Investigation into the circumstances surrounding the death of a man in May 2010 at a hospital while in the custody of HMP Belmarsh

Report by the Prisons and Probation Ombudsman for England and Wales

June 2011

This is the report of the investigation into the circumstances surrounding the death of a man in May 2010, at a hospital, whilst he was in the custody of HMP Belmarsh. He was 43 years old. The post mortem report noted that the man died of natural causes due to heart disease and a cardiac arrest. I extend my sincere condolences to the man's daughter, family and friends. I must apologise for any anxiety caused by the delay issuing my report.

One of my investigators carried out the investigation on my behalf. A review of the man's medical care was commissioned with Greenwich Primary Care Trust (PCT). I am grateful to two clinical reviewers for carrying out that review, which is annexed to this report.

I would like to acknowledge the assistance from the Governor of Belmarsh and his staff. Particular thanks go to the liaison team for their help with this investigation. Furthermore, I am grateful to the head of healthcare and his team for their help.

The man complained of severe chest pain. He collapsed while he was being assessed by a nurse. Despite resuscitation efforts, the man was taken to hospital where he was pronounced dead.

I make ten recommendations for the attention of the Governor, the Head of Healthcare and the Chief Executive of NHS Greenwich PCT. I consider the management of healthcare services, training healthcare staff, the quality of entries in clinical records, working with locum doctor agencies and chronic disease management. I also comment on the lack of information provided by the prison's family liaison officer to the investigation. Finally, I note the professionalism of an officer who carried out resuscitation following the man's collapse.

In this final report, Belmarsh have accepted six recommendations and partially accepted two recommendations. At the circulation of this report, NHS Greenwich PCT has not responded to their recommendations. One of my family liaison officers has been unable to make contact with the man's daughter, to ask if she would like to see the draft report. A copy of the final report will be retained by my office should the man's daughter, or any member of his family, ask to see it.

Jane Webb
Acting Prisons and Probation Ombudsman **June 2011**

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SUMMARY

1. The man was remanded to HMP Pentonville in September 2009 charged with murder. His reception health screen document noted that he had several chronic diseases. (This document is completed when a prisoner first comes into prison and records their general health and any medical conditions.) The man told staff that he had gout, asthma, high blood pressure, high cholesterol and depression. He was assessed by a doctor and appropriate medication was prescribed.

2. Following a court appearance, the man was taken to Belmarsh in December. On examination his blood pressure was noted to be high and his medication was reviewed. However, the man said that he did not need any further medication for depression. A chart to monitor his blood pressure was started and weekly reviews were planned.

3. A non urgent x-ray was ordered by the doctor on 22 December, when it was recorded that the man had some wheezing on his chest. On 17 February 2010, he was placed on an Assessment, Care in Custody and Teamwork (ACCT) document as a suicide prevention measure after receiving some distressing personal news. Following a short stay in the healthcare unit, the man returned to his cell on the wing as he felt brighter with no thoughts of self harm.

4. A chest x-ray taken on 20 February showed no serious problems with the man's heart. On 5 May, he was convicted of murder and sentenced to life imprisonment and returned to Belmarsh.

5. Two days later, on 7 May, the man was seen by a nurse in the morning for pain in his foot. The nurse spoke to a doctor who prescribed Diclofenac (for pain relief) without seeing the man. About 3.55pm a prisoner told an officer that he had seen the man on his bed struggling with chest pain. The officer saw the man and then went to the wing treatment room to alert the nurse that there was a medical emergency. The nurse visited the man and, whilst taking his medical observations, he became unresponsive.

6. The nurse raised the alarm for a medical emergency and asked for an emergency ambulance to be called. Cardiac pulmonary resuscitation (CPR) was started. The nurse was joined by other healthcare staff and an officer who was trained in first aid and the use of a defibrillator. (A defibrillator is a machine that sends an electric shock to re-start the heart.) A locum doctor attended the man's cell and administered Adrenaline, to increase his heart rate and contract the blood vessels. Staff continued with CPR until the paramedics arrived at 4.25pm, during which time the officer used the defibrillator twice.

7. Paramedics took over the man's treatment until 5.00pm. At that point, he was escorted by two officers to a hospital in an emergency ambulance.

Despite the further efforts of hospital staff, the man's death was confirmed at 5.58pm.

8. A clinical review of the man's healthcare indicates concerns about healthcare services at Belmarsh. In particular, the review comments on medical records, staffing issues, the use and quality of locum doctors and their ability to work effectively in the healthcare unit. The clinical reviewers are also concerned about the training of one member of the nursing staff, poor chronic disease supervision, and a range of poor policy and procedures management in the healthcare department.

