

**Investigation into the circumstances surrounding the
death of a man in a hospital in May 2009,
whilst in the custody of
HMP Norwich**

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

October 2010

The man was admitted into a hospital on 26 May 2009 after being taken ill whilst a prisoner. He died the following day aged 30. The cause of death was meningitis secondary to sinusitis.

A senior investigator, family liaison officer, and I would like to offer our condolences to the man's family and friends for their sad loss.

I wish to thank the Governor for his assistance in making the necessary facilities and information available to the investigator.

To assist the investigation, I asked for a clinical review to be carried out into the medical care received by the man whilst he was in prison. I am grateful to NHS Norfolk who appointed a reviewer to review the care the man received. They also asked an independent consultant to oversee the review. I appreciate their assistance.

This investigation has identified a number of issues relating to not only the man's medical care, but also that of a more general medical nature. Although the clinical review recommendations made in this report relate directly to his care, I encourage NHS Norfolk to read the clinical review report in full and consider the wider findings.

In addition to the medical findings, I make one recommendation regarding the decision to appoint an untrained person to be the prison family liaison officer for the man's family.

Since taking over responsibility in April 2004 for the investigation of all deaths in custody, there have been 17 deaths at the prison, including that of the man. In nearly every case the Ombudsman has identified issues relating to healthcare. I am aware that the PCT has developed its own action plan to deal with those recommendations and those of its own internal auditing procedure. Additionally, the PCT are aware of the clinical review findings in this case and have incorporated them into their action plan.

Jane Webb
Acting Prisons and Probation Ombudsman

October 2010

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SUMMARY

The man was sentenced in June 2008 to four years nine months imprisonment. He was taken to a prison and, during the routine reception procedure, told prison staff that he was a regular user of drugs. He made it very clear in the early stages of his imprisonment that he wanted to change his behaviour and so he engaged with the support services to help break his habit.

As part of his commitment to changing his lifestyle, and wanting to help others, the man became one of the prison Listeners. Listeners are selected and trained by the Samaritans and offer an invaluable support to prison staff in helping keep vulnerable prisoners safe.

Over the following months the man settled into prison life. He was well liked by prisoners and staff and gave no cause for concern. It is for this reason that the report concentrates in the main from the point when he first showed signs of illness.

In April 2009, after a nurse noticed that he was not his usual self, the man spoke to her and said he was experiencing headaches. His condition was assessed and, as a precautionary measure, he underwent specialist assessment at hospital's Neurological Department. The tests did not find anything abnormal.

On 26 May, the man was found on his cell floor conscious but incoherent. Following assessment by a prison doctor, he was admitted into the prison healthcare for observation. It was whilst in healthcare that he became unconscious and was transferred later that day as an emergency patient to hospital. Sadly the man died the following day. I understand that the Coroner has said that he died as a result of meningitis secondary to sinusitis.

The clinical reviewer has identified a number of issues relating to healthcare procedures at the prison, although not all are directly linked to the man's medical care. I make one recommendation which relates to the decision to appoint an untrained prison family liaison officer.

THE INVESTIGATION PROCESS

1. Once the Ombudsman had been notified of the man's death, the investigation was allocated to a Senior Investigator. A Family Liaison Officer (FLO) was also appointed.
2. To assist the investigator, I asked NHS Norfolk to carry out a clinical review. A reviewer was appointed to review the medical care. NHS Norfolk asked an independent consultant, to oversee the review and ensure a proper level of independence.
3. In the meantime, the FLO contacted the man's family and invited them to contribute to this investigation. His mother told the FLO that she wondered whether her son had received the same level of healthcare as he would have received in the community. She felt that her son would have received faster treatment if he had been seen by his own doctor.
4. The mother also said that her son had not been prescribed antibiotics and, had he done so, his meningitis may not have developed. Additionally, she said that her son complained of headaches for several weeks and had been prescribed pain killers, but the treatment had not been reviewed.
5. A further concern for the man's mother was that her son had been to hospital for a scan. She said this indicated that prison staff were aware that he had a potentially serious condition. The mother questioned why it was over four hours after her son was found "mumbling" in his cell, before he was taken to hospital. The man's family received a copy of my draft report. I am grateful to them for the time they have taken to consider my findings. Some of the matters they raise are for the Coroner to consider at the inquest. Those which are relevant to the findings of my investigation are included and addressed within the issues section of this report.
6. On 13 July, the investigator, clinical reviewer, and the FLO met the Governor at the prison. The purpose of the meeting was to open the investigation and to identify any key issues relating to the man's care.
7. Following that meeting, the investigator and clinical reviewer began their investigation and interviewed a number of staff. Two days later, they met the Governor and gave their preliminary findings. Following that meeting, the investigator wrote to the Governor outlining the feedback given, reminding him that the case was still under investigation, and the initial findings were subject to change.
8. On 31 July, at the invitation of NHS Norfolk, the investigator attended a clinical review panel meeting. The purpose of the meeting was to discuss and review the progress of the clinical review and identify any issues relating to the man's medical care. The meeting was chaired by the Chief Nurse for NHS Norfolk. In addition the following people attended:

Commissioner for Prison Healthcare

Deputy Head of Prescribing and Medicines Management, NHS Norfolk
Head of Clinical Governance NHS Norfolk
Independent Monitoring Board HMP Wayland
Independent Consultant
Prison Liaison Officer representing HMP Norwich
The Clinical Reviewer

9. The following month, on 11 August, the investigator and clinical reviewer returned to the prison to continue the investigation. Over the next two days, they interviewed healthcare staff and two prisoners. Before leaving the prison on 13 August, the investigator and clinical reviewer met the Governor to give additional feedback. The Governor accepted the feedback and said he would discuss the issues at a meeting the following day with the commissioning authority for healthcare.
10. On 1 December, the investigator and clinical reviewer met the prison Head of Healthcare, prison liaison officer representing the Governor and the Coroner's Officer. Unfortunately, the Healthcare's Assistant Director of Quality was unable to attend the meeting. The purpose of the meeting was to feedback the findings from the clinical review and to allow the healthcare commissioning authority the opportunity to incorporate the report within their ongoing action plan. It also enabled the coroner's officer to listen to the issues raised during this investigation and to prepare a briefing report for the Coroner.
11. The Head of Healthcare told the meeting that a number of the issues were already being dealt with, but that she recognised that they should be identified in this report. Both she and the prison liaison officer accepted the findings and recommendations. I wish to thank them, and the coroner's officer, for their assistance.

The Prison

12. HMP Norwich is a local training prison, with a separate young offender institution. The adult side of the prison holds male sentenced and remand prisoners. It also has an older prisoner unit.

Healthcare

13. Healthcare services are commissioned by NHS Norfolk and provided by Norfolk Community Health and Care, Norfolk Waveney Mental Health Partnership NHS Trust, Independent providers and East Anglia Ambulance Service. The healthcare service provided at the prison consists of:

- primary medical and nursing services
- out of hours and 24 hour nursing cover
- mental health in reach services
- community services
- dentistry
- in patient care unit
- life sentence prisoner inpatient unit.

14. Norwich prison healthcare use a computerised documentation system, known as SystemOne.

Her Majesty's Chief Inspector of Prisons

15. Her Majesty's Chief Inspector of Prisons reports on all Prison Service establishments. In November 2006, the Chief Inspector of Prisons carried out an unannounced inspection at Norwich. In her report, published in March 2007, and referring to a previous inspection, she said this inspection found that the prison had tried with some success to grapple with some of the key problems identified, but national population pressures had either undermined, or thrown off course, much of the work being done. The Chief Inspector of Prisons went on to say that previous criticisms of suicide and self harm procedures had been fully addressed.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) and their role is to monitor the prison and to report any concerns that they have regarding the prison, or how prisoners are treated. Board members are able to visit any area of the prison at any time and have direct access to any prisoner who they wish to see, or who requests to see them. The Board holds regular meetings in the prison, with the Governor attending for part of the meeting. The Chairperson of the Board produces an annual report to the Secretary of State for Justice.

17. In their latest annual report, covering the period 1 March 2008 to 28 February 2009, the Board, when referring to healthcare, said:

“the continued absence of a dedicated GP service puts the proper provision of healthcare, including mental health, within HMP Norwich seriously at risk. Action should be taken to ensure that patients with health, including mental health, needs receive treatment equivalent to that given in the community in general.”

18. They went on to say:

“Although the provision of healthcare to the prison population has improved since it has been financed by the NHS, there is still some way to go before prisoners have the same access to healthcare as those outside prison. There is an even greater distance to cover for them to get access to healthcare that fully meets their needs.

“The most serious risk to the provision of healthcare within the prison is that after a number of years, there is still no dedicated GP service. The locum service has been shown to have serious deficiencies.

“Nurse practitioners have been introduced and are seeing an increasing number of prisoners, thus taking some pressure off the GP service. However, some prisoners are missing their appointments because it is believed, of a lack of commitment to escort them to clinics...”

19. The Board also said “clinical reviews of deaths in custody have identified the need for the current provider to urgently undertake a skill mix review to reflect the importance of reception screening by appropriately skilled staff”.

Prison Service Orders (PSO)

20. Prison Service Orders are long term instructions which are intended to last for an indefinite period. Any mandatory instructions to Governors or Directors of contracted prisons are written in italics. Each PSO is given a title and unique reference number.

