

**Investigation into the circumstances surrounding
the death of a man in April 2010 at hospital, while in the
custody of HMP Bedford**

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

February 2011

This is the report of the investigation into the death of a man who died in April 2010, at hospital, while in the custody of HMP Bedford. He was 81 years old at the time of his death.

I extend my condolences and those of my colleagues to the man's family and those that knew him. I trust this report goes some way to answering any questions they may have. I regret that my report is delayed and apologise for any additional distress that this may have caused to the family.

The investigation into the man's death was undertaken by one of my investigators. In addition to my own investigation a Quality Monitoring Manager from NHS Bedfordshire has undertaken a clinical review of his care whilst in custody. I am grateful to her for her review and I commend it to both the Governor and Healthcare Manager at Bedford.

I would also like to thank the Governor of Bedford and his staff for their help and assistance with this investigation. I also thank the liaison officer for his assistance to my investigator during the investigation.

Her Majesty's Coroner for the District of Bedfordshire and Luton informed the investigator that no post mortem examination was carried out on the man. However, the doctor at the hospital concluded that he died of natural causes, aspiration pneumonia (inflammation of the airways from breathing in stomach contents) and large cerebellar infarct (a stroke).

The man had a number of chronic illnesses for which he was treated at Bedford Prison. Having been taken ill on the morning of 21 April, he was admitted to hospital. Despite the efforts of medical staff, he died the following day at 1.40pm.

I endorse the recommendations made by the clinical reviewer that relate to the man's medical care. I also make my own recommendations for the Governor of Bedford. I am concerned about how emergency calls are made and that the man, a frail 81 year old, was restrained by an escort chain when he was taken to hospital.

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

Jane Webb
Acting Prisons and Probation Ombudsman

February 2011

CONTENTS

Summary	4
The Investigation Process	6
HMP Bedford	7
Key Events	9
Clinical Issues	18
Other Issues	23
Conclusion	27
Recommendations	28

SUMMARY

The man was sentenced to three years' imprisonment on 8 April 2009. On his arrival at HMP Bedford, he was assessed by healthcare staff and it was noted in his medical records that he suffered from a number of chronic diseases, including an enlarged prostate. Following the healthscreen, he was re-prescribed the medication that he had been receiving in the community. He had not been in prison before.

He was monitored in the prison's healthcare unit before being located on one of the prison's regular wings. On 25 April, he was assessed again by a nurse because of ongoing problems passing urine. He was admitted to the healthcare unit where staff completed a full assessment of his needs, including, washing, dressing, incontinence and medication management.

Over the following months, the man continued to receive treatment for his various conditions. On one occasion he signed a disclaimer refusing to go to an appointment for a bone scan. During his time at Bedford, whether in healthcare or on the wings, staff recorded that he appeared settled, was in good mood and engaged in conversation. No other issues or concerns were raised.

On 15 July, healthcare staff talked with him about his care needs as an older prisoner, for example, he required assistance to have a bath. However, he refused to accept support. Staff continued to monitor him and ensure that he looked after himself appropriately. He continued to take the medications prescribed to him.

Having been seen drinking his own urine on 29 August, he was assessed by one of the prison's psychiatric nurses. The nurse was unable to evidence any signs of mental health issues or risk of self harm. She reported that, although he presented as cheerful, he also appeared frail and was unable to recall his earlier actions. As a consequence, he was again admitted to the prison's healthcare unit. Staff noted that he had given the impression that his recent behaviour was as a consequence of not wanting to share a cell with another prisoner.

The man was discharged from healthcare on 1 September. Over the following months he was assessed regularly by the prison's mental health team, who continued to report no concerns. He continued to receive treatment for his conditions, reporting no problems or issues of concern with staff.

On 8 April, he complained of severe vertigo and was treated by nursing staff. He was given an anti-sickness tablet to ease his symptoms. For the following two weeks, no concerns were raised about his health.

However, in the early hours of 21 April, he began vomiting. The following morning, his cell mate told staff that he thought the man needed to see a doctor. His condition deteriorated. Although he was seen by a nurse mid morning, it was not until an emergency call was made for healthcare assistance at around lunchtime that he was assessed and arrangements made for his immediate transfer to hospital by ambulance. My investigator was presented with differing accounts by staff of what happened on the morning of 21 April.

Despite receiving treatment at hospital, he died at 1.40pm the next day. His next of kin who had been informed earlier of his condition, were making their way to the hospital when they were advised of his death.

My report concludes that, for the most part, his chronic conditions were treated appropriately. However, in light of the clinical review, I make a number of recommendations to the healthcare manager about care plans, prescribing and medical records. I also make five recommendations for the Governor of Bedford related to the emergency response and use of restraints during his transfer to hospital.

THE INVESTIGATION PROCESS

1. I appointed one of my investigators to conduct the investigation into the man's death. He opened the investigation on 29 April 2010, speaking with a number of staff at the prison, including the prison's family liaison officer.
2. The Ombudsman's terms of reference, and notices to staff and prisoners, were sent to the Governor at the beginning of the investigation. I understand that they were displayed around the prison inviting prisoners or staff to contact the investigator should they wish to. At the time of publication of the draft report, there had been no response to the notices. During the investigation, the investigator provided verbal and written feedback to the Governor of Bedford and to the prison's family liaison officer.
3. The investigator's contact details were made available to members of the Independent Monitoring Board (IMB) and the Prison Officer's Association. (The IMB are volunteers who monitor the day to day life of the prison to ensure that proper standards of care and decency are maintained.)
4. A review of the man's healthcare was commissioned from NHS Bedfordshire, the responsible primary care trust (PCT). The review was undertaken by a clinical reviewer.
5. My investigator reviewed the man's medical records and other prison documentation. He also interviewed a number of staff at the prison, in conjunction with the clinical reviewer, and spoke to the prisoner who was sharing the cell when the man was taken ill.
6. My senior family liaison officer wrote to the man's family informing them of my investigation into his death. Up to the circulation of this report, the family have not raised any concerns. However, I trust that my report explains the circumstances around his death and answers any questions that they may have.