9. An interim meeting with the Governor and head of healthcare addressed the most immediate and urgent healthcare issues identified following the initial investigation. I endorse nine recommendations from the completed clinical review for the attention of the Governor, the Head of Healthcare and NHS Greenwich PCT and a nurse. Furthermore, there is one recommendation for the Governor in relation to the role of family liaison officer as part of this investigation.

THE INVESTIGATION PROCESS

10. The investigation into the man's death was opened on 17 May, when my investigator visited Belmarsh and was met by a Senior Officer (SO). She reviewed the man's prison file and arranged for an officer to compile the relevant documents and send them to her. My investigator also visited house block one, the wing where the man lived and spoke informally to the wing manager.

11. The Ombudsman's terms of reference and notices of investigation were sent to Belmarsh in advance of my investigator's visit. My investigator's details were made available to the Independent Monitoring Board (IMB) and Prison Officer's Association, although neither organisation asked to see my investigator. (The IMB are volunteers drawn from the community who monitoring the day to day regime of the prison and the welfare of prisoners.)

12. My senior family liaison officer wrote to the man's daughter outlining the process of the investigation. Another of my family liaison officers, also wrote to the man's daughter to update her on the progress of the investigation. To date, she has not raised any issues which she would like to be considered.

13. Although my investigator received some of the documents she asked for, further documentation was not made available until mid July three months after the man's death, despite continued attempts from my investigator and the intervention from my then assistant ombudsman. My investigator only received three statements made by staff which described the response efforts on 5 May. However, on 5 July, my investigator received a letter from a prisoner naming the prison staff who were on duty when the man collapsed. On the basis of that information, four wing officers and a prisoner were interviewed by my investigator on 25 August.

14. On 28 September, an assistant ombudsman and my investigator visited Belmarsh to interview two members of the healthcare staff. One month later, my investigator and two clinical reviewers, interviewed three members of the healthcare staff at Belmarsh.

15. On 26 November, my investigator, the two clinical reviewers and three members of Greenwich PCT visited Belmarsh to feedback to the Governor and head of healthcare. This meeting was to inform the prison of the immediate healthcare concerns identified by the clinical reviewers in advance of this report.

16. The clinical review was received by my office on 25 January 2011.

HMP BELMARSH

17. HMP Belmarsh was opened in April 1991, and operates as a local prison serving the courts of South East London and South West Essex. It has an operational capacity of 910 and is part of the high security estate holding category A prisoners. (Category A prisoners are those thought to be of greatest risk to the public.) It contains a full time healthcare unit with a nursing ward for 33 prisoners.

Her Majesty's Chief Inspector of Prisons

18. The former HM Chief Inspector of Prisons conducted an unannounced full follow-up inspection from 27 April to 1 May 2009. The report said that:

> "Healthcare services had deteriorated since the last inspection, and there was an urgent need for re-engagement between the prison and the primary care trust."

In her report, the Chief Inspector went on to explain that, at the time of the inspection, she was concerned about the ending of the GP services contract, poor management of clinical records and some problems in the pharmacy service. However, the report noted that in the in-patient unit, "relationships between staff and prisoners appeared appropriate and relaxed."

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) made up of members of the community. The IMB's role is to ensure that the prison is properly run and that prisoners are treated decently. Each IMB produces an annual report for the Secretary of State, the most recent of which from the Belmarsh IMB covers the period 2007 - 2008. The report described security issues as being paramount at Belmarsh, which is understandable in a category A prison. However, the IMB commented that the prison now needs to focus more on the needs of individuals.

20. Since my office took responsibility for investigating deaths in custody in 2004, there have been eight natural cause deaths at Belmarsh prior to the man's death. Only one of those deaths was as a result of a heart attack.

KEY EVENTS

21. The man was born in Essex in 1966 and was unemployed at the time of his arrest. He lived in London with his partner, his co-accused. The man had two young children and an older daughter from another relationship. He had previous convictions and this was not his first time in prison.

22. In September 2009, the man appeared at a Magistrates' Court where he was remanded to HMP Pentonville, charged with murder. He underwent a first reception healthscreen when he told the nurse that he was suffering from a depressive disorder, high blood pressure, gout, high cholesterol and asthma. After further assessment by the nurse, it was noted that the man was receiving medication for his depression, but he had no thoughts of self harm. A doctor examined the man and continued his prescription for Simvastin for high cholesterol, Sertaline for anxiety, Paroxetine for depression, Allopurninol for gout, Ramipril for high blood pressure, Ranitidine for excess stomach acid, and Salbutamol for asthma.