Prison family liaison officer (FLO)

21. Following any death in prison, the prison Governor is required to appoint a family liaison officer to be the first contact in the prison for the deceased person’s family. PSO 2710 contains advice and guidance that supplements the mandatory instructions in the PSO.

Counselling, Assessment, Referral, Advice and Throughcare service (CARATs)

22. CARATs teams are in place in each prison in England and Wales. The service provides support and non-clinical treatment to prisoners with substance misuse

needs. CARATs offer a number of interventions for prisoners, including one to one counselling and groupwork, and liaising with community services prior to release.

Rehabilitation of Addicted Prisoner Trust (RAPT)

23. RAPT deliver drug and alcohol services in prisons and in the community, aimed at helping people move away from addiction and crime. The services provides a variety of support, including advice, counselling, group work and intensive treatment. They also work with the families and carers of substance misusers, as well as substance misusers themselves.

KEY FINDINGS

24. Imprisonment was not a new experience for the man. He had been in prison in September 2001 after being sentenced to two months imprisonment. He was released the following month.
25. On 2 June 2008, the man was sentenced to four years and nine months imprisonment. He was due to be released on 18 October 2010. Following his appearance at court, the man was taken to HMP Norwich, which is where he remained until he was admitted into hospital on 26 May 2009.
26. During the reception procedure, the man told prison staff that he had a daily drug habit. He said that he had regularly used heroin and crack cocaine, which he said he smoked. He hoped to use his sentence as an opportunity to stop his drug use. As part of that commitment, the man was offered support from the Counselling, Assessment, Referral, Advice and Through care service (CARATs) team and, later on in his sentence, he joined the Rehabilitation of Addicted Prisoner Trust (RAPT) programme.
27. In addition to telling reception staff about his drug habit, the man said he had suffered from depression some years earlier. In her clinical review the clinical reviewer said the man had, on that occasion, been prescribed Prozac. She added that he recommenced treatment and continued to be treated for depression throughout his sentence.
28. It appears from the prison records that the man settled down well into prison life and, on 10 November 2008, he attended the first of a 12 session RAPT programme.
29. At interview, a Focal Counsellor for RAPT said the man had asked to join the programme because he wanted to change his life and because his drug use had affected his family and relationships. The counsellor said when he first joined the programme he was quiet and polite. She said after about two weeks, he told her that he had taken drugs in the prison and been tested as part of the prison drug test routine. The counsellor added that when the test result came back it was negative.
30. The man continued to attend the RAPT programme and, according to the counsellor, he became more positive and willing to express his views. However, on 8 February 2009 during a routine drug test, he tested positive for heroin. The counsellor said he was remorseful and regretted his actions. She said it was a turning point in the man's life as he recognised that he needed to address his vulnerability.
31. The counsellor went on to say that the man had also become a Listener. She said this was something he enjoyed doing as he "felt good at helping others".
32. The man had been diagnosed as positive for hepatitis C prior to coming into prison and had undergone further diagnostic tests to enable a treatment plan to be provided for the remainder of his sentence. The clinical reviewer said

the ongoing investigations showed that, although this was rare, the level of the virus was reducing. She said that discussions were taking place between specialists to see whether his body was clearing the virus naturally.

33. As the man had hepatitis C, he was given support within the prison by a Registered General Nurse (RGN), a specialist nurse. The RGN ran a group meeting for prisoners with hepatitis and got to know the man well. She described him as an articulate, intellectual and humorous man.
34. On 21 April, the RGN spoke to the man as she was concerned that he was not his “normal self”, describing him as looking “off colour”. The nurse said he told her that he had a headache, which he said had started some days earlier. He also said that he might have hit his head about two weeks earlier although the prison has no record of an injury. Concerned about the continuing headache, the RGN arranged for the man to be assessed by a prison doctor that day.
35. At about 4.15pm, the man was seen by a doctor. The clinical reviewer explained to the investigator that the man’s medical notes show a ten day history of headaches which started suddenly and became worse during coughing and forward movement. In order to rule out any bleeding in the brain, the doctor discussed the symptoms with a neurological registrar at the hospital. Following their conversation and to enable further investigation, arrangements were made to transfer the man as an emergency patient to hospital. He was admitted the same day under the care of a Consultant Neurologist.
36. While in hospital, the man underwent blood screening, lumbar puncture investigation and a computerised tomography (CT) scan of his head. (A CT scan uses computerised tomography, a combination of x rays and computer software to see into the body.). There were no abnormal findings and sinusitis was also ruled out.
37. Two days after being admitted, on 23 April, the man was discharged from hospital and returned to the prison. The hospital doctor recommended that he should continue to take mild pain relief and that no follow up action from the neurological team was required. He was given a supply of pain relief and anti inflammatory medication, and told to refer back to healthcare if the headaches continued. The clinical reviewer notes that there is no record of the man referring himself back to healthcare. However, when a nurse saw him on 30 April, it was noted that there had been an improvement in his condition.
38. On 19 May, the RGN met the man as part of her ongoing support for prisoners with hepatitis. She said that he “was not himself” and told her he had not renewed the pain killer prescription, as he had felt better. However he also told the nurse that the headache had returned. The RGN said there was no doctor available in the prison at the time and so she examined him. Her examination revealed that he had a slightly enlarged pupil in his right eye, which was the only thing which was abnormal. The nurse contacted the