HMP BEDFORD

7. HMP Bedford is a male local prison. The prison takes sentenced and remand prisoners from Luton Crown Court and Bedford and Luton Magistrates' Courts, as well as sentenced prisoners received as a result of overcrowding in London prisons. It has an operational capacity of 506 prisoners. The prison has been on its present town centre site since 1801. A new gate lodge, house block, and healthcare centre were added to the earlier Victorian wings in the early 1990s.
8. Healthcare services at Bedford are commissioned by the National Health Service (NHS), through the local Primary Care NHS Trust (NHS Bedfordshire). The provider arm of NHS Bedfordshire is Bedfordshire Community Health Services (BCHS). BCHS provides a healthcare team based in the prison. The team is made up of doctors, nurses and nurse managers. It provides diagnostics, including blood services, in-patient care, and an integrated drug treatment Service (IDTS), as well as other primary care services. A mental health in-reach team is provided by the South Essex Partnership Foundation University NHS Trust. Bedford's healthcare unit can accommodate up to 13 in-patients.
9. Since the Ombudsman started investigating deaths in custody in April 2004, there have been ten deaths at the prison, including that of the man's. One of the deaths, like the man's, was from apparent natural causes. I note that two issues dealt with in this report were also raised in previous investigations by this office: clinical record keeping and a lack of care plans.

IMB Report – 2008-2009

10. The most recent report by the prison's Independent Monitoring Board covered the period July 2008 to June 2009. The report raised no major issues with regard to the provision of healthcare at the prison commenting that:

"The Health Care Manager has overseen the day to day running of the unit with the help of two matrons, one in charge of the in-patient unit and the other clinics and administration. Regular team meetings have improved communication between staff members and the flow of information. During the year recruitment and retention of staff has improved with less dependency on agency nurses."

Inspectorate Report 2-6 March 2009

11. The last full inspection of Bedford, by the former Chief Inspector of Prisons, was in 2009. Her report noted that Bedford was:

"... a well-run prison with positive staff attitudes, which serves to mitigate some of these [its] problems and difficulties. This inspection, commendably, found that the prison was performing reasonably well. Healthcare services at Bedford were commissioned and provided by the local Primary Care Trust. Access to health services was generally good and the overall standard of care high. The healthcare centre was well resourced and fully staffed but

had little administrative support.”

12. The Chief Inspector went on to write that,

“Prisoners were treated professionally and respectfully, and we observed a number of helpful and supportive interactions between prisoners and health services staff. A member of the nursing team had recently been nominated as the lead for older prisoners. She had gained previous experience in the care of older individuals and had been involved in the development of a local policy for the care of older prisoners. This had yet to be fully implemented. There were 22 prisoners over 50 at the time of the inspection...”

13. The Inspectorate reported that medical records were maintained electronically using a computerised records system, as well as paper records. At the time of the inspection, records were up to date and comprehensive, and there was some evidence of care planning.

KEY EVENTS

14. In December 2007, the man was arrested and charged with a number of serious sexual offences. Having been convicted in February 2009, he was sentenced to three years imprisonment on 8 April. He was received into custody at HMP Bedford later that afternoon. It was his first time in prison.
15. On his arrival at the prison, he went through the reception process. As with all new prisoners he was assessed by one of the prison's nurses. The nurse noted in his electronic medical record (System 1), that he had recently been discharged from the mental health unit having been admitted several times over the previous ten years. He had received treatment at the mental health unit for the management of depression, associated psychosomatic symptoms (physical symptoms originating from mental or emotional cause) and suicidal ideas. He told the nurse that he had no current thoughts of harming himself. However, given his previous admission to the unit, the nurse made a referral for him to be assessed by one of the prison's community psychiatric nurses (CPN) and a doctor.
16. Given the man's recent contact with mental health services, he was located in the prison's healthcare unit and staff opened Assessment, Care in Custody and Teamwork (ACCT) procedures on him. (ACCT is the system used by the Prison Service to assess, observe and support prisoners who maybe at risk of harming themselves.)
17. The following day, 9 April, he was assessed by the prison doctor who obtained further details of his medical history from him. The doctor recorded on System 1, that he had undergone a cholecystectomy (removal of the gallbladder), suffered from irritable bowel syndrome (IBS a mixture of abdominal symptoms for which there is no apparent cause), and a hiatus hernia (where part of the stomach pushes into the lower chest through a defect in the diaphragm). The doctor noted that he suffered from an enlarged prostate, (which can cause problems with passing urine), and depression.
18. The doctor re-prescribed him with the medications that he had been taking whilst in the community. They included Lansoprazole (to reduce the production of stomach acids in the treatment of a hiatus hernia), Gabapentin (a strong analgesic used to control neurological pain, and used in the treatment of IBS), Nitrazepam (for insomnia), Duloxetine (to treat stress incontinence and depression), Tamsulosin (to treat the symptoms of an enlarged prostate), Beclomethasone (a steroid) and Tramadol (used for the treatment of moderate pain and symptoms of IBS).
19. That day, the man was seen by a number of staff including the prison chaplain as part of his induction. An ACCT review was completed and he was noted as being "... quite settled in mood and presentation", telling staff he neither had thoughts of harming himself, nor any other concerns at that time. He was assessed by two community psychiatric nurses from the prison's mental health team who encouraged him to speak to staff if he had any other problems.

20. Over the following week, he remained in the prison's healthcare unit. It was noted that he slept well and raised no concerns with staff. During ACCT reviews, he was recorded as being pleasant and polite when spoken to, and in good spirits. On 17 April, he was moved from the healthcare unit to the prison's vulnerable prisoners' unit. However, he refused to share a cell with a smoker, and returned to the healthcare unit later that day.
21. The man moved back to the vulnerable prisoners' unit on 20 April, sharing a cell with a non smoker. Later that day, he was found to have urinated in his clothing and told staff that he needed to be in the healthcare unit. Nurse A, was called to speak to him. The nurse spoke with one of the prison's doctors, who decided that there was no medical need for him to be located in the healthcare unit. On 22 April, he was issued with incontinence pads.
22. On 25 April, he was reviewed by a nurse about the problems he was experiencing passing urine. The nurse reported a strong smell of urine in his cell and noted that he should return to the healthcare unit for a full assessment of his needs, including washing, dressing, medication management, incontinence need, and dietary intake. He returned to the healthcare centre the same day. Over the following weeks, a number of blood and urinary tests were also undertaken with regard to the ongoing treatment of his chronic conditions. Although the records are not clear, it would appear that he moved back to the vulnerable prisoners' unit on 28 May.
23. Five days later on 30 June, as part of the ongoing treatment for his prostate condition, he was informed that he would require a bone scan. Nurse A noted in his medical record that:

“... he does not want to attend hospital re scan if has to be chained to an officer – would rather suffer the cancer – advised needs to discuss this with the Doctor.”