23. Two days later, a doctor saw the man for a secondary healthscreen. (A secondary healthcare assessment is a physical health check, similar to that received in the community when a patient joins a community practice.) His blood pressure was noted to be 122/84, (average range is 130/80) and he was overweight. The man told the doctor that he smoked about 19 cigarettes per day. The doctor also prescribed Co-codamol for pain relief and Zopiclone to help him sleep. Later that day, the man was assessed by a healthcare assistant and following this consultation was allowed to have his medication in his possession. (All prisoners are risk assessed as to whether they might retain their own medication instead of collecting it from a dispensing area.)

24. On 16 November, a psychiatrist assessed the man at the request of his solicitor. There is no information held in his medical record as to why this assessment took place or to its findings.

25. Following a court appearance in December, the man was taken to Belmarsh. He was seen by the reception doctor who recorded his blood pressure at 141/102. The doctor reviewed the man's medication and, at his request, the prescription for Paroxetine and Sertaline was discontinued. The man told the doctor that he was no longer depressed. The doctor wrote in the medical record that the man should have his blood pressure checked every seven days.

26. Two days later, a nurse took a blood pressure reading of 161/104 from the man and noted that a chart to monitor his blood pressure had been started. On 22 December, the doctor recorded a blood pressure reading of 160/100 and asked for the man to be booked in for a blood test. A referral was made for him to have a non urgent x-ray as he was experiencing some wheezing on his chest.

27. In February 2010, the man was moved to the Listener's suite after becoming upset following a meeting with his solicitor the previous day. (Listeners are Samaritan trained prisoners who support prisoners in times of crisis. A Listener's suite is a designated cell where prisoners can talk to a Listener within a safe environment.) He was visited by a healthcare assistant in the Listener's suite. He told the healthcare assistant that his solicitor had told him some difficult news about his personal life. The man was visibly distressed, tearful and rocking to and fro on a bed. He told the healthcare assistant that he had self-harmed many years ago by throwing himself through a window.

28. The healthcare assistant arranged for the man to be transferred to the inpatient healthcare unit and the Assessment, Care in Custody and Teamwork (ACCT) support procedures were put in place. (An ACCT monitors and supports prisoners assessed as at risk of suicide or self-harm. The prisoner is observed at pre-determined intervals according to the perceived level of risk. Each prisoner is assessed within 24 hours of the ACCT being opened, and then reviewed at intervals decided on an individual basis.)

29. Later, the man was transferred to the healthcare unit and four hours later he told a nurse that he was feeling better. The following day at 2.10pm, during an ACCT assessment interview, the man said that he had no suicidal thoughts because his children visited him regularly. Later, he was seen by a psychiatrist who noted the man's previous physical and mental health history. The man asked if he could return to house block one. The psychiatrist agreed that he could return to the house block and advised that the man should be found a structured activity.

30. On 19 February, the man returned to house block one and remained subject to ACCT procedures. In a review prior to his discharge from the healthcare unit, he was noted to be happy to go back on the wing with no thoughts of self-harm.

31. The man had his chest x-ray on 20 February. Following the x-ray, it was written in his clinical record that his heart was of normal size with some deformity of the left rib from previous surgery. No lesions were found on his lung.

32. A case review of the man's ACCT document took place on 23 February. He told staff that he was happy to be back on house block one and a SO said he would help him apply for a job as a wing cleaner. With the man's agreement, the ACCT document was closed. An ACCT post closure review took place on 2 March. The man said that he was fine and would seek help from a Listener or chaplain if he felt the need to.

33. The man settled into the prison routine, working as a wing cleaner. There were no recorded health issues between March and May 2010.

34. In May, at a crown court, the man was convicted and sentenced to life imprisonment for murder, with a tariff of 17 years.

7 May

35. The man was seen by a nurse on the morning of 7 May. He told the nurse that he had pain in his foot and thought it might be gout. The nurse examined his foot, there were no signs of swelling and the foot was soft and cool to touch. The nurse spoke to a doctor who prescribed Diclofenac for anti inflammatory pain relief. The doctor did not see the man.

36. About 3.55pm, the man shouted to a prisoner from his cell. The prisoner found him lying on his bed and asked him if he was all right. The man replied to him in a distressed voice, “no, my chest, please call someone”. The prisoner could see that the man was burying his hand in his chest area and was in obvious pain.

37. In interview with my investigator, the prisoner said that he went to the open door of the cell and saw an officer. The prisoner called to the officer, indicating that there was a medical emergency in the man’s cell. The officer asked the prisoner to repeat himself and he told the officer again that there a was a medical emergency in the cell.