neurological team at the hospital and spoke to another Neurological Consultant. The clinical reviewer said the consultant did not consider it necessary to see the man that day, but had said a neurological registrar would return her call, once the records from his previous admission had been reviewed.

39. The next day, a secretary from the neurological team telephoned the prison to discuss arranging an out-patient appointment. At the end of the conversation, the secretary wrote offering the man an appointment for 10.00am on 29 May. (The prison told my investigator that the letter was not received at the prison until after the man returned to hospital.)
40. As part of this investigation, the investigator spoke to two prisoners. One of them said that he had been into the man's cell over the weekend of 23/24 May and had found him lying on the floor. He said that he told an officer who told him that other officers were aware of the situation. The prisoner was unable to remember who he had spoken to.
41. The other prisoner said that he too had spoken to prison staff about his concerns for the man, but like the first prisoner, could not remember who the officer was. He said that the man had been so ill that he had collected his meals for him and taken them to the cell. Despite efforts to identify and speak to the officers concerned, the investigator has not received any response to his requests for information.

26 May

42. At about 9.00am, an officer unlocked the man's cell to allow him to go to work as a wing cleaner. At interview the officer said he spoke to the man who was still in bed at that time. The officer said the man acknowledged him by waving. He added that it was not unusual for him to still be in bed and that he was not concerned about him.
43. About 90 minutes later, the officer returned to the man's cell as he had not started his cleaning duties. When he went into the cell he spoke to the man but could not obtain a coherent response. Concerned about his welfare, the officer left the cell to speak to a nurse. Initially, the officer had some difficulty speaking to a nurse as they were busy. As he did not consider the man's condition to be serious, he said he did not ask for urgent medical assistance at that time.
44. After making the telephone call, the officer returned to the man's cell. When he went into the cell he saw him lying on his back on the floor, with his feet on the bed. He was waving his arms around and was incoherent. The officer left the cell and telephoned the Day Centre where he was able to speak to a nurse. He said that after telling the nurse he wanted someone to see the man, a nurse arrived very quickly.
45. The officer said the nurse had a look around the man's cell and found various empty packets of medication. The empty packets were:

Mitripizine 45mg, an antidepressant medication.
Diclofenac 75mg, an anti-inflammatory medication.
Brufen 400mg, an anti-inflammatory medication.
Co-Codomol 500mg, a pain relief medication.

46. The officer said the nurse thought that the man might have taken an overdose of drugs. The officer said the nurse checked the man's vital signs and that she told him they were normal. The officer said that by this time the man was beginning to grab at things and pulling items out of his locker.
47. In her evidence, the nurse said that when she arrived, she saw the man lying on the cell floor, wearing just his underpants. She said examination was difficult due to the way the man was kicking out and that the prison staff were concerned that she might be hurt. The nurse said she had been able to monitor his pulse rate, and found it to be within normal limits and regular. Nevertheless she was concerned about his condition, and asked for the prison doctor to be called urgently.
48. The duty doctor that day was asked to assess the man; he went straight to the cell. When he arrived, he saw him lying on the cell floor, tapping the wall. At interview the doctor said the cell was "disorderly" and, during his examination, he saw a number of medication packets in the toilet bowl. He said the man did not respond to his questions and was reluctant to have a physical assessment. However, the doctor continued with his examination, which he said revealed normal power to the limbs, equally reactive pupils and a steady pulse.
49. There was another officer present at the same time. He told the investigator that the man was lying underneath a table holding onto one of the table legs. The officer said the man was shaking. He said the man had a small drink of juice, but was incoherent.
50. After completing his examination, the doctor decided to refer him to the mental health team, as he was unsure whether the condition was psychological or organic. (This means the doctor was not certain if the problem was a result of mental or physical health problems.)
51. The clinical reviewer said that a member of the mental health team arrived at the man's cell within about ten minutes, but was unable to assess his condition properly. (The name of the team member who attended is not recorded in the medical record.) A decision was made to transfer him to the prison healthcare department, as it has an inpatient facility. Because healthcare is located on the opposite side of the road to the main prison, it meant he would have to be taken out of the main prison in a vehicle. The journey required prison transport to be used and the transfer was given priority. A number of prison officers helped and supported the man to the vehicle and during the short journey, as he was unable to walk unaided. A nurse also accompanied him in the vehicle.

