Investigation into the circumstances surrounding the death of a man who died in hospital whilst a prisoner at HMP Preston in June 2006

Report by the Prisons and Probation Ombudsman for England and Wales

August 2008

This is the report of an investigation into the circumstances surrounding the death of a man in June 2006 in hospital whilst in custody of HMP Preston. The man was 31 years old at the time of his death.

A post mortem examination concluded that the man's death was due to natural causes. The man had suffered a cardiopulmonary arrest due to acute peritonitis (inflammation in the stomach area) caused by a perforated gastric ulcer.

During his month in custody, the man spent three weeks on the detoxification wing at Preston. He was then located to A wing. The man became ill over a three day period with severe stomach pains and collapsed in his cell late on the third evening. The man died within one hour of being transferred from the prison to the hospital.

I extend my sincere condolences to the man's family and friends at the tragic loss of a young man. I apologise for the delay in producing this report. This was due to the police investigation which concluded in June 2007 and a protracted draft consultation process

I would like to thank the then Governor of Preston and his staff for their patience and co-operation in this investigation. I also would like to thank Lancashire Constabulary for allowing my investigator access to the review of the man's medical care carried out by a qualified doctor with legal experience. I am particularly indebted to a Detective Inspector, a Detective Sergeant and a Police Family Liaison Officer for their help and support. This report is an example of good practice in partnership working between Lancashire Constabulary and my office.

I acknowledge the support of Central Lancashire Primary Care Trust.

I have relied heavily upon the clinical review by the doctor. It is comprehensive and offers the opinion that the man's death was potentially preventable. An earlier referral to hospital would probably have resulted in a high or very high choice of surgical/medical intervention being successful. The doctor says that, in his opinion, the standard of medical care by certain medical staff fell below common and acceptable medical practice.

This is a second version of my draft report. The first version in September 2007 was subject to restricted circulation at the request of Central Lancashire Primary Care Trust (PCT). Subsequently, Central Lancashire PCT asked for a second independent review specifically looking at the delivery of health services in Preston. The second review also addressed the recommendations and issues raised in the doctor's report. I agreed to this second review and a nurse practitioner completed her findings for the PCT at the end of January 2008. I am grateful to the nurse practitioner for her review which I have annexed to this report.

Based on the clinical review by the doctor, I made six recommendations in the first draft report for the attention of Central Lancashire PCT. In this second version of the draft report, three of those recommendations have been addressed. 's findings are noted alongside those of Dr Lloyd-Jones. A further 13 recommendations have been added to this second draft report as a result of the nurse practitioner's review and responses to the recommendations of the first draft report. The report has been seen by the Prison Service and they have not made any comment.

In this final version of my report, I acknowledge the enclosures from Central Lancashire PCT in regard of the second draft report. Included in those documents are responses from Central Lancashire PCT, individual comments by Dr A, Nurse C,

Nurse Y, Nurse Z and Nurse W, a Root Cause Analysis undertaken by the PCT and an action plan. The individual responses by medical and nursing staff included their comments on the clinical review by a nurse practitioner.

During the consultation process, a number of individuals have been criticised. I have also found some of the individual responses contradictory. However, my investigator has forwarded those individual responses to the Coroner

Central Lancashire PCT endorses the clinical review by a nurse practitioner and has written to my office in support of that review, which is annexed to this report. Also annexed is the Root Cause Analysis and action plan. I have made certain changes to the report where factual inaccuracies have been identified by the PCT.

Of the 13 recommendations made in the draft report, Central Lancashire PCT have accepted nine of the recommendations, partially accepted two of the recommendation and do not accept the last two recommendations.

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

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SUMMARY

The man was remanded to HMP Preston in May 2006 from Magistrates' Court. A week later, he was convicted of burglary and returned to Preston to await sentencing. The man had been using heroin, crack cocaine and benzodiazepines since he was 21 years old. He had previous convictions and this was not his first time in prison.

On reception into Preston, the man saw a member of healthcare and a reception screening document was completed. The man was described as fit and well in this document, but in need of detoxification from methadone and benzodiazepines. He was located onto C wing, Preston's detoxification unit. Whilst the man was on C wing he attended 'special sick' a total of seven times, four of those for dyspepsia. After completing his detox, the man was transferred to A wing on 30 May.

On 1 June 2006, the man complained of pains in the stomach and was seen twice by healthcare/nursing staff, once at 1.30pm and again at 2.15pm. He was given paracetamol and Gaviscon 10mls. On 2 June, he saw a nurse in the morning as he was still feeling very unwell and was in pain. His observations were taken and a urine test, taken the previous day and unobserved by healthcare staff, proved negative for any illicit drug use. At 4.30pm, the man was taken by wing staff to see a member of healthcare. He continued to complain of stomach pain. The man saw two nurses on a landing of A wing. His blood pressure was elevated and he was complaining of pain in his stomach. A doctor who was passing by was asked by the nurses to look at the man. The doctor offered an examination of the man and prescribed medication for nausea and to settle his stomach.

The man was seen by a different nurse, Nurse C, at 5.50pm in his cell. Observations were again taken and his blood pressure was within the normal range. The man was more settled and said the pain was receding. Nurse N thought he might have swallowed a package containing drugs or that he was still withdrawing from drugs. She felt that she had told other nursing staff that the doctor should see the man.

The nursing staff to whom Nurse C handed over did not interpret her instructions in the same way. They thought that a doctor need only examine the man if he complained of further stomach pains. Consequently, no doctor examined him. The night shift nurses were not specifically told about the concerns surrounding the man.

At 9.00pm, the man's medication was passed to him under the cell door. This was received by the man's cell mate and given to him with some water. The man was not examined at this stage. He was lying on his bed and the Nurse said he did not complain of further pain.

On 3 June, at 30 minutes past midnight, an Operational Support Grade (OSG) was alerted by the man's cellmate that his friend was unwell and in severe pain. The OSG contacted healthcare for staff to attend A wing. On arrival at the man's cell, healthcare staff immediately requested an emergency ambulance. The man became unresponsive and Cardio Pulmonary Resuscitation (CPR) was commenced by the healthcare staff.

An emergency ambulance, with paramedics, attended the prison and went immediately to A wing. The paramedics took over CPR from healthcare staff.
The man was transferred to hospital. He died at 1.50am.

A post mortem examination concluded that his death was due to natural causes. The man had suffered a cardiopulmonary arrest due to acute peritonitis caused by a perforated gastric ulcer.