38. The officer went to the man’s cell and asked him if he needed a nurse. The officer described the man as “breathing heavily”. The officer went to the wing treatment room to ask for medical assistance. The prisoner stayed by the man’s cell door.

39. A nurse was dispensing medication from the treatment hatch on the wing that afternoon. The officer told the nurse that a prisoner needed urgent medical help. The nurse then locked up the medication storage. The officer repeated the urgency of a prisoner needing medical assistance. The nurse spoke to his manager and explained that he was required elsewhere. He then unlocked the cupboard to collect the observation bag, picked up the bag and locked the cupboard again. During interview for this investigation, the nurse said that he “didn’t waste time at all”.

40. In his interview, the officer described his frustration with the nurse, who he described as “pottering about” in the treatment room, before finally accompanying him to the man’s cell. The prisoner guessed that six or seven minutes passed between the officer going to get medical assistance and the nurse getting to the cell. The prisoner saw the nurse approach the cell. and he moved away from the cell door.

41. The nurse found the man lying on his bed complaining of pain to his left foot and chest area. The nurse attempted to lift his trousers to examine his foot but the man found this too painful. The man’s blood pressure was normal at 142/83 with a normal pulse rate of 83 beats per minute. Once he had taken these observations, the nurse was in the middle of telling the man that his clinical observations were fine, when he realised that he was not

responding. The nurse told my investigator that he shouted at the man twice to get a response. He described the man as “slightly sort of pale”. The nurse checked and found that the man had no pulse and was not breathing by this time.

42. The nurse immediately shouted for help and an emergency ambulance. He shouted that this was a possible cardiac arrest, and started cardio pulmonary resuscitation (CPR). An officer, a trained defibrillator operator, heard the call over the prison radio and made his way to the man’s cell from the security office. (A defibrillator is a machine used to send an electrical shock to the heart.) A senior healthcare worker also made his way to the cell from the treatment room bringing with him emergency equipment including oxygen. A second nurse joined her healthcare colleagues in the man’s cell.

43. The wing manager, an SO, responded to the emergency and went to the cell. On his arrival he saw a nurse and the senior healthcare worker carrying out CPR on the man who was on his bed. The SO left the cell and went to the wing treatment room, where he knew there was a doctor. The SO asked a doctor to come immediately to the man’s cell. The doctor failed to respond to his request and so he repeated his appeal but the doctor said that she was unable to come. The SO then insisted that the doctor accompany him to the man’s cell, which she did.

44. The trained defibrillator officer attached the defibrillator pads to the man’s chest and it advised that a shock was necessary. The officer announced he was going to shock the man when he saw the first on the scene nurse approaching the man. The officer repeated that everyone needed to stand back, while he delivered the electric shock. Following the use of the defibrillator, CPR was re-started by the officer and the second on the scene nurse.

45. The trained defibrillator officer saw the doctor and the senior healthcare worker with the oxygen machine, which was seemingly not working. They were trying to attach the pipe from the oxygen tank to the face mask, which became detached as soon as the oxygen valve was open. A second shock from the defibrillator was used and again this officer had to ask the nurse to stand away.

46. The nurse inserted a venous canula (a tube inserted into the vein) into the man’s right hand. The doctor administered Adrenaline to increase his heart rate and contract the blood vessels. The doctor then apparently left the exposed syringe needle on the man’s bed. The trained defibrillator officer told my investigator, that when he moved the defibrillator, the needle passed through his opened fingers narrowly missing his skin.

47. At 4.25pm, the ambulance arrived and the paramedics made their way to the man’s cell. By the time the paramedics had unpacked their equipment, the doctor had left the cell. The doctor was found several minutes later and she returned to the cell to give her account of her involvement to the

paramedics. A nurse passed on further information and the officer gave a briefing about his use of the defibrillator. However, he was unable to pass on a memory chip from the machine as it was missing. (The memory chip holds information on the cycles used of the defibrillator.)

48. Paramedics continued to treat the man, in his cell, until 5.00pm when he was lifted into the ambulance and escorted to the hospital by two officers. A security risk assessment was completed, as is normal practice for a prisoner being taken out of the prison, and the man was not restrained.

49. On arrival at the accident and emergency department at the hospital, doctors treated the man and CPR continued up to 5.58pm when his death was confirmed.

50. My investigator was told by wing staff that, after her father's death, the man's daughter visited the prison and her father's cell. I have not been able to establish how the man's daughter was told of her father's death or by whom. Despite enquiries made by the investigator the prison's family liaison officer has failed to provide her with that information. I regret that I am therefore unable to indicate what support was given to the man's family or whether funeral expenses were offered.