52. Shortly before 1.00pm, the man arrived at the healthcare department. He was unable to walk and was taken into healthcare in a wheelchair.
53. When he arrived in healthcare, the man was assisted into bed. The nurse with him at that time said the man was unsteady, but was able to walk a few paces with “considerable help”. She said there were no baseline clinical observations taken of his temperature, pulse and blood pressure, as he was a “good colour”. The nurse said she understood the plan for him was that he would be reviewed later by a doctor.
54. A Senior Officer (SO) is the manager for the discipline staff employed in healthcare and he was there when the man arrived. At interview he said that the man was incoherent. Over the lunchtime period, the man pressed his cell’s emergency call button on at least two occasions, possibly three. The SO said he went to the cell each time, but could not understand what he was saying.
55. At about 2.40pm, the SO went to the man’s cell as part of a routine check. He looked inside the cell, through the door observation panel, and saw him slumped over on his bed. The man did not respond to the SO. The SO said that, although he could see him breathing, he immediately called for a nurse. Having called for assistance, the SO went into the cell and noticed a discharge from the man’s nose and that he had moved.
56. At interview, a nurse said when she went into the cell she saw that the man had urinated and there was froth coming from his mouth. She placed him into the recovery position and asked for an ambulance to be called. Additionally, she asked another nurse to assist her by taking his clinical observations.
57. A nurse said that when she went into the cell she carried out her own checks. She said that the man’s right pupil was fixed and dilated and his right hand was “spastic” (meaning that it was contorted and rigid). The nurse checked his reflexes, but there were none. She also noticed that there was froth around his mouth.
58. In her clinical review, the clinical reviewer said the man, for his own safety, had been moved to the floor on his mattress. She said the paramedics’ record shows that when they arrived, they found him lying on the floor, unconscious. The paramedics decided to transfer him as an emergency patient to hospital. He was assessed by hospital staff and placed onto a ventilator to assist his breathing. Additionally, he was given intravenous antibiotic and antiviral drugs, as well as a CT scan. The CT scan results were sent to Addenbrooke’s Hospital for a specialist medical opinion.
59. The man was later transferred to the hospital’s intensive care unit. His brother, who was with him at the time, was told of his poor prognosis. His parents, who at the time were on holiday, were contacted and they made arrangements to fly home. His condition worsened over the next 24 hours. At about 7.00pm on 27 May, his parents arrived at the hospital. Sadly he

died very soon after their arrival and at 7.15pm he was pronounced dead. The cause of death has been recorded as “meningitis secondary to sinusitis”.

Following the man’s death

60. Following the man’s death, the Deputy Governor appointed the prison Violence Reduction Coordinator as the prison family liaison officer (FLO) even though she had not undergone the Prison Service FLO training. Although five other staff were trained as FLOs, they were unavailable.
61. During an informal meeting with the liaison officer, she told the investigator that both she and her line manager had expressed concern to the Deputy Governor regarding his instructions that she was to act as FLO. The Deputy Governor did not change his mind. The liaison officer said she had received no training and was unhappy at being the family liaison officer, but carried out the role to the best of her ability.
62. I understand that following the man’s death, those prisoners being monitored as being at risk of suicide or self harm were spoken to by prison staff. This was to ensure that his death had not adversely affected them and is in line with proper procedure.
63. However, a number of staff interviewed as part of this investigation felt they had not been given proper support by managers. The investigator has already made the Governor aware.
64. An inquest was held into the man’s death in October 2010. The jury returned the following narrative verdict:

“[The man] initially complained of headaches on the 21st April 2009. After speaking to a doctor about this he was immediately sent to hospital for further tests which showed no signs for concern and so he was discharged on the 23rd April, 2 days later.

Between being discharged from hospital and up until the 23rd of May, Prison staff and medical staff acted as would be expected; this included a second referral to the hospital Neurology Department given the symptoms [the man] was showing at that point in time. [The man] was using prescribed painkillers to deal with the headaches he was having.

On the 23rd May a significant change in [the man’s] condition was apparent due to his spending the next few days in bed and not eating and not interacting with fellow prisoners as was his normal character. This did not seem to cause alarm with the prison officers although fellow prisoners say they were concerned with his unusual condition.

His subdued condition over the weekend seemed no better on the morning of the 26th May when at 9am his cell was opened for cleaning duty by the duty officer. [The man] remained in bed and at

about 10.30am the duty officer checked on him to find him still in bed but making incoherent noises. Seeing this, the duty officer attempted to contact a nurse but none seemed available. Then, returning to the cell about 15 minutes later, [the man] was found lying with his back on the floor, feet still on the bed, making involuntary movements of his limbs.