Although no discussion with the doctor is noted on System 1, he signed several forms to confirm that he refused medical treatment.
24. The man was moved back to the healthcare unit on 4 July, for further assessments, having been observed drinking his own urine. He was continually observed during his time in healthcare and over the following week, various entries on System 1 record that he appeared settled, was in good mood and engaged in conversation. No other issue or concerns were raised.
25. On 15 July, Nurse B, one of the prison's nurses, talked with him about his care needs as an older prisoner, for example assistance to have a bath. He admitted that he was unable to get in and out of the bath, but declined help saying that he was able to have a full body wash each day. Nurse noted: “doesn't feel he needs any help therefore an elderly care plan has not been opened. Staff to ensure that he changes his clothes and bed clothes regularly.”
26. He remained in the prison's healthcare unit. During his time there he took regular exercise, participated in association, cared for himself, and kept his cell

clean. He continued to take the medication prescribed to him and he expressed no issues or concerns. He transferred back to the vulnerable prisoners' unit on 27 August.

27. On 29 August, the man's cell mate reported to staff that he had been making tea using his own urine. He was seen again by one of the prison's community psychiatric nurses. She reported that he presented as cheerful but appeared frail and his cell smelt of stale urine. She spoke to him about whether he put urine into the kettle. He said he could not recall doing it and was transferred back to the healthcare unit for further supervision. She noted that consideration should be given to transferring him to a prison which was better able to meet his needs.
28. During interview for this investigation, Prison Doctor B was asked about the occasions where the man apparently drank his own urine and his problems of incontinence. The doctor's assessment was that he liked to be in healthcare under the care of nurses. He said:

“... there are instances where you'll find that things are said to us that he is incontinent and we can't keep him on the wings, you've got to keep him in healthcare, which we [then] automatically moved him back to healthcare and that relief on the wings as well. Because when he came over to healthcare there was no evidence of him doing anything mentally disturbed, drinking his own urine, and it was never witnessed, it was only witnessed by officers, it was never witnessed by a member of healthcare, and it's strange that in less than half an hour he comes to healthcare and we don't see any of that...”
29. On 1 September, he was again taken back to the vulnerable prisoners' unit. It was noted in his medical record that his recent behaviour may have been as a consequence of not wanting to share a cell. On 5 September, he was assessed again by Nurse C. She noted that he appeared settled, was chatty and showed signs of conventional and rational thought. The nurse noted that there was no evidence of any mental health problems.
30. The man was seen by Nurse C again on 27 September, having received reports from staff that he spent most of his time in his cell. He told the nurse that he preferred his own company and liked to stay in his cell writing and praying. The nurse noted concerns about his general hygiene and lack of showering, although reported that his cell appeared neat and tidy. He again declined offers of help with washing, including going to the healthcare unit for a weekly bath.
31. Throughout October and November he was reviewed regularly by the prison's mental health team. During this time it was reported that he remained “settled in mood”, expressed no concerns, and kept himself busy with crosswords and writing. Between 10 November and 24 February 2010, it was reported that he continued to take his medication and he continued to raise no issues or concerns with staff.
32. On 21 February, wing staff noted that the man, who although unable to work, went to education and continued to be polite to staff. Similarly, two entries in

March, described him as, "fine" and said that he remained the "same", being polite to staff and other prisoners.

33. Reporting to Prison Doctor C on 1 April, the man complained of a nasal blockage and a referral was made for him to be seen by an ear, nose and throat specialist at hospital.
34. On 8 April, he complained of severe vertigo and was seen by Nurse D. He told the nurse that he had experienced something similar the previous year, whilst being treated at the mental health unit. The nurse discussed him with Prison Doctor C by telephone. The doctor suggested that he should be given Buccastem, (an anti-sickness tablet that dissolves on the tongue and eases the symptoms of sickness).
35. An entry in the man's wing history sheets on 18 April, noted similarly to previous entries, that he continued to show no concerns and was relaxed in his manner.
36. The man's cell mate, who had shared a cell with him since 11 March, said that he was a typical 80 year old man who suffered from various aches and pains. He described the man as "a very private man" who rarely left his cell. He said that he never took a shower, preferring to get up very early in the morning to have a "strip wash" in the dark. The cell mate said that the man was always clean and tidy.
37. He said that, on the evening of 20 April, the man appeared to be his normal self and went about his daily routine. He said that the man watched the news and then went to bed at about 6.30pm. The cell mate told my investigator that there was no indication that the man was unwell.
38. The cell mate said that in the early hours of the morning of 21 April, he was woken by the sound of the man vomiting. He said he asked him if he was okay and he said, "Yes, I wish I was at home, it's so bad to be ill in prison." He said from that point the man appeared to deteriorate. He told my investigator that at around 8.00am the following morning he informed the wing officers that the man needed to see a doctor.
39. At 7.30am, Officer A completed a routine check of the man's cell. He told my investigator that the man and his cell mate were asleep and appeared fine. However, on unlocking the cell at 8.15am, he was told by the cell mate that the man had vomited throughout the night from about 2.00am. The officer said he was not "overly concerned" about the situation at the time saying, that although he thought the man seemed unwell, he appeared "okay in himself". Surmising that it might have been something he had eaten, the officer returned to the wing office and telephoned the healthcare unit to ask a nurse to attend at the earliest convenience. He told my investigator that he was told that healthcare staff were busy and that someone would come over "as soon they could".
40. The officer said that he continued to monitor the man until he awoke at around 9.40am. The man told him that he had felt unwell for most of the night and all he wanted to do was to sleep. The officer said that his voice was weak, that he

appeared feverish, and looked “very pale”. At 10.00am, Officer B also contacted the healthcare unit. He was also told that, due to a shortage of staff in healthcare, no one was available to attend to the man at that time.

41. At approximately 10.20am, Officer A returned to the man’s cell and told the cell mate that the man would need to be monitored until someone from healthcare was able to see him. The cell mate told the officer that the man had vomited again. The officer said he appeared “more feverish and slightly delirious”. He told my investigator that he was moaning and appeared to be “in a world of his own”. The officer noticed that there had been a “notable drop” in his condition. He advised him “to drink fluids and to try to get some more sleep”, still thinking that he may have been suffering from food poisoning.
42. During the investigation my investigator was told by staff of a number of different accounts of what happened on the morning of 21 April. I therefore report the differing accounts by staff separately.
43. According to Officers A and B, Nurse E, a Registered Mental Nurse (RMN), arrived on the wing at approximately 11.10am to hand out prisoners’ medications. Officer A recalled that the man was still in a feverish state and “had thrown up just prior to arrival”. The officer said that the nurse took his blood pressure and gave him his medication with a cup of water. He said the nurse told him she would be “back in ten minutes to give [the man] a better check over”.
44. The cell mate told my investigator that he asked officers several times during the morning for someone from healthcare to attend. He was told by the officers on duty that healthcare had been notified. He said that by the time Nurse E attended, more than three hours after staff were first told that he was poorly, he believed that the man had “had a small heart attack”. He told my investigator the nurse asked the man how he was, but he was “unable to verbally respond, slurring, mumbling and dribbling”. He said he helped the nurse to get him a cup of water, adding that at that time he was hunched over his bed with his head in his hands.
45. At approximately 11.45am, Officer C, who had previously worked as a healthcare officer, arrived on duty. Officer A said he told Officer C what had happened that morning. He said that Officer C checked the man immediately. Returning “in a state of urgency”, the officer said Officer C radioed for immediate healthcare assistance. He said:

“I looked in on the man who at this point was now slumped on the floor and was delirious. He was now vomiting up a green liquid and it was obvious that he was a lot worse than he had been approximately half an hour before.”
46. Within a few minutes of the emergency call, Officer A said that Nurse F, Registered General Nurse (RGN) arrived on the wing followed by Prison Doctor B. Officer A said that he made the call for an emergency ambulance, as instructed by the doctor, and then he returned to his normal duties on the wing.

The officer said that the man was taken from the wing shortly before 12.30pm.

47. In his incident statement, Officer C said that he arrived on duty at about 11.45am, although his official start time was not until 12.15pm. He told my investigator that on arrival at the wing he “could not recall” anyone else informing him that the man had been ill.
48. The officer told my investigator that at around midday Nurse E came to the wing office, where he and the other officers were sitting. According to him, the nurse told them that she would be talking to the doctor with a view to admitting the man to the healthcare unit for further observations. The officer said that he was on duty the lunch time period, when prisoners are locked in their cells. He explained:

“if there is a problem all the prisoners know there is a bell there to make us aware and his cellmate didn’t press the bell so the man obviously didn’t press the bell at the time. “
49. The cell mate told my investigator that he collected his own lunch and returned to the cell. He said the man was “turning himself around on the bed and tapping his leg asking for the time and where he was”. He said he again alerted staff to the fact that he was very ill between 12.00pm and 12.30pm. He said that by 1.00pm, “The man’s vomit was green and had blood in it, he was now sat on the cell floor and no one could move him”. He told my investigator that he thought that he “had a stroke and appeared unconscious”. He said that an emergency response nurse arrived at approximately 2.00pm and, on looking at the man, immediately called for an ambulance. He said it was at this point that he was moved to another of the wing’s cells.
50. At 2.30pm, Officer C said the cell mate told staff that the man was unwell and could not stand up. He told my investigator that this was the first time that he had seen the man that day. He said he “looked pale at that stage. He seemed to have a problem standing or supporting his own weight”. The officer said that some time between 2.30pm and 3.00pm he contacted healthcare, by telephone, asking for a nurse to attend immediately. Contrary to Officer A’s recollection, the officer told my investigator that he did not make an emergency call by radio. He said that he was instructed by Nurse F, the emergency response nurse, to ask for the prison doctor to attend immediately. He said that he tried to contact the doctor, but could not get in touch with one. Eventually, he called the healthcare centre and asked a member of staff to find the doctor and ask him to go to the vulnerable prisoners’ unit. As soon as the doctor arrived, he requested that an ambulance was called, which the officer requested at 3.10pm.
51. Nurse E told my investigator that on the morning of 21 April, the nurse scheduled to hand out medications on the vulnerable prisoners’ unit had called in sick. The nurse said that, in addition to dispensing the medications to prisoners on D wing, she was also tasked to dispense medications on the vulnerable prisoners’ unit. The nurse said that her duties on D wing took until about 10.45am to complete and, by the time she reached F wing, it was about 11.15am. When she arrived on the vulnerable prisoners’ unit, she was informed by one of the officers that a

number of calls had been made to healthcare for someone to attend to the man. She was told that he had been unwell the previous night, but that officers had been unable to obtain a response from the healthcare centre. The nurse went briefly to his cell, and then returned to healthcare to collect a blood pressure machine. When she got back, at approximately 11.30am, she took a number of his vital signs, including blood pressure and pulse, which were all within the normal range.

52. The nurse told my investigator that she gave him his normal morning medication. She put the medication in his mouth for him, and helped him to drink some water. She said that, as a consequence of him having a slightly raised temperature, she gave him paracetamol, without prescription, and removed some of his clothes to lower his temperature. During their conversation, she said that he was responsive and alert, but softly spoken. The nurse told him and the officers that she would discuss her observations with the doctor and return to the wing later.

53. In her incident statement, the nurse said that having returned to healthcare at approximately 11.50am she:

“... informed Prison Doctor B that the man was unwell, that he was unable to sit or stand and had been vomiting since the night before. He, the doctor, asked if the vital signs had been done, the readings were shown to him, he then said, ‘I will write up anti-sickness medication for him’. I personally handed the man the drug chart to so that the medication could be prescribed.”

The nurse said she handed the man’s drug chart to the doctor and that he prescribed the anti sickness drug, Buccasten.

54. She said that, shortly after lunch, she collected the signed prescription from the doctor and took it to the prison’s pharmacy. She said that between approximately 1.30pm and 1.45pm, she checked when the prescription would be ready and was told “very soon”. She said that, whilst she was in the pharmacy, she telephoned the officers to let them know that she would be returning with the medication. However, during the call she was told by one of the officers that the man had fallen, was unable to stand, and would need to be admitted to healthcare.

55. The nurse said she immediately left the pharmacy and informed Nurse F of the situation. She asked if preparations could be made for the man’s transfer to the healthcare unit. She said that when she and the other nurse started the process for him to be transferred to healthcare, just before 2.15pm, there was an emergency call for Hotel 2 on the vulnerable prisoners’ unit, (call sign for the emergency nurse). She said that Nurse F and Prison Doctor B, both nearby, responded.

56. In an entry in the man’s clinical record made at 3.01pm, the nurse recorded her interaction with him earlier that day. She recorded his vital signs, including blood pressure and temperature, and that she removed some of his clothes. She noted that she had given him 1000mg of paracetamol, had informed the doctor

of the situation and that he had prescribed anti-sickness medication.