ISSUES

Clinical care

51. A clinical review of the man's healthcare was commissioned by Greenwich PCT. Two clinical reviewers carried out that review on behalf of the PCT. Both reviewers and my investigator carried out interviews with healthcare staff and evidence was taken from the man's medical records. Following interviews, the PCT and the investigator wrote to the Governor to feedback their concerns which had been identified in the course of the investigation.

52. A feedback meeting was held on 26 November 2010, at Belmarsh. I am pleased to note that it was attended by the Governor, the head of healthcare, members of Greenwich PCT, the clinical reviewers, my investigator and an assistant ombudsman. The issues at the meeting raised included the response to the man's collapse, healthcare staff and resources. An action plan compiled by the clinical reviewers outlined actions to be implemented as a high priority. The Governor and the head of healthcare explained that they had already begun to address the areas identified for learning. A minute of this meeting is annexed to this investigation report.

53. Following the feedback and subsequent meeting, the clinical reviewers completed a final review of the man's clinical care. This is the first annex to the investigation report. This provides a thorough review of the systems, policies and procedures in place and the clinical review team makes 16 recommendations. I commend this document to the attention of the PCT, Governor and the head of healthcare and draw on its findings as the basis for my own conclusions.

Chronic disease management

54. The clinical reviewers note that the responsibility for the review of chronic diseases rests with the doctors. However, many of the clinical observations such as blood pressure are made by the nurses. Five blood pressure recordings were made, all of which were unacceptably high. Additionally, the man had a medical history of high cholesterol, gout and depression.

55. In December 2009, the doctor asked for his blood pressure to be monitored but the medical records show no record of any checks being made in the five months prior to his death. The clinical reviewers explained that there needs to be a clear procedure for monitoring such patients indicating who is responsible.

56. At interview, a nurse commented that patients with chronic diseases should be referred to the doctor for review. However, there is no identifiable written criteria when the nurse should refer a patient with a chronic disease back to the doctor.

57. In response to feedback about chronic disease management, the head of healthcare updated the investigation team that a nurse has been appointed to co-ordinate chronic disease management. Through the clinical IT system, when a prisoner has a first reception health screen completed by a nurse, any chronic medical conditions will be highlighted and a care plan will be activated so that the condition can be monitored via the clinical IT system.

58. There are no current guidelines for doctors to follow when they look after patients with chronic diseases. There seemed to be reluctance on the part of the head of healthcare to acknowledge the need for guidelines because so many locum doctors work at the prison and he felt that continuity of care is difficult to achieve. I agree with the clinical reviewers that employing locum doctors provides even more reason to have guidelines. Lack of clear guidelines for nurses and doctors exposes patients with long term conditions to unacceptable risks.

59. At the feedback meeting, the head of healthcare responded that Belmarsh is currently using an agency to employ doctors and some of the professional standards of their work is not what would be expected. An induction pack is sent to the agency, prior to a doctor working in Belmarsh. Further to this, a handbook is being prepared for doctors to identify the specific issues for working in the prison.

60. I am pleased with the head of healthcare's proactive approach to developing procedures for effective chronic disease management. However, I agree with the clinical reviewer's serious concerns about its delivery at Belmarsh and make the following recommendations:

The Primary Care Trust, Head of Healthcare and the Governor must work together with the new healthcare provider to ensure the effective delivery of chronic disease management by nurses and doctors.

The Head of Healthcare must produce appropriate policies and procedures for repeat prescribing and medication reviews, significant events, dealing with performance concerns, recalling patients for review or regular blood tests, shared care of chronic diseases by nurses and doctors, accurate attribution of data by computer data summarisers and cold debriefs.

Cardio pulmonary resuscitation (CPR) Training

61. The reviewers note that staff attended to the man when the call for urgent medical assistance was given. The defibrillator was used effectively, as well as CPR and a canula was inserted to administer Adrenaline by the doctor. Although concerns were noted by discipline staff about the doctor's role and her level of competence, it is the reviewer's opinion that the man's cardiac arrest was well handled by competent nurses and discipline staff.

62. At interview for the investigation, the clinical reviewers note that the managers' records demonstrate that CPR training is updated annually. However, a nurse told the investigation team that she has not had CPR training for three years and thought that the other nurses were in a similar position. She told the reviewers that the CPR training and the defibrillator training she had undertaken three years ago was incorporated into a first aid training course. During the feedback meeting, the head of healthcare told the investigation team that training had been offered since this time but that the nurse had refused to attend as she believes that the training offered was not appropriate. The nurse said that she had sought advice and written to the Nursing and Midwifery Council on this issue.