The clinical review by the doctor, indicates that at several junctures, there was a failure to refer the man to a general practitioner (in this instance the prison's medical officer). In consequence, the standard of medical care fell below common and acceptable medical practice. Whilst acknowledging that it would require an expert in surgery to consider whether, and at what time, an earlier referral would have led to successful medical/surgical treatment, the doctor suggests that, if such a referral had been made, the man's chances of survival would have been high or very high. The second reviewer, the nurse practitioner, also makes recommendations concerning the quality of clinical care.

The nurse practitioner's clinical review was based on the medical and nursing practice of the man care. The nurse practitioner made recommendations in relation those practises.

The Crown Prosecution Service (CPS) considered the evidence contained in the staff statements, police interviews and also the expert opinion of the doctor. They decided against any criminal prosecution.

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THE INVESTIGATION PROCESS

On 13 July 2006, my investigator met a Detective Inspector (DI) and a Detective Sergeant (DS) of Lancashire Constabulary to discuss the police investigation into the death of the man.

Later that day, my investigator visited HMP Preston. She met with a Governor and the Deputy Governor. My investigator handed the Governor notices of investigation and terms of reference. She then met with the Chair of the Independent Monitoring Board (IMB), and a representative of the Prison Officers' Association (POA), to inform them of the Ombudsman's investigation. My investigator was handed a copy of the man's prison file and medical record.

On 3 November, my investigator met with the DS. It was agreed that the investigation by the Ombudsman's office would not proceed until the police had completed their enquiries and the Crown Prosecution Service (CPS) had made a decision in regard of any proceedings.

On 29 January 2007, my investigator received the clinical report by the doctor into the man's medical treatment prior to his death. This report had been commissioned by Lancashire Constabulary at the request of the CPS.
In June 2007, the CPS decided not to proceed with any criminal prosecution.

On 5 April 2007, my investigator re-visited HMP Preston after Lancashire Constabulary agreed that this part of the investigation could be pursued. She spoke to the Manager of the Counselling, Assessment, Referral, Advice and Throughcare (CARAT) team. The manager informed her of the work of the Preston CARAT team and the involvement of the team in the man's detoxification.

One of my Family Liaison Officers wrote to the man's mother shortly after his death. At the time of issuing this draft report, there has not been any response from her.

My investigation has been delayed whilst waiting for the CPS to review the medical evidence presented by the doctor. In June 2007, Lancashire Police and the CPS completed their enquiries and my investigator was able to finalise this report.

The draft report was circulated in September 2007. Following consultation with Central Lancashire PCT, I agreed to hold back full disclosure of the draft report until the PCT had commissioned a second independent clinical review. The nurse practitioner, and my investigator, interviewed prison medical staff in January 2008. At the end of January, the PCT forwarded the report of the review by the nurse practitioner. This second review addressed specific issues raised by the doctor's review and the delivery of medical services within HMP Preston.

On 9 May 2008, my Family Liaison Officer and my investigator visited the man's sister at her home to discuss the draft report. She asked for two minor changes to the report and told my colleagues that she would pass the report to the family's solicitor.

HMP PRESTON

Preston prison is a large Victorian building situated near the town centre. It has operated as a local prison since 1990, serving Magistrates' and Crown Courts in Lancashire and Cumbria.

At the time of The man's death healthcare at Preston was commissioned and delivered by the Preston Primary Care Trust. The service is now provided by Central Lancashire PCT. At the time of the investigation, eight healthcare officers were still employed by the Prison Service, while the remainder were employees of the Preston PCT. Nursing cover is provided 24 hours a day. General Practitioners are available between the hours of 9.00am to 5.00pm, Monday to Friday and visit at other hours.

The healthcare unit provides inpatient facilities for up to 30 prisoners on two floors: 22 beds on H1 landing are available for those with mental health problems and the remaining eight on H2 landing are for patients with general medical ailments and physical healthcare needs.

Preston was last inspected by HM Chief Inspector of Prisons, Ms Anne Owers, in 2004. No serious concerns about healthcare services were raised by Ms Owers in her report.

Between April 2004 and May 2006, seven prisoners died at Preston. Three of the deaths were from apparently natural causes.

KEY EVENTS

The man was received into custody at Preston on 1 May 2006. He was on remand from Magistrates' Court. At the time of his reception into Preston he was being prescribed methadone through a community based drug project.

The man was seen by a reception nurse and a first reception health screen document was completed. This recorded that the man did not have any problems with his physical health. His methadone dosage of 80 millilitres was noted. The man's reception urine test proved positive for benzodiazepines, cocaine, opiates and methadone. He was then located on C wing, the detoxification unit at Preston.

On 2 May, the man was assessed for a 12 day detoxification programme by Nurse Y. Nurse Y recorded the man's substance misuse and observed symptoms of his withdrawal, a gaunt appearance, irritability, poor concentration and insomnia. Nurse Y made contact with a Community Drug Action Team who confirmed the man was receiving methadone in the community. Nurse Y noted on his assessment document that the man would be referred to the Counselling, Assessment, Referral, Advice and Throughcare (CARAT) team, and to the hepatitis B clinic, and that the GP would prescribe medication as required. There is an entry in his medical record by Nurse Y noting the referrals as set out in the substance misuse assessment document. There is no record of the man seeing a GP at this time. The man completed a 12 day programme on the detoxification wing.

The manager of the CARAT team, told my investigator that the man would have been treated symptomatically for any medical issues associated with his withdrawal. This would have included dihydocodeine as a painkiller and medication to aid sleep. There is no record that he received any additional medication whilst on his detoxification regime.

On 8 May, the man was convicted at Magistrates' Court and remanded back to Preston to await sentencing at Preston Crown Court.

On 12 May, the man was seen by a member of Preston's CARAT team. An assessment was completed detailing his drug use and personal history. A care plan was activated. Whilst on C wing he attended special sick seven times. He was prescribed paracetamol and Gaviscon for dyspepsia.

On 30 May, the man's detoxification ended and he was moved to A wing. The prescription and administration record chart was not available to nurses on A wing and those nurses were not notified when a prisoner is transferred between wings. Nurses were only made aware of the transfer of a prisoner when he attended the treatment area on the new wing for his medication.
The man was placed in a cell with another prisoner. There is no record of him seeing any healthcare staff that day. According to his cell mater, on 31 May the man started to complain of abdominal pain and was vomiting. The man was apparently seen by healthcare staff, although there is no evidence of this in his medical notes. His cell mate described the vomit as dark brown/black. He said he was very worried and called for help.

On 1 June at 1.30pm, the man's medical notes record that he was seen in his cell by two members of healthcare staff, Nurse Z and Nurse W. The man had been complaining of severe abdominal pain. His blood pressure was elevated and he asked to be taken to hospital. The man told the nurses he had been having pains for a few days, but that day the pain was acute. Nurse Z said that the man was quite

agitated and that she thought this might account for his elevated observations. The nurses told him that they would speak to the doctor about it, and he was given paracetamol and Gaviscon and told to rest on his bed. The information was relayed to Dr A, a medical officer at Preston, but not documented or recorded anywhere. Nurse W asked Nurse Z to go back and check on the man in an hour.