57. Nurse F remembered that the emergency call was made sometime between 3.00pm and 4.00pm. He told my investigator that he responded immediately. He said that, on approaching the cell, he could hear "... heavy breathing like a rattly chest ...". On hearing the man's chest, the nurse said that he asked the officers to get the doctor "immediately". He says that the man, although conscious, was "breathing heavily", "did not have much movement with his limbs" and "could not hold his head up", so it was "hanging forward" in front of him.
58. Prison Doctor B had previously worked as a medical officer at the prison, and currently worked as a substance misuse specialist doctor. He told my investigator that at about 1.15pm he was told by Nurse E that the man had vomited once that morning. The doctor asked the nurse if she had any concerns. In interview, he recalled that the nurse told him "he looked well so it might be just a one-off, it might be just a stomach bug, it might be just a one-off". He looked at the results of the nurse's medical examination and agreed his clinical observations were normal. The doctor was asked to write a prescription for Buccastem. He told my investigator that he often does not see a prisoner himself in these circumstances: "lots of times it's just the nurse who sees them and gives us information".
59. He told my investigator that during his afternoon clinic, some time between 3.05pm and 3.10pm, he received a telephone call asking him to go to the vulnerable prisoners' unit immediately for a medical emergency. He said that, whilst making his way to the wing, he could hear that the man's chest was making a gurgling noise. The doctor said that when he got there "he was lying on the floor and there was bile all over the floor". He described him as just conscious, and unresponsive to commands. He told my investigator that he could tell the man was suffering from pneumonia because of the "gurgling" noise coming from his chest and "bubbles foaming from his mouth". The doctor described him as being "very pale" and "close to death". He said he "immediately called for an ambulance" and gave him oxygen, "that was the only drug I gave him".
60. The East of England Ambulance Service confirmed that the emergency call for an ambulance was made at 3.14pm. The ambulance arrived at the prison at 3.20pm; paramedics were with the man by 3.28pm and left the prison at 3.40pm.
61. Before the man left the prison staff completed an escort risk assessment. Restraints or handcuffs are frequently used on prisoners who are required to leave the prison. Before restraints are used, a security risk assessment is completed to ascertain the level of risk that a prisoner poses with regard to their potential to escape or to harm members of the community. The assessment determines the number of escorting officers and the type of restraint to be used (single cuffs or two metre long escort chain with a cuff at either end). It also determines the circumstances and the authority required for the restraints to be removed. The risk assessment completed on the man concluded that an escort chain would be necessary during his escort to hospital and until further

assessment by hospital staff had been completed. The closet chain was applied at 3.38pm, shortly before the ambulance left.

62. Nurse E said that she was told by Prison Doctor B to tell the officer that only one cuff should be used for the escort to hospital. (In interview she said it was the first time she had heard of the phrase but was told by Nurse F that it meant that only one of the man's hands was to be cuffed rather than both.)
63. On his arrival at hospital, the man was treated by accident and emergency staff. Blood samples were taken in addition to x-rays and a head scan. At 5.50pm escort staff were informed that he was most likely to have suffered from a stroke. He was subsequently moved to the hospital's stroke ward. During his time at hospital he remained cuffed until 0.44am on the morning of 22 April, when permission was sought from the prison for their removal.
64. The man's health deteriorated further during the night. At 1.20am one of the hospital doctors contacted the prison to obtain the contact details for his next of kin. An address for his brother was provided, although there was no telephone number. The hospital doctor advised that he did not want the prison to contact the brother via the police, so the information for contact was left with the hospital.
65. In the early hours a request was made for the prison's catholic chaplain to attend the hospital to give the man the Last Rites. The chaplain attended and also led prayers later that morning at 9.00am.
66. The prison's family liaison officer was told about the man's condition at 8.00am. The hospital told him that they had tried to contact his brother via the police, but had been unsuccessful. After looking through his records, the family liaison officer established that the man received visits from a friend. He contacted the friend and discovered the telephone number for the man's nephew. Contact was made with the nephew at 11.00am, and his brother was subsequently informed shortly before midday.
67. The man died in hospital at 1.40pm. The prison's family liaison officer telephoned the man's nephew and brother, who were on their way to Bedford, to inform him of the news. On their arrival at Bedford, the brother and nephew were met at the train station by another of the prison's family liaison officers and one of the prison chaplain's. They accompanied the family to hospital, where they spent some time with him. The funeral expenses were offered to the family and both prison family liaison officers attended representing the prison.

CLINICAL ISSUES

Chronic disease management

68. The clinical reviewer reports that the man suffered from a number of chronic diseases. They included benign prostatic hypertension (BPH), more commonly known as an enlarged prostate, irritable bowel syndrome, hiatus hernia and depression.

69. The clinical reviewer notes that his treatment for his prostate ranged from continued monitoring without active treatment, through to other medical interventions including surgery. In the review, she concludes that:

“The care the man received for his enlarged prostate was appropriate. He was referred to secondary services when the doctor suspected a combination of symptoms: urinary tract infections, confusion (assumed to be caused by the urinary tract infection), incontinence and pain in his hips and legs, indicating a possibility of the enlarged prostate being malignant.”

In her report she goes on to conclude that the man’s pain was treated appropriately.

70. The clinical reviewer also comments on the management of the man’s incontinence. She notes that, despite the fact that his symptoms were highlighted to staff, no immediate action was taken. It was not until several days later when he told staff that he was controlling his “leaking” by using toilet paper, that he was provided with incontinence pads. She reports that no record of an assessment of his incontinence needs was made. She reports that Department of Health (DH) and Royal College of Nursing (RCN) guidance recommends that full assessments and reassessments are made for those patients suffering from incontinence. She also reports that at the time of his condition, Bedfordshire Community Health Services (BCHS) employed a specialist continence team who would have been in a position to provide additional guidance and support, ensuring a good outcome.

71. Reporting on the man’s irritable bowel syndrome (IBS), the clinical reviewer said that, despite suffering from IBS symptoms, and him losing weight, there was no evidence of either bowel monitoring or dietary advice as suggested by National Institute for Health and Clinical Excellence (NICE) guidance.

72. However, she reports that the treatment of his hiatus hernia was appropriate, given that he was not suffering from any symptoms. She also reports that, based on the evidence available, his mental health treatment was appropriate and comparable to the care he might have received in the community.

73. The clinical reviewer made the following recommendation with regard to the management of the man’s chronic illnesses, which I endorse:

The Healthcare Manager, along with Bedford Community Health Service, should review the systems for managing chronic disease to ensure

compliance with NICE guidance and ensure that there is a full understanding across healthcare staff of relevant roles and responsibilities.

