governor that afternoon. The letter did not come to the attention of the clinical manager until 22 December. The clinical manager found it was likely that the prison department that processes correspondence did not handle the fax until 20 December when it was probably left in her pigeon hole. Unfortunately, the clinical manager was not working on 20 December and was in meetings on 21 December. She found the letter on 22 December. The

nature of the letter was such that a non-clinical member of staff would not have understood the urgency of the matter. As soon as she found the letter, the clinical manager reviewed the man's medical records and went to see him on the wing. I agree with the clinical manager that good record-keeping is essential for the good running of a healthcare centre.

The clinical manager should ensure that there is a system in place whereby all correspondence addressed to the healthcare centre or involving healthcare matters is reviewed within 24 hours by a suitably qualified medical practitioner to identify whether the correspondence requires immediate attention.

60. The man's wife told my investigator that she was shocked by the manner of both of the people to whom she spoke when she called the prison on 19 and 21 December. She did not take the individual's name, but thought that they called themselves the 'Duty Officer'. She tried to raise concerns about her husband but neither officer would put her through to the healthcare centre. There is no record of anyone from the prison speaking with the man's wife on 19 or 21 December. The clinical reviewer was assured that anyone who asked to speak to the healthcare centre would be put through. It is a matter of concern that the man's wife was not able to speak with healthcare staff to discuss her husband's condition. I cannot overstate the importance of a professional and helpful attitude of staff who answer the main enquiry line at the prison. Although his wife's claims cannot be evidenced, I hope that they represent isolated incidents and staff do facilitate all callers' enquiries, especially health-related enquiries, as far as possible. The clinical review makes the following recommendation, which I endorse:

A healthcare telephone record book should record all enquiries made to the healthcare centre.

61. On 21 December, the man's wife was told by one officer that she could not speak to anyone in the healthcare centre and that she would be contacted if there was a problem with her husband's health. The next day, she was contacted at 9:27pm to be told that her husband had been taken to hospital in a collapsed state around five hours before. Understandably, she has expressed her anger that her husband's condition had deteriorated so significantly before she was contacted by someone from the prison.

62. The man's wife was concerned that, when her husband was taken to hospital, he remained in restraints until 27 December. This is in line with Bullingdon's policy to restrain a prisoner until a Duty Governor has carried out a risk assessment. Once a Duty Governor has assessed the risk of a prisoner, the restraints can be removed. The man was in a critical condition when he left Bullingdon. While I do not criticise staff for following procedure, a risk assessment could have been made at the time that he was taken to hospital to avoid the use of restraints.

63. The man's wife was incorrectly told by an officer on 24 December that she needed a prison visiting order to be able to see her husband. In fact, following a governor's risk assessment, a prisoner's family can visit the prisoner during all

hospital visiting hours and not following prison visiting policy. The member of staff involved has now been reprimanded.

Conclusion

64. The post mortem determined the man's cause of death as peritonitis due to or as a consequence of a perforation of the small bowel. Other contributing factors were listed as chronic pancreatitis with diabetes mellitus and anaemia. The post mortem examination could not determine the reason for the perforation of the man's bowel. It was likely that his diabetic condition impaired his response to peritonitis because his physical state would have been weakened.

65. The man's death may have been caused by several factors but there was not one significant contributing factor. While it is not possible to say with certainty that his poorly managed diabetes contributed to his death, it is no less a matter of considerable concern that the management of his diabetes had degenerated to the point of collapse on the wing. The clinical review has identified a significant number of learning opportunities that I hope will enable Bullingdon to improve the care that they offer for diabetics.

RECOMMENDATIONS

These recommendations have been updated with the Prison Service's response to the report and the actions that have been taken since the draft report was issued in October 2007.

I have made one recommendation:

The Clinical Manager should ensure that there is a system in place whereby all correspondence addressed to the healthcare centre or involving healthcare matters is reviewed within 24 hours by a suitably qualified medical practitioner to identify whether the correspondence requires immediate attention.

The prison has introduced a policy for dealing with correspondence and indicates nominated persons to 'browse' incoming correspondence within 24 hours for any significant or urgent comment.

The clinical reviewer has made 16 recommendations. I list them below with a comment following each.

The transit history record from custody/court to prison should include all health information on insulin dependent diabetics.

An agreement has been made between the Clinical Manager and the transport provider to ensure more effective communication.

For all insulin dependent diabetic prisoners arriving at the prison, staff should record details of any equipment or insulin accompanying them, recent food intake, blood sugar results and insulin details if staff or self-administered. Prisoners should see a GP at 9.00am the next morning for insulin prescription.

The Clinical Manager has issued an operational instruction to healthcare staff to this effect. *A full and comprehensive document on the guidance and protocol for the management of diabetic prisoners has been produced and covers the process to be undertaken in reception.*

Staff conducting the first reception health screen should ensure that significant health conditions mentioned on transit history record, especially insulin dependent diabetics, should be entered in prison healthcare records.