The entry in the medical record reads:

> "1/6/06 Hotel 2 call. Severe abdominal pain. 1.30 seen in cell, temp 36.5, BP elevated 160/120. P120. Wants to go to hospital, knows painkillers won't work … After his lunch had pain for (last) few days, but nothing like this. Given two tablets of paracetamol and Gaviscon 10mls. Review by nursing staff if no improvement."

At 2.15pm, the man was seen again by Nurse Z. She had checked his medical notes to see if there was any history of abdominal pain. There was no relevant information documented. The prescription and administration charts from C wing would have shown that the man had been treated for dyspepsia on four separate occasions whilst on that wing. In interview, Nurse Z said that if she had seen the charts she felt that it could have led to a different outcome. The man said the pain had receded and his blood pressure was back to normal. A urine sample was tested and it gave a negative result for the presence of any drugs. The medical record was updated with this information by Nurse K on behalf of Nurse Z.

At 8.25am on 2 June, the man was moved to another cell to share with another prisoner. The man and the prisoner were friends, having known each other since childhood. At 9.20am, the man attended a 'special sick' appointment in the healthcare unit with Nurse Z. He was complaining of pain in his stomach and shoulders. He had been vomiting water earlier in the morning, but had been able to keep down some Rice Krispies at breakfast. His observations were recorded and noted to be within normal limits. (His pulse was a little high at 100.) A note on his medical record by Nurse Z said his symptoms indicated he might be suffering from a stomach bug. It further recorded that he had some relief from paracetamol, and that Gaviscon was also given. The man was happy to take it again and see how he felt. Nurse Z told my investigator she spoke to Dr A who was happy with what she had administered. This conversation was not documented.

Around 4.30-5.00pm, an officer was on duty on A wing. He was locking up prisoners following the tea meal. The officer asked the man if he had collected his tea meal. The man answered no. The officer saw that the man was breathing heavily and asked him if he was all right. The man told the officer he felt awful. The officer noticed that the man's face was pale, he was breathing heavily and his lips looked darker than normal. The man told the officer that he had reported special sick earlier in the day with vomiting and stomach pains. The officer became concerned for the man's welfare and assisted him towards the treatment room on the second landing of A wing.

When they reached the second landing, the officer saw Healthcare Support Worker (HSW) M at the landing gate and asked the nurse to look at the man. HSW P said she would be back to take his observations, blood pressure and temperature. HSW P approached Nurse C on another wing and informed Nurse C that the man was looking unwell on A wing. Nurse C told HSW P to take the man's observations and come back to her. (Nurse C had no previous knowledge of the man.)

The man was now sitting on a chair near to the laundry room. HSW P to take his blood pressure. The man asked if he could have some water as he was thirsty and this was collected from the treatment hatch. HSW P had then been joined by Nurse Y. Nurse Y did not have any previous knowledge of the man. They were having problems taking the man's blood pressure, and it was showing an abnormally high reading of 230/? Nurse Y re-checked his blood pressure and the new reading was 185/130. Nurse Y asked the man whether he had taken any substances, any drugs or tablets or anything like that. The man said that he had not.

Dr A, one of the medical officers at Preston, was passing by. The doctor stopped to look at the man's blood pressure and temperature readings. As Dr A was literally passing by, she said that she only saw a 'snapshot' or a 'window' of the man's ongoing problems. The doctor examined him, she applied pressure to his upper abdomen and this provoked a complaint of pain. The man did not exhibit any guarding or rigidity that Dr A would otherwise have expected to be the key symptom of a perforated ulcer. The man said it was quite painful when she did that. The Nurse X was also passing at the time and observed the doctor's examination of the man.

Dr A verbally prescribed medication in tablet form which the man took with some water. The officer then escorted the man back to his cell. HSW P told the officer she would look in on the man later.

In interview, Nurse Y said that Dr A only asked that Maxolon 10mg be given and this is what she gave. Later that evening whilst travelling home on the train, Dr A made a note in her filofax that she had verbally requested Buscopan 20mg and Maxolon 10mg. This was also confirmed by Nurse X. Nurse Y did not record the event in her notes nor that she gave drugs from a verbal instruction.

Dr A was enroute to see an emergency patient in reception and technically off duty when she stopped to see the man. Therefore another medical officer, Dr N, wrote a prescription for the man later that same evening. Notes indicating that Dr N was going to write up the medication for which Dr A had given the verbal orders were incorrect. Dr N wrote a prescription for the man for Maxolon 10mg as required and Buscopan 20mg qds. These were given at 9.15pm by Nurse L.

HSW P saw Nurse C about 30 minutes later and told her that the man has been attended to by Dr A, with Nurses J and S. HSW P told Nurse C about The man's observations and elevated blood pressure.

Nurse C made the decision to visit the man in his cell at 5.35 pm.
He was lying on the top bunk. His cell mate, told Nurse C that his friend was hot. Nurse C asked the man how he was. The man told the nurse he was thirsty. Nurse C noted that his stomach cramps had ceased, his blood pressure reading was somewhere around 130/80, his pulse rate was good, but his respirations were fast. The nurse noted that he seemed dehydrated. Nurse C was conscious that the man had just completed a detox programme and thought he looked as if he was still 'withdrawing'. Nurse C asked him if he had taken anything (meaning illicit drugs). The man denied this. Nurse C finished the cell visit and recorded in the man's medical notes, "Abdominal cramps ceased, appears dehydrated? Still withdrawing? Taken some form of drugs. Refer GP."

In interview, Nurse C said that she spoke to the officer on the landing and told him that she was concerned that the man had swallowed something. She said that she told him to get straight back on the buzzer if the pain came back. Nurse C said she

was going to hand over to the next shift and tell them to tell the doctor about the concerns.

Nurse C spoke to Nurse Z who told her that she had seen the man the previous day. Nurse Z added that she had thought the man might have taken an illicit substance, but a urine test had proved negative.

Nurse C said that she told Nurses J and S that she thought the man might have swallowed something or was withdrawing. Nurse C said she asked them to tell Dr N and to give him the man's file. Nurse C said, during interview, that she expected Dr N to actually examine the man after reading what she had written. A wing officer said that she was present when Nurse C examined the man. She said that Nurse C ended her visit by saying, "... I'll write him [the man] up for the doctor to see him and some meds."