63. At the feedback meeting, the head of healthcare distributed training records for all healthcare staff for Anaphylaxis and Intermediate Life Support (ILS). (Anaphylaxis is a severe allergic reaction which might be life threatening.) All but one member of staff has completed the ILS course and are in date. Only this nurse had not attended the ILS, despite the head of healthcare's assurance that three courses had been made available to her. He explained that she declined to attend. Furthermore, according to the head of healthcare, she has declined to attend anaphylaxis course. He explained that he had brought this matter to the attention of the PCT prior to the man's death but had not received a response.

64. The clinical review team makes two recommendations to the nurse to take responsibility for her training needs. Although I do not repeat them here, I agree with the clinical reviewers' recommendations. A healthcare professional must take responsibility for their own training needs. However, I am concerned that the head of healthcare had raised the difficulties he was experiencing with the nurse and did not feel supported by the commissioning PCT.

Emergency response

65. An officer was called to the man's cell by a prisoner. The officer assessed the man as in need of urgent medical attention and spoke to a nurse, who was on duty in the wing treatment room. I am told that there seemed to be a six to seven minute delay before the nurse arrived at the man's cell. The nurse told my investigator that he had to lock up the medicine cupboards before he could leave the treatment room. The SO said that he had to insist that the doctor attended the emergency. In future I hope that healthcare staff respond to medical emergencies in a more timely manner.

66. The trained defibrillator officer responded to the man's collapse as a trained first responder to the medical emergency. He took control of the CPR attempts together with another nurse and applied the defibrillator to shock the man's heart. I note that the officer narrowly avoided injury from a wrongly and exposed syringe needle whilst carrying out CPR. The new emergency bags, that are now in situ on all wings, contain a disposal unit for used needles. I acknowledge the professionalism shown by this officer in these circumstances.

67. In their feedback, the clinical reviewer's noted that resuscitation bags did not hold all the medications needed for a medical emergency. They were also concerned that the oxygen bag, used during the resuscitation attempts on the man's life, was faulty.

68. During the feedback meeting, the Governor and the head of healthcare explained that 15 emergency bags have been ordered and will contain comprehensive drugs and equipment to cope with all medical emergencies. Healthcare staff will be trained in the correct use of all emergency equipment held in the bags. Fourteen of those bags will be placed across the prison and the extra bag will be stored in the healthcare unit so it can replace a bag that has been used. An officer will take initial responsibility for ensuring the bags are re-filled and checked after it has been used. This responsibility will then pass to a member of the healthcare staff.

69. In response to feedback, the Governor also added that,

> "Belmarsh has invested heavily in providing emergency bags, defibrillators and fire fighting equipment. These pieces of equipment will be located on all wings and will be clearly identified. Emergency responses will be nurse-led however, other prison staff can undertake the first response training."

70. The had of healthcare went on to say,

> "In the first instance two registered general nurses will respond to an emergency and will be supported by other staff. There are ten discipline staff trained to act as first responders. However, Adrenaline cannot be administered by nurses. The Orderly Officer is able to escort healthcare staff to unlock the pharmacy, out of hours, to access medication."

71. I am satisfied that appropriate emergency equipment is now in situ at Belmarsh.

Defibrillator

72. It was noted that the recording microchip from the defibrillator was missing when the officer handed over to the paramedics following its use on the man. At interview, the head of healthcare told the reviewers that the Device Search Team (DST) might have removed this from the machine. The head of security confirmed that he spoke to the DST who said they have not removed anything of this nature from any medical equipment. The clinical reviewers noted that in the interview transcript of the trained defibrillator officer he claimed that the senior healthcare worker said he had taken it out a while ago. At interview the senior healthcare worker said he did not know what happened to the microchip.

73. At the feedback meeting, the Governor assured the investigation team that of the 19 defibrillators across the prison, those that have removable memory

chips will be replaced. He told the investigation team that is not standard practice to remove the memory card from a defibrillator that has been used in a death in custody. I am satisfied that corrective action has been taken and that a recommendation is unnecessary.

Locum doctors

74. Concerns were raised that the locum agency, (Med Team), which sent the doctor to work in Belmarsh had not ensured that she would receive an adequate induction, with written instructions on healthcare policies and procedures. Furthermore, the agency did not make certain that the doctor's had an up to date CPR qualification. Following the man's emergency, the doctor was no longer employed at Belmarsh.

75. The clinical reviewers considers the use of agency staff in their clinical review. In their opinion, there are fundamental concerns about the organisational failures in healthcare's policies and procedures. The reviewers note:

> "An isolated care environment with autocratic management culture. A failure to ensure adequate GP [doctor] staff induction and provide induction handbooks to locums. A lack of clinical governance audits including quality of GP [doctor] clinical care."