Communication between discipline and healthcare staff

74. In her clinical review, she comments on communication between wing and healthcare staff leading to the man's emergency admission to hospital. She reports that communication between them was not evidenced in either wing or healthcare records, despite at least three requests from wing staff for healthcare assistance on the morning of 21 April. She highlights that there is no formal process for the triage of a prisoner who needs to be seen urgently by healthcare staff on the wings, but does not require urgent medical assistance. (Triage is a process for assessing injured people into groups based on their need for or likely benefit from immediate medical treatment) In particular, she notes that there is no evidence that healthcare staff log calls from wing staff or assess the severity of a patient's needs. Additionally she reports that there is no process for nurses to refer calls for assistance to the wing nurse managers to action appropriately, if they are unable to take the appropriate action.
75. The clinical reviewer concludes that the wing staff acted appropriately in their treatment of the man given their understanding that he was suffering from an upset stomach. She writes that they appropriately escalated their concerns when his health deteriorated. However, she is concerned that the wing staff did not keep a record of who they spoke to. This would have been useful to ensure that an appropriate member of the healthcare team took details of his condition and was the best person to advise them.
76. I agree with the clinical reviewer's findings and her recommendation that:

The Governor and Healthcare Manager should develop a process which supports prison officers on the wing in order to access timely and appropriate levels of medical assessment.

The Healthcare Manager should develop a process for receiving, recording and actioning requests for healthcare assessments. Consideration should be given to using a communication tool such as SBAR, (Situation Background, Assessment, and Recommendation), to facilitate the recording of such information.

Nursing cover

77. The clinical reviewer established that on 21 April, the healthcare unit at Bedford was short staffed which was not unusual. She reports that there was no process in place to ensure that ad hoc requests for medical assistance were covered during periods of short staffing. She writes that "it is unclear how promptly the man would have been seen even if the unit was fully staffed".
78. She also notes that Nurse F was a mental health nurse originally employed to work in the prison's integrated drugs treatment service (IDTS). However, due to

injury, she had been assigned to work dispensing medications on the wings. The clinical reviewer says:

“Registered Mental Health Nurses would have a level of formal training in assessing physical health needs, but it may be pertinent to look at ensuring specific skill sets which a member of staff is employed for are considered, even during periods when staffing levels are not optimal.”

79. The clinical reviewer concludes that Nurse F acted appropriately by assessing the man, alerting the doctor and ensuring that the medication he prescribed was requested. However, she makes the following recommendation with regard to the skills profile of nursing staff:

The Healthcare Manager and Bedford Community Health Service should consider the skills set of nurses and other healthcare staff employed to ensure that their competence for additional and infrequently undertaken roles are considered in the allocation of duties.

Issues of un-prescribed medication and assessment for medication

80. Nurse E confirmed that it was normal practice to give paracetamol at Bedford without a prescription. The nurse said that she gave the man the medication to help him feel better while she sought further assistance from the doctor. The clinical reviewer concludes that the decision to administer paracetamol on the morning of 21 April was reasonable and would not have caused him any harm.
81. In her clinical review, she reports that the doctor prescribed the “appropriate medication” to treat the man’s vomiting, given the nurse’s assessment. Nurse E said that this is normal practice for doctors to prescribe in light of a nurse’s assessment, rather than seeing the patient face-to-face. She explained that there are not enough medical staff at the prison to see all prisoners who required prescriptions. However, the clinical reviewer considers that “the appropriateness of the practice needed to be examined to ensure that it facilitates access to treatment and does not impinge on the safety and quality of the service”.
82. In light of her findings, the clinical reviewer makes the following recommendation with regard to the prescribing and assessment of prisoner’s medication needs, with which I agree:

The Healthcare Manager and Bedford Community Health Service should stop all staff issuing medication which has not been prescribed immediately and introduce a system to enable prisoners’ access to appropriate, timely, over the counter medications.

Healthcare care plans

83. In her clinical review, she notes that “no care plans were opened” on the man by healthcare staff at Bedford. Even:

“when an action is recorded, for example to monitor weight, there was no record of frequency or plan. The recordings on weight, food intake, continence, hygiene and blood pressure all appeared sporadic and unstructured, with no evaluation of results and on occasions, no evidence of action.”

84. It is clear from his medical files that the man had difficulty managing “personal care activities”, including taking a bath. The clinical reviewer considers how this was managed by healthcare staff. There was no assessment of his personal care needs until 15 July when it is recorded that an elderly care plan was not opened as he denied needing support. There are no care plans in his medical notes. The clinical reviewer concludes that, “it would have been best practice to have a plan of care for staff to follow and evaluate progress against even if the patient did not want to participate”. She recommends that:

The Healthcare Manager and Bedford Community Health Service should review the current use of care plans for elderly prisoners ensuring that care needs are met and that any needs are assessed, actioned and evaluated appropriately.

85. The Department of Health publication ‘Guidance Notes – Prison Health Performance and Quality Indicators’ suggests that “all patients have an up to date care plan”. The man did not have such a nursing care plan. If he had, the plan would have formally set out what interventions healthcare staff were able to deliver and what he could have expected to do for himself.

Clinical record keeping

86. The clinical reviewer reports on the lack of clarity in the man’s medical notes about the timing of the medical care he received. According to his medical records, due to pain he experienced in his hips and legs, a bone scan was requested. However, he refused to go to the appointment, telling staff that he would rather die of cancer than be handcuffed to an officer in public. In line with procedure, he signed two ‘refusal of treatment’ forms. However, the clinical review writes:

“It is not evident in the records that a doctor discussed with the man the consequence of his decision [in receiving treatment] and no record of discussions with prison security are documented about the balance of medical need and security.”

87. In her clinical review, she also notes that medication charts were not completed, with vital details including dated of birth, name and prison number absent from a number of prescription charts. The clinical review also comments “that there is no record of the indication for the medication prescribed. This does not support informed prescribing decisions. The information should be recorded, assessed at relevant time intervals, and passed to other healthcare professionals involved in the care.”
88. She considers that there was evidence of some good record keeping practice by staff. However, she was concerned with some examples of poor record

keeping. In particular, she noted that System One did not record if an entry was face to face, third party contact or carried out remotely. She notes that System One did, "... not positively support structure data inputting, except on reception assessment, to include history, current medications, assessment, plan of care, outcome, and location of consultation." I endorse the following recommendation:

The Healthcare Manager and Bedford Community Health Service should complete an audit to assess current practice of record keeping, ensuring that it meets NHS Bedfordshire best practice. An action plan should be developed and implemented in order to improve the quality of record keeping, including medication chart records.

89. The clinical reviewer also notes that System One records the time the entry is made, rather than the time of the healthcare professional's contact with a patient. Therefore, there is no record as to when Nurse E actually had contact with the man on the morning of 21 April, although she made her entry on System One at 3.00pm. She makes the following recommendation:

Bedford Community Health Service should consider the efficacy of the current electronic data entry system to identify areas where the system could be improved to support the work they do. For example, data entries should include clear historical accounts of the patient and detailed documented evidence of patient examinations and contacts.

The clinical reviewer recognises that the IT system used by healthcare in Bedford is a national system and any requirements to improve forced positive actions of full communication recording would need to be effected at a national level.