The man did not in fact see a doctor that evening. His medical notes were left at the nurse's station for the medical officer, Dr N, to write up the prescription. Nurse C had a conversation with Nurse X in regard of the man's medical care for that evening. It was Nurse X's understanding that Nurse C had said that, if the man complained further of pain or was not settled, then a doctor should see him. There is therefore some dispute as to what Nurse C said and meant, and what other nurses heard and understood. Nurse C said in interview that it was her intention for the man to be seen by the doctor.

Nurse X was the person who handed over to the night nursing staff, in particular to Nurse V. He said, during interview, that he did not specifically recall handing over details about the man. Nurse V said that she was informed that the man had been complaining of abdominal pain. Nurse X went off duty at 8.30pm.

Dr N said that he had no recollection of having met or spoken to the man. He confirmed that he wrote up a prescription for Maxalon and Buscopan and recalled that he was told the man had a stomach bug. Dr N said that he was not asked to examine the man at any time, but was simply asked to prescribe the medication. He said, "the impression I was given by the nurse was that this was a routine matter and it was not suggested that I ought to see the man to make a full diagnosis."

The man's cell mate, rang the cell bell at about 8.45 pm. He reported that his friend was still looking unwell and had not seen the doctor. The cellmate was told that a doctor was not coming, but a nurse would be there shortly. He was told to ring the bell again if his friend got any worse. The cell mate felt that his friend could not have been any worse.

At 9.00pm, the man's medical notes record that Nurse L visited the man in his cell on A wing. Following the alert by his cell mate, wing staff had phoned healthcare to remind them that the man had been complaining of stomach pains throughout the day and was requiring his medication. The man was given his prescribed medication by Nurse L under the cell door. Nurse L did not enter the cell to examine him. The cellmate took the medication, and gave it to his friend with some water. Nurse L saw the man take the medication. The man did not complain of anything when Nurse L saw him. She said, "There was no groaning, no complaining, no moaning. He was only thankful to have his medication."

On 3 June at 0.30 am, healthcare staff were asked to attend the man's cell. An Operational Support Grade (OSG) contacted healthcare after being alerted by the man's cell mate that his friend was ill. The OSG also made contact with the

communications room. The night orderly officer, a Senior Officer (SO), and officer were contacted by phone to inform them a prisoner was in need of medical attention on A wing. The officers and Nurses L and R arrived at the man's cell within a few minutes.

Nurses L and R entered the man's cell with the SO. When they entered the cell, the man's appearance gave them immediate cause for concern and Nurse V asked for an emergency ambulance to be called. (The time recorded for the emergency ambulance to be called was 00.42 am.)

The man was lying on the top bunk. On examination, he was clammy to touch, bruising had appeared on the left side of his body, his mouth and fingers tips were cyanosed (turning blue in colour), his tongue was white and dry and his abdomen was hard all over. The nurses were unable to find a pulse and the man was breathing fast and shallowly.

The nurses placed a mask over his face and started to administer oxygen. A few moments later he vomited. The nurses, with the SO, moved the man from the top bunk onto the floor. The man became unresponsive and cardio pulmonary resuscitation (CPR) was commenced by the nurses. They were unable to insert an airway tube into his mouth. The nurses then requested the automatic external defibrillator machine from the treatment room on A wing. The defibrillator machine arrived and was attached to the man. It advised not to shock. The nurses continued with CPR until the arrival of the paramedics at 0.59am.

On their arrival, the paramedics inserted a line into one of the man's veins to administer fluids. He was unconscious by this stage. A defibrillator was used by paramedics as he went into Ventricular Failure (VF). (VF is a term to describe the onset of heart failure.) The man was given two shock treatments to try to re-start his heart.

At 1.30am, the ambulance left Preston with the man and a two officer escort. The man was taken to the accident and emergency department at a hospital but sadly died there at 1.50am.

A Governor obtained details of the man's next of kin. This was his mother. The Governor made contact with local Police who visited to inform her of her son's death. His mother's home did not have a telephone and, due to the time of night, the prison made the decision that a police visit was more appropriate.

On 4 June, a remembrance service with the lighting of candles in the man's memory was held in the prison chapel. On 7 June, a member of the prison's chaplaincy and a Governor visited the man's mother at her home to offer their condolences and support. A member of chaplaincy and a Governor attended the man's funeral service. The prison offered financial assistance towards funeral expenses.

The post mortem was carried out by a consultant forensic pathologist. He concluded that the man's death was due to natural causes. The man had suffered a cardiopulmonary arrest due to acute peritonitis (inflammation in the stomach area) caused by a perforated gastric ulcer.

ISSUES

A review of the man's clinical care was undertaken by a qualified doctor, with a LLM in the Legal Aspects of Medical Practice. The doctor has experience as an expert witness for the Crown Prosecution Service (CPS), the Police and HM Coroner.

The doctor was appointed to carry out a full and thorough investigation into the medical interventions leading up to the death of the man. The report was commissioned by Lancashire Constabulary, following advice from the CPS. All those members of healthcare staff who had seen the man, or been involved in his medical care, were interviewed by Lancashire Constabulary. A file was subsequently sent to the CPS. In June 2007, the CPS decided not to lay any criminal charges.

The doctor took evidence from police statements, the man's medical notes and the post mortem report. Statements made by prison officers on duty on 2 June 2006 were also considered. Lancashire Police readily agreed to me using this report for the purposes of my investigation. I am most grateful to them for this. The report is a comprehensive insight into the man's medical interventions and contains opinions about the actions of those healthcare staff involved in his care.

I agreed to the request from Central Lancashire PCT for them to commission an independent review of the man's care whilst in Preston, following circulation of the first draft report. A senior nurse practitioner, an independent professional adviser and Registered General Nurse, reviewed the man's healthcare and interviewed medical staff who had interventions with him at Preston. The nurse practitioner had sight of the first draft report, a copy of the man's medical notes and the doctor's report. The full copies of both clinical reviews are attached to this investigation report.

Review by the doctor with additional comments by the nurse practitioner

The man started using illicit drugs at the age of 21 years. Criminal activity meant that he spent some periods in prison. Over time, he had received treatment for his drug addiction and to some degree this was successful. However, by February 2006, he was smoking four bags of heroin a day, though he denied ever using any drugs intravenously.

On 1 May 2006, the man started a one year custodial sentence at Preston. Prior to his entry into prison he was using heroin, crack, and valium (benzodiazepines). The man was also receiving methadone treatment for his addiction. On 2 May, he started a 12 day detoxification programme. This would have finished around 14 May. On entering prison, the man underwent a standard nurse assessment. This did not reveal that he had any problems with his physical or psychiatric health. His substance misuse history was noted. Whilst on C wing a prescription chart noted that the man had been treated for four episodes of dyspepsia.