At this point concern for [the man's] health grew and immediate medical assistance was sought. A nurse arrived who quickly called for a doctor who made some observations on his condition, but no referral to hospital was made, however the nurse did request the attendance of mental health nurses who arrived promptly.

Over the short period of time some observations were made by medical staff although communication between them was lacking.

By around 11.30am it was decided [the man] should be transferred to the Prison Healthcare Wing. He was helped by four officers to a vehicle since he was unable to walk. On exit of the vehicle he was put into a wheelchair. At this point still no decision was taken to get [the man] to hospital yet his deteriorating condition was clear to see.

On arrival in Healthcare, [the man] was put in a cell and made as comfortable as possible. However there were no immediate clinical observations made, no nursing plan or assessments as nurses were busy with other priorities.

Between 1300 and 1440 [the man's] emergency cell alarm was activated three times. An officer attended but no nurse was called.

At 1440 on routine patrol the Duty Officer checked on [the man] and found him barely conscious, still breathing and it was obvious his physical condition indicated a severe deterioration. At this point the officer called for a nurse and at 2.55pm an ambulance was called to take [the man] to hospital.

When [the man] arrived at hospital he was quickly moved to Critical Care where blood tests and a CT scan were taken.

These tests showed damage and swelling to the brain and infection within the blood. Treatment was given for suspected meningitis.

[The man] was declared dead at 7.15pm on the 27th May 2009 at the Norfolk and Norwich University Hospital.

The death being by meningitis due to sinusitis and therefore of natural causes.”

ISSUES

Clinical care

65. In her clinical review, the clinical reviewer makes a number of recommendations relating to her findings. For ease, they are broken down between the healthcare provider and commissioner.

Reception health screening

66. The clinical reviewer said there appears to have been some confusion during the reception health screening process regarding drug detoxification medication, which the man said he was prescribed whilst in the custody of Great Yarmouth Police. She said a nurse from the prison telephoned the custody sergeant at the police station to clarify what the man had been prescribed. Unfortunately, the doctor who saw him at the police station had not recorded the visit or treatment.
67. There is no evidence of a substance misuse assessment being carried out during the reception health screening process and no plan recorded for detoxification. The clinical reviewer said that the nurse decided that the man did not appear to be suffering from withdrawal symptoms, and did not refer him to a proper assessment process. The nurse had said the man was to be prescribed Lofexidine, which is a drug used to assist with opiate withdrawal. The clinical reviewer adds that doses are meant to be administered in a stepped approach and should be recorded to show how they have progressed to the optimal dose. However the actual doses administered were not recorded in this fashion.
68. In addition to the question of withdrawal, the clinical reviewer said it was noted during the reception health screening that the man reported previous symptoms of depression. She said that a mental health assessment was not carried out and neither was his risk of self harm assessed or mitigated. At the time of her clinical review, there were no systems to support a robust mental health screening. However, she added that a system has since been put in place to ensure that all prisoners are risk assessed during the reception health screening process.
69. The clinical reviewer also noted that, despite the man giving his permission on 3 June for his community medical records to be obtained, this was not done. She said there was no consistent system at that time to ensure that community records are requested. The clinical reviewer makes the following recommendations concerning the reception health screening process, which I endorse:

The provider [that is prison healthcare] should ensure that only experienced staff with the appropriate skills and training should undertake reception screening. Those staff would require specific training in relation to the various elements of the screening programme which includes substance misuse and mental health assessment where appropriate.

The provider should ensure that the local guidelines for reception screening (June 2005) are reviewed and updated to meet the national standards.

The provider should put in place a regular audit programme which ensures that all areas of the screening assessment are competently completed and correct care pathways are followed.

Mental health and substance misuse assessment and management

70. The clinical reviewer said the treatment for the man's depression over the following weeks was erratic. There is conflicting documentation regarding the timeframe for his previous period of depression and the drug regime used for its treatment prior to his arrest. She went on to say that access to the man's own doctor's records might have provided information of his history and treatment of depression and enabled a more coordinated approach to his care.
71. In her clinical review, the clinical reviewer said that the prescribed detoxification regime did not appear to ease the man's symptoms adequately. He presented on three further occasions over the next three weeks with symptoms of opiate withdrawal. She considers that he was just given more medication rather than being given a planned and coordinated regime.
72. In their response to the draft report, the man's family asked why it had taken from 10 May, when the man first requested mirtazapine which had worked well for him in the community, until 14 May for it to be prescribed. In her response to the family's comments to the Coroner, the former Assistant Director for Primary Care, NHS Norfolk, said:
- “ ... we can offer a possible explanation for this. In accordance with NICE guidance, mirtazapine is recommended where first line medication is not effective. We suggest that the GP therefore started the man on Atalopran as a first line medication and then progressed onto mirtazapine. In addition he was seen by different GPs on each occasion which may account for the differences in prescribing.”
73. The clinical reviewer said when the man came into prison in June 2008, that prison healthcare was not following the nationally recommended regime for the administration of Lofexidine. However, she noted that since then, a new policy was implemented in May 2009, which outlined best practice for the administration and monitoring of patients undergoing withdrawal of opiates using Lofexidine. The clinical reviewer makes the following recommendations to address the management of mental health and substance misuse:

The provider should ensure that all healthcare staff are trained to undertake mental health assessments and the management of substance misuse, to ensure that the care provided offers the most appropriate treatment regimes for the conditions of prisoners and maintains their safety.