In light of these strong findings, I endorse the following recommendations made by the clinical reviewers for the attention of the Head of Healthcare.

The Head of Healthcare to review work patterns to enable long term locums to attend weekly team meeting and share learning.

The Head of Healthcare to produce job descriptions and review roles and responsibilities of all members of the primary care team.

The Head of Healthcare to implement an ongoing induction and educational programme for all clinical staff including locums, to promote shared learning, effective chronic disease management and ensure effective implementation of new systems and procedures.

76. The doctor was the locum employed at Belmarsh from the Med Team Agency. She saw the man for his secondary screening on 14 December 2009 and later reviewed him and ordered medical investigations. She attended the man's cell when he collapsed and gave him Adrenaline medication.

77. The reviewers interviewed the doctor and concluded their assessment of her professional conduct whilst at Belmarsh by saying;

> "Factors affected the way the doctor functioned before and during the incident. The man's BP [blood pressure] and cholesterol levels were poorly controlled during the five months he was in Belmarsh. However,

there is no evidence that if control had been good during this period, the outcome would have been any different. "

78. I therefore endorse the following recommendations made by the clinical reviewers for the attention of the head of healthcare:

All locum doctors attend CPR training and demonstrate competence in managing critical incidents.

An induction programme of all healthcare staff is undertaken before working in the prison healthcare unit to identify local procedures and systems for repeat prescribing, patient recall, guidelines for chronic disease management and medication reviews.

79. I acknowledge six further recommendations made in the clinical review in regard of the doctor and the locum agency Med-Team Agency. I ask that the head of healthcare works with Med Team to ensure their implementation.

Salbutamol

80. Salbutamol is medication used to relieve asthma, which the man was known to suffer from. In the course of the investigation it had been evident that Salbutamol was not readily available to nursing staff to treat urgent cases of asthma. Therefore, in the clinical reviewer's opinion, this point should be dealt with as a matter of urgency. I agree with the clinical reviewer's findings.

Records and record keeping

81. The reviewers note that the quality of entries by the doctor were good. However, there were serious concerns about the system of record keeping used. On transfer of medical information from hand written notes to SystmOne, the electronic medical information system, it was noted that an information technician (IT) summariser was employed to transfer this information. The IT entered their own name onto SystmOne omitting the name of the clinician who had originally entered the information on the hand written notes. Therefore it was unknown which clinician had seen the man.

Both reviewers noted that this could have serious medical and legal implications and I agree that this matter should be addressed urgently. The head of healthcare will wish to ensure that all summarisers record the name of the clinician who made the entry on the clinical notes and further record that the entry was made by the summariser. As well, the entries already on SystmOne should be reviewed to ensure that the entries are updated to include the clinicians identity.

New provider of healthcare services

82. In February 2011, healthcare services at Belmarsh will be taken over by Harmoni, a private healthcare provider. Following evidence provided at interviews and taken from The man's medical records, the clinical reviewers have made the following recommendation to NHS Greenwich PCT which I endorse:

    Review the new Primary Care Trust contract with Harmoni, due to commence on 1 February 2011, to ensure inclusion of all the policies and procedures recommended for healthcare.

    Develop a written procedure to ensure that each doctor's performance concerns are referred to the PCT medical advisor.

Incident statements

83. My investigator was surprised to find only three staff statements were made to the Governor about the events of 7 May. There is a formal requirement set out in PSO 1400 – Incident Reporting for staff to make statements following a death in custody. When my investigator raised this with the Governor, he shared my concern that more statements had not been taken. He assured my investigator that such statements are routinely taken following a death in custody and that action would be taken to ensure that in any future cases, statements would be taken from all staff involved.

Family liaison

84. To date, my investigator has not received any communication from the family liaison officer. My investigator was unable to gain any information on how the man's daughter was informed of her father's death, whether funeral expenses have been offered or what support has been given to his family. I expect all prisons to ensure this information is made available to my investigators. Prison Service Order 2710 – follow up to deaths in custody require that prison staff must co-operate fully with my investigation. I therefore make the following recommendation for the attention of the Governor:

    The Governor, as a matter of urgency, ensures that all relevant information is passed to my office by the family liaison officer following a death in custody.

85. Following the issue of this report, I trust that the Governor will make arrangements for information relating to liaison with the man's family to be passed to the investigator.

CONCLUSION

86. The man already had several chronic diseases when he arrived at Belmarsh. He was assessed by a nurse and later saw a doctor who prescribed medication to manage his medical conditions. A blood pressure monitoring chart was opened to review the man's raised blood pressure on a weekly basis, however there is little evidence to indicate that this was completed. Furthermore, there is no evidence that there was a management plan to monitor his other chronic diseases: gout, asthma and high cholesterol.