From 30 May until 2 June, the man shared a cell with a prisoner. During this time there is evidence that the man had been unwell and had attended special sick. The chronology of events appeared to start on 31 May. The man's problem may have symptomatically pre-dated this, although there is no evidence to support this. The prisoner said that on the afternoon of 31 May the man started to complain of 'stomach pain'. Several nurses attended to him. If several nurses attended to him then this should have been recorded in his medical notes. The doctor could not find any evidence of these clinical interventions. If the man was indeed attended to by nursing staff and this was not recorded in his notes, the failure to document the

consultations would have fallen below common and acceptable medical practice. During that day (31 May), according to the prisoner, the man vomited several times. Whilst there is no medical record of this or that the man reported his vomiting to healthcare staff, the information was noted in the prisoner's police statement.

On 1 June, at about 1.30pm, Nurses Z and W were asked (via radio) to go and see the man. Both nurses attended to him together. From the documentation it was not clear whether they had taken the man's medical file with them. On arrival at his cell, he was standing at the rear of the cell looking anxious. The man told the nurses he was suffering from abdominal pains and the pain was getting worse. He told the nurses he wanted to go to hospital. Nurse W was puzzled as to why the man looked anxious. They asked him relevant and general questions to ascertain the cause of the pain. They also performed some baseline observations. The man's blood pressure and pulse were both elevated. The doctor says that, on the balance of probability, they were elevated as a reaction to the pain he was suffering. Nurse W asked Nurse Z to return and check the man in one hour and check his urine for illicit drugs. The rationale for the latter test was that her working diagnosis/observations were that he might have taken some drug(s) and this could have been the cause of the pain.

The man was given paracetamol and Gaviscon and he 'leaped from his chair'. The nurses were puzzled that a man in apparent pain could be so energetic. Nurse Z stated that she would discuss the man's case with Dr A.

About one hour later, Nurse Z returned and saw the man. She found him to be more comfortable. She re-checked his observations and found them to be within the normal range. She also checked his urine for illicit drugs and this was negative. This test was done unobserved by Nurse Z and the sample of urine was given to Nurse Z by the man.

Nurse W wrote up the first consultation on 1 June at 1.30 pm. Nurse Z asked Nurse K to write up her consultation at 2.15 pm. The doctor notes the statement of the prisoner who said that the man saw a nurse or nurses on 31 May. If that was the case, it was not documented and Nurse W would not have been privy to that information.

The man's detoxification programme began on 2 May and would have finished around 14 May. There was a gap of 17 days before the man displayed any symptoms that could be attributed to drug withdrawal. Untreated heroin withdrawal typically reaches its peak 36-72 hours after the last dose and symptoms will have subsided significantly after five days. The man's urine test performed at 2.15pm on 1 June was negative for illicit drugs. The doctor concludes that the symptoms that the man was portraying should not therefore have been attributed to drug withdrawal and/or 'new' drug consumption. Urine tests are limited to illicit substances and may not detect all drugs, prescribed or otherwise.

The nurse practitioner noted in her review that, at the time the man was in Preston, methadone was not given on C wing as part of the detoxification process. This has since been revised and methadone is now given on the wing as part of the treatment. Methadone has a longer duration of withdrawal symptoms.

The doctor commented that the joint consultation that Nurses B and F had with the man at 1.30 pm was common and good medical practice. The consultation Nurse W had with the man at 2.15 pm was also common and good medical practice. The fact that Nurse K transposed Nurse W's observations for her was acceptable in the

circumstances. The nurse practitioner commented that it was Nurse Z who saw the man at 2.15pm, not Nurse W and it was Nurse Z who asked Nurse K to write in the man's notes.

On 2 June at 9.20 am, the man went to the treatment room and was seen by Nurse Z. Nurse Z had seen him the day before at 1.30 pm. The man gave the nurse a history of continued abdominal pain and pain in his shoulders. Nurse Z attributed the pain in his shoulders to the fact he had been retching based on the information available at the time. The doctor says it would have been acceptable to attribute the pain to this reason, although on the balance of probability this was probably not the case. The man also gave a history of vomiting. Nurse Z again performed some baseline observations. Some of these were elevated and hence abnormal. Nurse Z said she would discuss the man's case with Dr A. According to Dr A, Nurse Z subsequently mentioned to her, during morning surgery, that she had seen the man. Dr A offered to see him if the nurse was worried and the Nurse said she would let the doctor know.

Nurse Z had knowledge of the man's problem in that she had already dealt with him the previous day. Nurse W said that he had pains for several days. Therefore there was a continuum of the abdominal pain/problem. Nurse W quite astutely and correctly ruled out the pain being attributed to the use of illicit drugs. Nurse Z was then given a new symptom of vomiting. The doctor says that at this stage it would have been common and acceptable medical practice for Nurse Z to have informed the man he needed to see a doctor. With his agreement, and although the symptoms were not those of an emergency, an appointment for the man to see the doctor at some time that day should have been made. The fact this did not happen is, in the doctor's opinion, below common and acceptable medical practice. Moreover, although Nurse Z had discussed the man with Dr A, this was not recorded in his medical file. Nor did Nurse Z formally refer him for a consultation with Dr A. Again, the doctor judges that this fell below common and acceptable medical practice.

The nurse practitioner also commented that this consultation between Nurse Z and Dr A had not been recorded in the man's medical notes. The nurse practitioner is of the view that Nurse Z was correct and professional in not formally referring The man to the doctor, as she had discussed his symptoms with Dr A who was not concerned at that time and did not ask to see him. Dr A comments that it was untrue to say she was not concerned about the man. It implied she was in full receipt of all relevant facts. At the time of his death, the system operated in Preston was that the doctor relied on information provided by nurses. Dr A said had she been in full possession of the man's symptoms she would have been very concerned and seen him that day.

At 2.52pm, the man had a telephone conversation with his mother and someone else. During the conversation he told them about the pain he was in. He said, "Stomach's killing me, thought my appendix burst last night, getting better now."

The next event was at 4.30pm on 2 June. The man was sitting in a chair outside the laundry. There is no direct evidence of when the next clinical encounter occurred. On the balance of probability, he must have told someone that he felt unwell.

The nurse practitioner noted in her review that an officer found the man unwell in his cell at tea time. The officer had escorted the man to the treatment room. HSW P passed by and went to inform Nurse C that the man did not look well. Nurse C instructed HSW P to go ahead and perform some baseline investigations on him and then to report back with the results. Nurse Y also passed by and asked HSW P if

she needed any help. Nurse X was also then brought into the discussion. The man informed Nurse Y that he had vomited a number of times and that he felt thirsty. She asked him if he had taken any illicit drugs/substances. He denied this. HSW P took the man's blood pressure which was abnormally high at 230/? Nurse Y retook it and it was 185/130.