The provider should ensure that treatment plans and the rationale for decisions made are clearly documented within SystemOne clinical records to enable continuity of care.

The provider should ensure that requests for community medical records are routinely made as soon as possible in order to inform better healthcare assessments and outline current needs. There should be an administrative process in place to facilitate this, and regular audit process to monitor effectiveness and response.

The provider should ensure there is clear guidance on drug detoxification available and followed, with appropriate and timely prescribing in order to palliate the wide range of withdrawal symptoms prisoners' experience. They should ensure that all healthcare staff are competent to assess and respond to this.

Events of 26 May

74. The clinical reviewer said that insufficient clinical, analytical and assessment skills were used in the care of the man that morning, with little consideration given to his previous medical history or normal behaviour. She said that despite prison officers telling healthcare staff that the man had not exhibited behavioural problems, made undue fuss, complained or feigned ill-health, this information was not considered as part of a holistic assessment.
75. In addition, she said that a link was not made between the man's history of headaches, the request for a further neurological review six days earlier and this episode. She commented that no consideration was given as to whether it was necessary to contact the neurological team for further advice or whether what occurred on 26 May was a related problem.
76. In her clinical review, she wrote that when the man was admitted into healthcare as an in patient, the doctor and nurse who attended him on the wing said that it was to enable further observation to take place. However, nothing was documented to say what information was communicated to healthcare staff, the intended care pathway or the timeframe for a further review.
77. The clinical reviewer said that, despite a nurse being present when the man was admitted into healthcare at 12.56am, neither a health assessment nor clinical observations were recorded until he was found unconscious at 2.40pm. She said there was no criterion for admission into healthcare, nor any evidence that there is a requirement of a minimum level of baseline medical care or observations for patients entering the facility. Healthcare staff were unable to determine what was wrong with him. Despite his behaviour and presentation being so significantly different to his usual conduct, no one considered that the man should have been sent to an external hospital for further medical review.
78. The clinical reviewer said the prison's healthcare facility offers a minimal level of qualified nursing intervention with only one member of nursing staff being on duty on the upper level, where the man was taken. The member of staff on duty is

also required to cover for meal breaks and evening drug administration for colleagues working on the ground floor. This means that the unit can be left without clinically trained staff for periods of time. The clinical reviewer said that this was the case during the man's admission, because the nurse was away from the unit visiting the pharmacy which is on the main prison site when he was found to have collapsed. The clinical reviewer makes the following recommendations:

The provider should ensure that healthcare staff have all the necessary information available to them at the earliest opportunity, changes should be made to the SystmOne template to allow ease of access to all categories of information held and support improved communication through documentation.

The provider should ensure that healthcare staff work to a clear criteria and assessment process to establish when the needs of a prisoner can safely and usefully be met in the healthcare centre or when it is more appropriate for care to be provided in other healthcare settings. They should ensure that they are acting in the prisoner's best interest. The provider should ensure a basic expected level of assessment is made by healthcare staff when prisoners are admitted to healthcare, with documentation of immediate care needs, treatment or referral plans, and longer term interventions. A programme of audit should be established to ensure this is in place.

The provider should ensure that all pertinent details regarding a prisoner's medical status are documented and shared so that relevant information is passed to outside agencies.

General medical issues

79. Commenting on the empty medication packs found in the man's cell, the reviewer said there was no documented risk assessment made in relation to him continuing to hold his medication in his own possession. This is contrary to the recommended practice in the "Pharmacy for prisoners", Department of Health 2003 policy.
80. The clinical reviewer went on to say that it became apparent to her during interviews that there were a number of teams and individual professionals involved with the continuing health and social care of the man. However, she added there did not appear to be an integrated approach to using information, and she considers that the services were working in a separate and disjointed way. No support was offered to the healthcare staff involved and a root cause analysis was not carried out which would have examined the processes and identified learning opportunities or changes.
81. The clinical reviewer makes several recommendations in her clinical review to the commissioners of healthcare services at the prison. Some of these relate to the matters covered above. While I do not repeat these recommendations here, I suggest that all involved in healthcare at the prison read the clinical review and ensure that they are aware of the issues raised.