87. The man became unresponsive whilst his clinical observations were being taken at 3.55pm on 7 May. Healthcare staff went to the cell and CPR was started. An officer trained in first aid and the use of a defibrillator assisted with CPR. However, I have found that the resources and the actions of some clinical staff were seemingly less than professional.

88. The clinical reviewers indicate failings throughout in the provision of healthcare services, including policy and procedures management, the care of chronic diseases, the employment of locum doctors, including the actions of the doctor who attended to the man and inadequate training of a nurse. Furthermore, entries on the SystmOne clinical records show that they have not been appropriately transferred from written notes to electronic records.

89. I recognise that the Governor and the head of healthcare responded effectively to the immediate concerns raised by the clinical reviewers. I welcome the installation of new equipment and the positive actions taken.

90. Whilst the clinical reviewers have identified 16 recommendations raised in the clinical review, nine of which I endorse, they also note the actions of staff that provided CPR to the man to be competent. I note the professionalism of the trained defibrillator officer who assisted with deliver CPR. Lastly I make one recommendation in relation to the role of the family liaison officer regarding the total lack of information being made available for this investigation.

RECOMMENDATIONS

The Chief Executive of NHS Greenwich PCT, The Head of Healthcare and The Governor

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1. The Primary Care Trust, Head of Healthcare and the Governor must work together with the new healthcare provider to ensure the effective delivery of chronic disease management by nurses and doctors.

   Accepted – "A major priority for Harmoni for Health is to remodel healthcare services to deliver a primary care led service, which incorporates effective clinical management of all long term conditions, based on NICE guidelines and national Service Framework performance standards."

The Chief Executive of NHS Greenwich PCT

2. Review new PCT contract with Harmoni for healthcare due to commence on 1 February 2011, to ensure inclusion of policies and procedures recommended for healthcare.

   No response from NHS Greenwich PCT

3. Develop a written procedure to ensure all doctors performance concerns are referred to the PCT medical advisor.

   No response from NHS Greenwich PCT

The Head of Healthcare

4. To produce appropriate policies and procedures for, repeat prescribing and medication reviews, significant events, dealing with performance concerns, recalling patients for review or regular blood tests, shared care of chronic diseases by nurses and doctors, accurate attribution of data by computer data summarisers and cold debriefs.

   Accepted – "Harmoni for Health are currently reviewing existing polices procedures and guidelines and implementing additional PPGs to assure that comprehensive polices and procedures are available to all staff, supported by excellent clinical governance and regular management and clinical audits."

5. To review work patterns to enable long term locums to attend weekly team meetings and share learning.

   Accepted – "Harmoni for Health have ceased reliance on regular locum GPs and now directly employ GPs to support Prison Health. All GPs are fully embedded in regular healthcare meetings and are supported by a lead GP, for training, development and clinical supervision."

6. To produce job descriptions and review roles and responsibilities of all members of the primary care team.

   Accepted – “All healthcare staff have existing job descriptions, and job profiles. JDs for directly employed GPs are currently being finalised.”

7. To implement an ongoing induction and educational programme for all clinical staff including locums, to promote shared learning, effective chronic disease management and ensure effective implementation of new systems and procedures.

   Accepted – “Harmoni for Health intend to develop a comprehensive induction pack for all new staff including locum and agency staff, covering administrative, security communication and clinical priorities.”

8. All locum doctors attend CPR training and demonstrate competence in managing critical incidents.

   Partially Accepted – “The Emergency Response Service at HMP Belmarsh is a nurse led service and does not rely on the availability of the GP. Nursing support is available 24/7 whereas; GPs are not present on site at all times. The responsibility for assurance of registration, experience training and development of agency clinicians rests with the relevant agency. Harmoni for Health work closely with agencies to evidence that agency staff are properly qualified, experienced and trained for the role they are providing.”

9. An induction programme of all healthcare staff is undertaken before working in the prison healthcare unit to identify local procedures and systems for repeat prescribing, patient recall, guidelines for chronic disease management and medication reviews.

   Partially Accepted – “All healthcare staff undertake an individually designed induction programme before working independently within healthcare services. For agency and locum staff, we have agreed with the training department that access will be provided to the induction training days for agency and locum staff, prior to commencing duties at HMP Belmarsh.”

The Governor

10. The Governor, as a matter of urgency, ensures that all relevant information is passed to my office by the family liaison officer following a death in custody

    Accepted – “A single point of contact will be implemented to ensure communication is effective between the Prison and PPO office.”