Dr A then apparently saw the man and noted that he looked a little pale. She enquired what was going on. Dr A was told by one of the nurses that the man had abdominal pain which had been coming and going all day. She was also told that he had vomited. Dr A performed a physical examination on him whilst he was lying back in his chair. Dr A found that he was tender in his upper abdomen but not rigid or shocked. Dr A was also informed that his blood pressure was 185/130, but the blood pressure machine could have been malfunctioning. Dr A asked one of the nurses to give the man 20mg of Buscopan and 10mg of Maxolon and to check him in two hours. Dr A then continued on her way to see another patient. Dr A did not make any notes in the man's medical records (but did make a note in her diary on her way home). Again, whilst this was an 'en passant' meeting, the doctor says a note should have been made on the man's medical record.

The nurse practitioner noted in her review that there was a dispute as to what drugs Dr A had verbally instructed Nurse Y to give. Dr A said Buscopan 20mg and Maxolon 10mg, Nurse X supported this. Nurse Y heard Dr A verbally instruct her to give 10mg of Maxolon and this is what was administered. Dr A also says that she had asked for a nurse to see the man, but this was not heard by Nurse Y or Nurse X who were present.

Nurse Y made no entry in the medical record about giving a drug on a verbal order, nor of the incident with the man. Dr A did not write up the drug as she was on her way to an emergency in reception, but she did make an entry in her filofax on the train on her way home.

Meanwhile, HSW P reported back to Nurse C with the man's observations. She also told Nurse C that Dr A had seen the man. Nurse C decided that she would go and see him herself. At some stage, Nurse C had a conversation with Nurse Z (thought to be at approximately 5.30pm). Nurse Z informed Nurse C that she had seen the man the day before and she suspected that he might have taken illicit drugs or some type of substance. She also told Nurse C that his urine had been checked for drugs and that it was negative. Nurse C assessed the man and she now also had a working diagnosis/idea that he might have taken some illicit drugs. She documented the consultation. Nurse C also told the man that if the pain returned he was to summon assistance via the call bell. Nurse C said that she informed one of the prison officers that she was handing his medical file onto the next shift, and that they in turn were to relay her concerns to the duty doctor. Nurse C further stated, "I wanted him referred to the GP." Nurse Z said she also spoke to Nurse X and Nurse Y and asked them to speak to Dr N. The prison log for 2 June at 5.50pm showed that Nurse C had attended to see the man and recorded, "doctor to see him this evening".

In summary, the evidence to support Nurse C's intention that the man should be seen by the duty doctor later that day was:

- Her hand-written notes in his medical records where she has written 'Refer GP'.
- The entry in the prison log stating 'doctor to see him this evening'.

- Her statement that she spoke to Nurse X and Nurse Y and asked them to speak to Dr N.

The doctor compared and contrasted this evidence with Nurse Y and Nurse X's accounts of events.

Nurse Y said, " Nurse C also brought the man's medical notes and put them on the nurse's station and had said that the notes were there for 'Dr N if he wanted to see them". Nurse X said that his interpretation of the conversation with Nurse C was to the effect that if the man complained any further then a doctor was to be summoned.

The doctor noted that the man clearly had an 'ongoing abdominal problem'. Nurse C had, quite correctly, gone to see him to gain first hand information and to 'get a handle' on the situation. This of itself was good practice. However, it was not clear from her entry and/or her interview statement whether she was or was not aware of the entries on the previous page, namely on 1 June at 1.30pm and 2.15pm, and also on 2 June at 9.20 am. It is the doctor's opinion that it was her responsibility to have been *au fait* with the previous entries.

Nurse C said that she felt that the man might have taken illicit drugs or swallowed a package. The doctor noted that Nurse C knew from Nurse Z that the man's urine test from the previous day had been negative for drugs. Therefore, to be consistent with her working diagnosis, he would have to have been actively taking drugs. A logical progression in the management process would have been to repeat the urine test, but Nurse N did not do that. If Nurse C genuinely felt that the man had swallowed some type of package or drugs (which she had put forward as a possibility), then in the doctor's view, Nurse C should have known that could have been a potentially serious situation or emergency. In that case, she should have summoned the doctor immediately and not waited for the next shift of nurses to inform the duty doctor.

The nurse practitioner commented in her review that Nurse Z gave Nurse C a handover of the man's history as the notes were not available at that time. Nurse Z then left. Nurse Z had been in attendance on the visits on 1 and 2 June. Nurse C wrote in the notes that information had been gained second hand from a healthcare assistant. She also recorded, 'seen by Dr A Buscopan 10 mg'. This was incorrect. Nurse C twice asked the man if he had taken any drugs and both he and his cell mate denied this. He also told her that he "gave a piss yesterday and it had been negative". Nurse C said that the man had refused to give a specimen which she felt was because of his dehydration. This was not reported in her police statement under caution. Nurse C admitted that she felt bad as she was on the wrong track with the drugs, but said she was thrown off track as the doctor had seen him only an hour before. When interviewed by the nurse practitioner, Nurse C said that she was suspicious of both the man and his friend as they were both quiet.

The doctor concluded:

- Nurse C should have been aware of the previous entries in the man's notes and his unfolding history. It is a possibility however that she was aware of this.
- If Nurse C felt that her working diagnosis was that of the man taking illicit drugs or some type of substance, then she should have re-checked his urine. She did not do that.
- If Nurse C felt that he had swallowed a package, she should have immediately referred him to a doctor as a potential emergency.

Nurse X's interpretation of his conversation with Nurse C was that it was in the form of a 'proviso'. That is, if the man complained any further then the doctor was to be contacted. On 2 June, Nurse X was due to finish his duties at 8.30pm and then hand over to night staff. The doctor says that if this interpretation of Nurse X's conversation with Nurse C is accepted, it was incumbent on him to have handed over the information to the night nursing staff. If Nurse X did not do this, then his standard of care would have fallen below acceptable medical practice. From the available evidence, the doctor says it is not possible to establish whether or not this happened.

The nurse practitioner further noted that, when Nurse X was interviewed about the verbal handover from Nurse C to Nurse Y and himself, he thought she was speaking to Nurse Y. It gave the nurse practitioner the impression that he was not giving it his full attention. Nurse X had been on duty since 7.45am that day.