The Clinical Manager has issued an operational instruction to healthcare staff completing first reception health screens. *The policy on reception screening has been adapted to include clear instructions that any information received from the escort record or other source is entered onto the EMIS record and is acted upon.*

For insulin dependent diabetics, the first reception health screen should gather details of the prisoner's current diabetes management. All insulin dependent diabetics should go to healthcare inpatients for their first night and should see a GP straightaway or the morning following their arrival.

The Clinical Manager has issued an operational instruction to healthcare staff completing first reception health screens. *This recommendation was partially accepted, with the following update:*

"This has been specifically included in the reception health screening policy and the diabetic policy. All insulin dependent diabetics are routinely admitted to healthcare inpatients for assessment if there are any concerns about their ability to manage their condition. Their blood glucose is recorded, and if they are stable and able to manage their condition, they are located on normal location; however, a GP is now in reception each evening and will see any diabetics with concerns. All other diabetics are reviewed by the GP the following day."

On admission to healthcare inpatients, all patients should have baseline observations recorded, as well as care plans, and at least one night and one day observation.

The Clinical Manager has issued an operational instruction to healthcare staff working in inpatients. *The protocol on healthcare inpatients admission is being reviewed to provide a more robust method of ensuring that all basic observations are recorded and that each patient has a comprehensive care plan. It is also a requirement that an entry is made 'per shift' on each patient's nursing notes.*

There should be a general review of all record-keeping across the whole prison.

This recommendation is under discussion with the Governor. *This recommendation has been accepted for healthcare. An IT and Data Quality Manager has bow been employed at Bullingdon. All record-keeping in healthcare is now reviewed on an annual basis by her. The remit of this post does not extend across the prison.*

A compact between individual diabetics and the healthcare team must be made, ensuring that the prisoner has a blood sugar record book. Staff should be reminded that a blood sugar record book must be produced at every occasion that the prisoner attends healthcare, including when he collects medication.

The Clinical Manager has issued an operational instruction to healthcare staff to remind them of the importance of the compact with insulin dependent diabetics. *This has been included in the comprehensive diabetic policy at Bullingdon.*

Before discharge from the healthcare inpatients, an assessment of the prisoner's competency to manage his own diabetes should be made. It should include assessing whether the prisoner understands his dietary needs and that the prisoner has been observed checking and administering his own insulin and been assessed as competent.

The Clinical Manager has issued an operational instruction to healthcare staff regarding the monitoring of insulin dependent diabetics. *A protocol for prisoners being discharged to the wing is being reviewed to ensure that all prisoners are fully assessed prior to leaving inpatients.*

A policy should be developed setting out guidelines to determine whether an insulin dependent diabetic is fit to be transferred from healthcare inpatients to ordinary location.

The policy was developed in May 2007. *The comprehensive policy document has been in use since May 2007.*

A daily wing well-being record sheet should be developed for use by prison officers on ordinary location to ensure that all insulin diabetic prisoners are effectively monitored.

The record sheet was devised in June 2007. *The recommendation was eventually not accepted. The prison responded:*

"If there were prisoners that the healthcare centre were particularly concerned about we would look at separate risk management procedures to manage individual cases."

All insulin diabetic prisoners should have a weekly appointment with a Registered Nurse in healthcare outpatients to discuss how they are.

The Clinical Manager has issued an operational instruction to this effect. *Clinics are held every week for diabetic prisoners. Insulin dependent diabetics are seen monthly and more frequently if required. This is in line with, and is more frequent than, community practice.*

Generic referral forms should be developed.

Action is still to be taken. *Generic referral forms have been developed.*

An Ibuprofen prescription flowchart should be implemented.

This recommendation is in progress. *This recommendation has been partially accepted. An Ibuprofen flowchart has been in place since 2004. It appears that the problem lies with a lack of awareness of its existence. This is being addressed with all staff being informed of it.*

The first reception health screen should record all beliefs that might affect health treatment and record any stomach problems. Where stomach problems are indicated, this should be recorded on the drug chart and the prisoner should be referred to the GP for a full assessment.

The Clinical Manager has issued an operational instruction to healthcare staff completing first reception health screens. *The reception health screening policy has been amended to include instruction that all prisoners' beliefs, either religious or otherwise, are recorded on the reception screen. Also that anything significant must be written on the prescription chart.*

A Patient Group Directive template (PGD) for the prescription of Ibuprofen should be introduced to the prison.

This recommendation is in progress. *A Patient Group Directive for ibuprofen is now in place.*

A healthcare telephone record book should record all enquiries made to the healthcare centre.

This will be implemented and accompanied by an operational instruction to all healthcare staff. *This recommendation has been partially accepted. A telephone record book is now in place, however, it is extremely difficult to record each call due to the sheer volume, therefore it has been agreed that all significant calls will be recorded.*