OTHER ISSUES

Emergency response

90. My investigator could not confirm when the emergency call was made for healthcare staff to attend the man. Officer A said that Officer C radioed for healthcare assistance shortly after arriving on duty at 11.45am and that healthcare staff responded within minutes of the call being made. The cell mate said that the emergency response nurse (hotel 2) arrived at approximately 2.00pm. Officer C said that he contacted healthcare by telephone for immediate assistance and told my investigator that he did not make an emergency call by radio. Nurse E said that, whilst preparing the man's move to healthcare just before 2.15pm, she believed that the emergency call for Hotel 2 to attend the vulnerable prisoners' unit was made. Nurse F said that the call was raised sometime between 3.00pm and 4.00pm. Prison Doctor B said that sometime between 3.05pm and 3.10pm he received a telephone call to attend the vulnerable prisoners' unit immediately.
91. I am concerned about the discrepancies between these timings. My investigators are often faced with inconsistencies in timings when conducting investigations, which is understandable given the pressure of an emergency situation. However, the difference in timings on this occasion is unusual. When and how the emergency call to healthcare staff cannot be determined by the control room's daily incident log, where such calls must be recorded. However, the daily incident log recorded that the ambulance was called at approximately 3.13pm, which corresponds with the timings of East of England Ambulance Service.
92. I am concerned as to why there are so many differing accounts as to when the emergency call for healthcare staff was made. However, all accounts are in agreement that, despite when or how the call was made, healthcare staff responded immediately to the man's needs when it was understood that his situation was urgent. In her clinical review, the reviewer also comments on this issue and concludes that, "... once the man's condition had deteriorated and he needed urgent medical assistance, the response was appropriate and timely." She goes on to say that the action taken by Nurse F was appropriate, as were the actions of the doctor.
93. However, there is some confusion in the accounts of both discipline and healthcare staff as to whether the emergency call to healthcare was made via radio or telephone. I am once again unable to establish with any certainty what happened. The fact that control room staff did not log the time that the emergency call was made either signifies that one was not made by radio through the control room, and thus was not recorded, or that control room staff simply did not record the emergency call when it was made.

The Governor should remind all control room staff that all healthcare emergency calls for Hotel 2 are recorded in the control room incident log.

94. During the investigation, the investigator also discovered that there was no emergency code system in place at Bedford to notify the control room of an incident. As such, healthcare staff were not aware of the nature of the emergency that they had been asked to attend. Although I appreciate that there are no mandatory requirements to use an emergency code system, many prisons use a code such as red (for blood loss) and blue (for breathing difficulties). The codes inform staff of the nature of an emergency in language that is easily understood to ensure that appropriate medical equipment can be brought to as quickly as possible.

The Governor should consider the introduction of a code system for emergency calls.

Invitation to attend hot debrief and incident statements

95. I also note that a number of those staff involved in the response efforts on the afternoon of 21 April, did not attend or were not invited to attend the hot-debrief which took place the following afternoon. (A hot debrief provides staff involved an opportunity to talk through the incident. Its purpose is to establish what happened and to provide reassurance and support.) PSO 2710 directs that, immediately after the death of a prisoner, a hot debrief must be held.

The Governor should ensure that a hot-debrief involving all relevant staff takes place after any death in custody or other serious incident.

96. During the investigation, the investigator was provided with incident statements from some of the staff involved. However, he was told that not all those involved, including Nurse F, were asked to provide statements. My investigator was also not made aware of, or forwarded, the statement of Nurse E, only discovering that there was one during his interview with her. Although I make no formal recommendation, I remind the Governor of the importance of collating statements from all the staff involved in an incident and for them all to be passed to my investigators upon request.

Use of restraints

97. Restraints or handcuffs are frequently used on prisoners who leave the prison environment. Before they are used, a security risk assessment is completed to ascertain the level of risk that a prisoner poses with regard to their potential to escape and re offend.
98. On his transfer to hospital the man was placed under restraint by the use of an escort chain. Nurse F told my investigator that the man was conscious but "breathing heavily", had "little movement in his limbs" and was unable to help himself or move about. My investigator asked Prison Doctor B if the man had been restrained when he was transferred to hospital. The doctor said:

"He would have been cuffed, I don't know if it was closet or not but I know he would have been cuffed... Yes, security would have cuffed him."

99. The investigator and the clinical reviewer asked the doctor if, in his opinion, cuffing a frail elderly man was excessive. He said, "Yes, I don't think he should have been cuffed." However, Nurse E told my investigator that the doctor had told her to tell the escorting officers to use just one cuff, the escort chain, on his transfer to hospital.

100. Bedford's local instructions regarding the completion of risk assessments for prisoners being escorted out of the prison lists a number of considerations for staff to bear in mind, including the prisoner's health. Local Instruction 2.38, section 2 requires:

"The prisoner's medical condition. Where there is doubt, the prison medical officer must be asked to advise on any medical objections to the use of restraints, and assess the prisoner's ability to escape unaided."

101. Both I and the clinical reviewer are concerned that the man was restrained, by the use of an escort chain, when he went to hospital. The doctor apparently raised no objection to their use, even asking the nurse to ensure that only one cuff was used. The man was 81, was seriously ill, apparently barely conscious and had committed his offences some years previously. In this instance, I believe that the decision to restrain him was far too cautious.

102. It is the responsibility of a governor to judge the risk a prisoner poses when considering whether to use restraints. However, it is also for healthcare staff to contribute to that process fully and to be invited to do so. I note that Bedford's escort risk assessment document includes a section which records whether or not there are any medical objections to the use of restraints or medical conditions likely to influence the escort. The clinical reviewer makes a similar observation. She says:

"When there are non medical issues requiring a medical opinion in relation to the prisoner/patient, a structured conversation should take place between security staff and medical staff which is documented, ensuring the patient's dignity is appropriately assessed and addressed whilst security is maintained and risks managed appropriately."

103. I understand the difficulties that staff face when considering whether or not restraints should be used during a transfer of a prisoner to hospital and I acknowledge the security implications of such a decision. However, whilst risk assessments should be thorough, and public protection is a fundamental priority for the Prison Service, a balance should have been struck between the risk that the man was as an older man in a critical condition. I do not think that an escort chain, as well as two escort officers, was necessary. I am however pleased to note that the restraints were removed several hours before he died. I therefore make the following recommendation:

The Governor should ensure that the minimum level of restraint is used especially for frail, elderly prisoners who are critically ill.