With regard to the consultation with Dr A, the doctor commented that the consultation with the man was very much 'en passant'. It was a very brief encounter, Dr A meeting him whilst going to see another patient. From the evidence before the doctor, Dr A was not given the man's medical records. Neither was she presented with the whole of his clinical history. The impression the doctor gained is that she only saw a 'snapshot' of a 'window' of the man's problem. Based on that, she made an examination and decided to treat him symptomatically and then check on him in one to two hours time. The doctor also notes that Dr A verbally prescribed medication for the man rather than formally writing up the medication on a prescription chart. This latter task was left for Dr N. The doctor concluded:

- That the medical care given by Dr A was common and acceptable medical practice.
- The fact that Dr A verbally prescribed the man's medication without formally writing it out was acceptable practice in the circumstances.

The nurse practitioner commented in her review that once Dr A stopped, questioned and examined the man did she not, by her actions, accept medical responsibility for his care?

With regard to Dr N, the doctor noted that he merely formally prescribed Dr A's verbal prescription. In this situation, that would have been acceptable practice.

The nurse practitioner commented that Dr A verbally prescribed medication for The man rather than formally writing it up on a prescription chart. The latter task was left for Dr N. The nurse practitioner considers that the statement suggested that Dr N was only writing up the drugs that Dr A had verbally prescribed. Dr A said that she would have written up her own prescription chart the following day. Nevertheless, Dr A was not on duty the following day at Preston. At this time verbal instructions were acceptable, although following the man's death a Root Cause Analysis highlighted this as inappropriate. Dr N wrote the medication chart for Maxolon prn and Buscopan qds. The nurse practitioner spoke with Dr N and he did not recall being asked to write up the verbal instructions of Dr A. He said that he had been asked to write up a prescription for a man who was vomiting/nauseous and had abdominal pain.

The nurse practitioner further commented that Dr N had prescribed drugs to a patient whom he had not seen and of whom he had no knowledge. The nurse who had asked him to prescribe medication had only limited knowledge, and he did not

question Nurse X with regard to the man's health status. The nurse practitioner criticised the manner of his prescribing practice.

On 2 June at 9.15 pm, Nurse L was on night shift. The man's cell mate had reminded prison officers that the man's medication was due. Nurse L attended and gave him his medication via a hatch. Nurse L had been able to see the man and there was apparently nothing about him that gave her any cause for concern. Nurse L also said that neither the man, nor his cell mate, gave her any indication that anything was wrong.

The doctor compared Nurse L's version of events with that of the man's cell mate. The cell mate stated that about 7.45 pm, "The man was still ill and told me the doctor had not been to see him." The doctor's own understanding of cell mate's account would be that his friend was expecting to see a doctor at some time on 2 June. He noted that according to cell mate's account, "I felt he needed to see a doctor … I pressed the buzzer again and was told that a doctor was not coming but a nurse would see him."

The doctor referred to Nurse X's version of events during the early evening of 2 June. Nurse X maintained that Nurse C's instructions were that, if the man summoned help again, he was to be seen by a doctor. There is some controversy here namely:

- Did Nurse C request the night staff to call a doctor?
- Did Nurse C request that a doctor be called if the man had further pain?

If Nurse X's version is to be accepted then clearly he should have passed this information onto the night staff. There is therefore clear evidence that the man asked for medication for his stomach pain, yet it appears that the night staff were not aware of this request or that it should have been a trigger for them to ask for the doctor to attend.

In the early hours of 3 June, the man's condition rapidly deteriorated. Prison officers and nursing staff, namely Nurse L and Nurse V, attended to the man. A 999 call was made and the paramedics arrived. They gave life saving support to him and took him to hospital. The man arrived there at 1.35 am and was certified dead at 1.49 am.

It is the doctor's opinion that, at several junctures, there was a failure to refer the man to a general practitioner. In consequence, "the standard of medical care fell below common and acceptable medical practice".

The doctor said it would require an expert in surgery to judge what the man's chances of successful treatment would have been had he been referred to a doctor sooner. He said he is not such an expert but, in his personal view and on the basis of research, he believes his chances of survival would have been high to very high.

However, this pre-supposes that a doctor would have referred the man there and then to hospital for secondary care. The doctor said it is impossible to say what action a doctor would have taken. It is possible that if the man had presented with 'classical' signs of an imminent perforation he would have been referred for immediate secondary care. However, if at the time the signs were not 'classical' then the doctor might have decided to adopt a more conservative approach by the use of medication, observe and review. The doctor added that, if the signs were not 'classical', then this latter approach would be common and acceptable medical practice.

RECOMMENDATIONS

My recommendations are closely based upon the clinical review.

On 31 May 2006, the man started to complain of stomach pain. He was apparently seen by more than one nurse. There is no record of any assessment or treatment in his medical record. The failure to document the consultations falls below common and acceptable medical practice. These recommendations are supported by the doctor and the nurse practitioner.

Medical consultations with prisoners must be recorded fully at all times. The medical notes should be dated, timed, and signed, and the author should print their name and qualification.

Accepted – The Director of Health Standards (PCT) will inform GP's working in prison healthcare of this requirement.

A record must be made of all medical discussions concerning patients made between nursing staff, doctors and other healthcare professionals.

Accepted – The Director of Health Standards (PCT) will inform GP's working in prison healthcare of this requirement.

Nurse Z

On 2 June 2006, the man went to the treatment room at 9.20am. He was seen by Nurse Z who had also seen him the day before at 1.30pm. Nurse Z made an entry in the medical record about her assessment, and could see that Nurse W had made an earlier entry that the man 'had pains for several days'. Nurse W had also ruled out the abdominal pain being due to the use of illicit drugs. It would therefore have been common and acceptable medical practice for Nurse Z to have referred the man to a doctor. Her failure to formally refer him to Dr A means that her medical care fell below common and acceptable medical practice. Nurse Z also failed to write up a note of her discussion with Dr A about the man's case.

Preston Primary Care Trust should commission an independent investigation into the apparent omissions on the part of Nurse Z and her failure to adequately record the consultations.

Response by the nurse practitioner within her clinical review

Nurse Z's standard of record keeping did not meet the required standard on three separate occasions and therefore her actions fell below the Nursing and Midwifery Council's Code of Professional Conduct

Having consulted Dr A and discussed the man's condition, the doctor agreed to see him in the afternoon if required. On being told that he had attended A wing treatment room, Nurse Z had been prepared to act and get the doctor to see him, only to be told that Dr A had already seen him. The nurse practitioner felt that Nurse Z had acted in a professional manner.

Accepted – The nurse practitioner commissioned to undertake this review. The out come and subsequent recommendations are included in this action plan.

Nurse C

Nurse C visited the man in his cell at 5.35 pm on 2 June 2006. She seemed to form a working diagnosis that he had swallowed a package or was detuning having taken illicit drugs. If she genuinely thought he had swallowed a package she should have immediately referred him to the doctor as a potential emergency. She did not do this. Nurse C's standard of care therefore fell below and acceptable medical practice.

Preston Primary Care Trust should commission an independent investigation into the apparent omissions on the part of Nurse C.

Response by the nurse practitioner within her clinical review

Nurse C's record keeping did not meet the required standard and therefore her actions fall below the Nursing and Midwifery Council's Code of Professional Conduct.

Nurse C did not act on her findings when she wrote in the notes that the man had taken some form of drugs. If she was very concerned, she should have rung the doctor herself and passed on this information. The fact that the patient was dehydrated should have been discussed at the same time. It would have then been the doctor's decision what action to take. The fact she did not do so means her actions fall below the Nursing and Midwifery Council's Code of Professional Conduct.

Accepted – The nurse practitioner commissioned to undertake this review. The out come and subsequent recommendations are included in this action plan.

Nurse X

Nurse X's interpretation of the instructions given by Nurse C was that a doctor was to be contacted if the man complained any further. If this was correct, it was his duty to pass this information onto the night nursing staff. There is no documentary evidence that he did this and therefore his standard of care fell below common and acceptable medical practice.

Preston Primary Care Trust should commission an independent investigation into the apparent omissions on the part of Nurse X and his failure to adequately record the consultations.

Response by the nurse practitioner within her clinical review

Nurse X and Nurse Y were responsible for receiving the handover from Nurse C. Both were equal in status. Nurse X did not take on board Nurse C's view that the man had taken some form of drugs. This piece of information was not passed on to the night staff and there were no enquiries made about his condition. The night staff do not appear to have been told that if the man complained again he should be referred to the GP for a review.

Nurse X did not mention to Dr N Nurse C's suspicion that the man had taken some form of illicit drugs prior to asking him to prescribe medication for him.

Nurse X's actions fell below the Nursing and Midwifery Council's Code of Professional Conduct.

Accepted – The nurse practitioner commissioned to undertake this review. The out come and subsequent recommendations are included in this action plan.

Handover at change of shift

There was no written record at the change from day to night shift nurses to inform the incoming staff of the medical interventions on 2 June in relation to the man.

At the change of nursing shifts, a documented handover must be given, detailing all relevant medical information given to the incoming team.

Accepted – The loose leaf handover sheets have been replaced with diaries. A management check is also in place to ensure these are completed.

The nurse practitioner suggested 13 further recommendations. These are listed below and are for the attention of Central Lancashire PCT.

Record keeping training is seen as a priority for all staff. A full audit of all records should be undertaken. Management to monitor an agreed percentage of records on a quarterly basis. I would recommend a combined shared record within the prison, two separate methods of recording could lead to omission of information.

Accepted – The PCT are currently delivering record keeping training. Healthcare staff will be scheduled to attend this training. A PCT wide record keeping audit is also taking place. HMP healthcare is involved in this PCT wide audit. An internal audit of records is also scheduled as part of the healthcare audit calendar.

There is a documented handover of care folder in use at the present time, this is a ring binder using loose-leaf papers. I would suggest that this is revisited, as it is open to abuse. I would recommend that the doctors prepare a written handover.

Accepted – The loose leaf handover sheets have been replaced with diaries. A management check is also in place to ensure these are completed.

PCT to decide on what action to take, if any, in relation to the breaches of the Nursing and Midwifery Code of Professional Conduct by Nurse Y, Nurse X and Nurse C. The actions of Dr N and Dr A should be referred to the Medical Director for guidance on what, if any, action is necessary.

Accepted – The clinical review undertaken by the nurse practitioner has been forwarded to the PCT Human Resources department for action in relation to Nurses J, S and C. The clinical review has been referred to the Core Performance team on 27 February 2008 for advice in relation to Dr N and Dr A.

A record should be kept of who is holding Hotel 2 radio at all times.

Accepted – This has been included in the handover diaries in use and a management check has been implemented to ensure this takes place.

The PCT and Prison Management to produce a protocol that ensures health staff are notified of prisoner movements as they happen and that all health records are collated and sent to an agreed point on the same day.

Partially Accepted – Prisoner location has always been determined by checking the Local Inmate Data System. At the time of the review records were either kept in healthcare administration or the drug dependency unit dependent upon patient

location. The healthcare service will go live with a clinical data system at the end of April 2008. This will enable staff to access electronic records including medication administered. During the next six months paper based records will be replace with electronic records. A support worker has also been employed in the Drug Dependency Unit who role entails ensuring transfer of records and prescription chart when patients/prisoners are relocated.

A Protocol must be included in the drugs policy regarding the use of verbal instructions for the administration of medicines.

Not Accepted – The PCT administration of medicines policy ratified in November 2007, does not permit medication to be given under verbal instructions. All medications administered should be either under a Post Graduate Doctor of prescribed by a suitably trained person.

Management to discuss with the Medical Director the practice by some medical staff of prescribing drugs without having seen, or having personal knowledge of the client, or having read the medical records.
Accepted – A meeting is planned with the Medical Director to seek advice on this area of practice.

Management to look at ways of reducing the high level of staff turnover.

Partially Accepted – Prior to and subsequently to this review management have worked with human resources to ensure recruitment and retention of staff is within acceptable levels and any areas of concern are addressed. Actions have involved recruiting staff with relevant experience and increasing the induction period. However, this area will remain under constant review.

Management to look at ways of identifying the reasons for the high levels of staff sickness.

Accepted – Training is to take place with managers to ensure sickness levels are proactively managed. Sickness levels are monitored as part of the PCT targets.

Management to look into ways of reducing the large amount of overtime worked.

Partially Accepted – Prior to and subsequently to this review management have proactively worked to address recruitment of staff. This has reduced the amount of overtime staff are working. Management also closely monitor overtime to ensure no staff work The introduction of bank staff has also reduced the amount of overtime permanent staff are required to work.

Management to revisit the use of agency workers and to work with the agencies to look at ways of providing experienced staff that has undertaken training in working within the prison setting.

Not Accepted – The use of a core group of agency and bank staff have always been in place due to the requirement to ensure all staff are security cleared. Agency and bank staff are also required to undertake a prison induction as well as healthcare induction.

Jail craft is a five-day course run by the Prison Service. It deals with life in the prison setting and how to deal with prisoners. This or something similar would offer a better insight into the health workers role within the prison.

Accepted – Previous enquires have been made about this course. Healthcare will work with the training department to determine the feasibility of running this course or something similar locally. All staff prior to commencement attend a two week prison induction. Staff also undergo a six week healthcare induction to ensure they are familiar with working in a prison setting.

A number of staff voiced that at times they had difficulties with prison personnel. I would suggest a working group to look at solving these issues.

Accepted – A local issue forum has been developed to improve joint working between healthcare and residential staff. Healthcare will also attend Smelt Mill, a team building event with prison staff.