Delay contacting the man's next of kin

104. It was not until the morning of 22 April that one of Bedford's prison liaison officers was informed of the man's condition. Although efforts had been made the previous night, by both the prison and the hospital, to identify and notify the next of kin, they were not informed until shortly before midday the following day, nearly 24 hours after he was taken ill.
105. Good communication with the family at this very emotional time can provide support and comfort. It also ensures that the practicalities following a death can be carried out sensitively. I appreciate that it can sometimes be difficult to balance security and concern for the rights of family and friends, especially during an admission to hospital. I also appreciate that prisons do not automatically notify next of kin when prisoners are taken to outside hospital for treatment. To do so for minor ailments or pre-arranged appointments would be disproportionate. However, if a prisoner is admitted as an emergency the prison should notify their next of kin as soon as possible. Indeed Prison Rule 22 states that:

"Notification of illness or death 22. - (1) If a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of mental disorder, the governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed."

106. I appreciate, however, that on occasions prisoners may not wish their next of kin to be contacted upon their admission to hospital, even for a serious illness. On such occasions, their wishes should be respected. However, when an individual cannot give his consent or otherwise, due to incapacity, the recorded next of kin should immediately be informed of the situation. As a consequence, I make the following recommendation:

The Governor should remind staff that a prisoner's next of kin should be told when a prisoner is admitted as an in-patient to hospital or for other potential serious conditions, at the earliest opportunity. Should a prisoner be insistent that their next of kin is not informed, this should be recorded in the bed watch log.

107. I understand that some prisons include a section in the escort risk assessment which records the details of the next of kin, and whether contact has or should be made. Although I make no formal recommendation, the Governor may wish to consider introducing such a change to his own risk assessment process.

CONCLUSION

108. My investigation has been frustrated by the differing accounts recounted by staff as to the events of 21 April, and the lack of post incident statements completed by staff. Although these inconsistencies have proved to be testing in establishing the sequence of events, I do not believe that the differences would have impacted on the eventual outcome.
109. In her clinical review, the reviewer indicates that the man's chronic condition or management of his conditions, in her opinion, did not affect the eventual outcome. She says that although making recommendations for improving practice, none of the factors highlighted would have altered the outcome in his case.
110. I agree with the clinical reviewer's findings and, although making a number of recommendations myself relating to the emergency response, I similarly believe that these would have had no bearing on the eventual outcome.

RECOMMENDATIONS

1. The Healthcare Manager, along with Bedford Community Health Service, should review the systems for managing chronic disease to ensure compliance with NICE guidance and ensure that there is a full understanding across healthcare staff of relevant roles and responsibilities.

Accepted - *Currently in process of managing into place chronic disease/LTC clinics. A Professor is developing the process and templates that will be used to collate the information, first clinic (respiratory) took place on 12-01-11.*

2. The Governor and Healthcare Manager should develop a process which supports prison officers on the wing in order to access timely and appropriate levels of medical assessment.

Accepted - *Nursing Triage agreed, utilising Odyssey triage system, to be implemented in Jan 31st. Moving from Triage have agreed walk in nurse led clinics as a further development to be held on main treatment on main wings.*

3. The Healthcare Manager should develop a process for receiving, recording and actioning requests for healthcare assessments. Consideration should be given to using a communication tool such as SBAR, (Situation Background, Assessment, and Recommendation), to facilitate the recording of such information.

Accepted - *Part of triage system.*

4. The Healthcare Manager and Bedford Community Health Service should consider the skills set of nurses and other healthcare staff employed to ensure that their competence for additional and infrequently undertaken roles are considered in the allocation of duties.

Accepted - *Utilising nurses with appropriate skill sets to triage and run clinics for GMS patients.*

5. The Healthcare Manager and Bedford Community Health Service should stop all staff issuing medication which has not been prescribed immediately and introduce a system to enable prisoners' access to appropriate, timely, over the counter medications.

Not Accepted - *Patient Group Directives (PGDs) sub group in place to generate PGDs for nursing staff to administer medication against. Not accepted as this instruction would preclude use of PGDs. Staff do not issue medication that is not prescribed.*

6. The Healthcare Manager and Bedford Community Health Service should review the current use of care plans for elderly prisoners ensuring that care needs are met and that any needs are assessed, actioned and evaluated appropriately.

Accepted - *Referral system in place for Care of the Older Person from Well Man*

Assessment screen. Patients then assessed and care plan put in place if appropriate

7. The Healthcare Manager and Bedford Community Health Service should complete an audit to assess current practice of record keeping, ensuring that it meets NHS Bedfordshire best practice. An action plan should be developed and implemented in order to improve the quality of record keeping, including medication chart records.

Accepted

8. Bedford Community Health Service should consider the efficacy of the current electronic data entry system to identify areas where the system could be improved to support the work they do. For example, data entries should include clear historical accounts of the patient and detailed documented evidence of patient examinations and contacts.

Accepted - *Relaunch in process for System 1 ,new templates configured, 2 days training for all staff to learn how to use S1 effectively .Transfer to new system occurring on 28th Jan, GO LIVE date 31st Jan. This will include reconfiguration of how S1 looks, and of the data and how it is added to the system. Read codes will be utilised to create data sets, new template development agreed as appropriate.*

9. The Governor should remind all control room staff that all healthcare emergency calls for Hotel 2 are recorded in the control room incident log.

Accepted - *Instruction to Control Room staff to be issued reinforcing the requirement for all health care emergency calls to Hotel 2 to be recorded in the Control Room Incident Log.*

10. The Governor should consider the introduction of a code system for emergency calls.

Accepted - *This has been considered, however, the Governor feels that responses to all incidents are already consistent and treated with the highest priority.*

11. The Governor should ensure that a hot-debrief involving all relevant staff takes place after any death in custody or other serious incident.

Accepted - *Contingency plans to be reviewed to ensure they include a requirement to hold a hot debrief involving all relevant staff following any death in custody or other serious incident.*

12. The Governor should ensure that the minimum level of restraint is used especially for frail, elderly prisoners who are critically ill.

Accepted - *Review LSS cuffing procedures to ensure they are appropriate for any prisoner that is taken critically ill, especially frail, elderly prisoners.*

13. The Governor should remind staff that a prisoner's next of kin should be told when a prisoner is admitted as an in-patient to hospital or for other potential serious conditions, at the earliest opportunity. Should a prisoner be insistent that their next of kin is not informed, this should be recorded in the bed watch log.

Accepted - *Review LSS to ensure consideration is given to informing prisoner's next of kin at the earliest appropriate opportunity where a prisoner is deemed to be severely/critically ill. If a prisoner insists that next of kin not be informed, this should be recorded in the bed watch log and this protocol should be included in the review.*