The man's prognosis

82. As part of her clinical review, the clinical reviewer wrote to the neurological department at the hospital asking for an opinion about whether admission into hospital four or five hours earlier on 26 May would have made any difference to the outcome. In response to her question, a Consultant Neurologist wrote back saying:

“it would be speculation to address this question, but it is certainly true to say that the earlier treatment for intracranial infection is commenced, the more likely a positive outcome will result. I am unable to give any specific opinion in this case”.

The doctor concluded by saying,

“Overall, it seems to me that his medical care was appropriate. Had he lived alone, he may not have come to medical attention as quickly as he did when his severe symptoms occurred and so I suspect that things were recognised and acted upon promptly while in prison, from what I have seen documented in the NNUH medical notes.”

Good practice

83. The clinical reviewer said there appears to be excellent provision for specialist nursing support for those with hepatitis C. She described the service within the prison for the treatment for hepatitis C as a gold standard service, possibly better than that offered within the community. She said it was evident to her that the relationships between the specialist nurse and her patients were very supportive and interactive. It was due to the intervention of the specialist nurse that the man received medical reviews in relation to his headaches. (However, she does add that the same level of service may not be provided for prisoners with other blood borne viruses.)
84. Regarding the healthcare documentation relating to the treatment of the man's hepatitis C, the clinical reviewer said it was clear and comprehensive. She added that there were clear pathways in place for accessing appropriate medical professionals for support.
85. The clinical reviewer said that when the man was assessed on 21 April, following his first presentation with headaches, the relevant advice was sought by the doctor and speedy and appropriate action taken to respond to his symptoms.

Prison Family Liaison

86. Contained within the supplementary guidance of PSO 2710 “Follow up to death in custody” is the following statement:

“Family Liaison Officers should be carefully selected volunteers who have the appropriate qualities and skills. They must understand the bereavement process resulting from a death occurring in prison. It is

recommended that Family Liaison Officers attend a Family Liaison Officer training course before being deployed to support a family.”

87. It is clear from the prison’s family liaison officer that both she and her line manager objected to the Deputy Governor’s decision that she should be the prison FLO. Although there were, I understand, five trained staff at the prison, it would appear that they were not available, hence his decision. The role of FLO is a specialised task and should only be carried out by those who volunteer and are trained to deal with the work. It is not a task that can be given out to anyone and nor should it be.
88. The liaison officer told the investigator that she did not think that her visit to see the man’s family went well and she had felt out of her depth. It is also clear that she felt that his family were frustrated and angry at her because she was unable to tell them what had happened.
89. At a time when families are grieving and confused, they expect to be supported properly and decently. It disappoints me that in this case they were not. I consider that the Deputy Governor’s decision to appoint the Violence Reduction Coordinator Officer was wrong. My comments are no reflection on what she did as I am sure she did her best in the circumstances. I see many cases where the work of the prison FLO has produced first class evidence of support and trust. Sadly the same cannot be said in this case.

The Governor must ensure that prison family liaison officers at the prison are properly trained volunteers in line with the guidance contained within PSO 2710.

Family response to the draft report

90. The man’s family provided detailed feedback to the draft report into his death. Some of these issues are matters that should be properly raised at inquest. A couple of others have already been noted in paragraphs 51 and 71 above and I will cover those that I am not able to provide a response to in a separate letter to the family. There remain, however, several other issues which were raised by the family and which I have asked NHS Norfolk to comment on. They have done so by means of a management letter which the Coroner has kindly shared with me. Below, I list the questions raised by the family and the responses from NHS Norfolk.
91. The first matter they have raised concerns the management of the man’s opiate withdrawal. The family have asked whether the system has now been changed. In response, NHS Norfolk have replied:

“The treatment of drug misuse has changed dramatically at HMP Norwich with the introduction of the Integrated Drug Treatment System (IDTS). Following the receipt of government funding, the IDTS was implemented which increased the range of available treatment options in line with National Guidance. In particular this programme supports substitute prescribing to enable stabilisation,

maintenance and detoxification from opiates within a safe environment. All prisoners with an active substance misuse history are now located on the new A wing where healthcare staff are all appropriately trained and experienced in the management of substance misuse. A registered nurse is available 24 hours a day and GPs now have extended hours until 8pm Monday to Friday and until 4pm on Saturdays. The nurses are also able to provide immediate symptom relief for opiate withdrawal without the need for a GP prescription by using the Patient Group Directions.”

92. The man’s family also asked about the clinical governance structure for the healthcare staff at the prison and has there been any subsequent improvement following his death.

93. NHS Norfolk replied:

“In November 2008, NCH&C [Norfolk Community Health and Care] commissioned an external Clinical Governance Review. The review contained a series of recommendations. Following receipt of the review an action plan was developed, implemented and is now complete. This resulted in a robust Clinical Governance system with a strengthened management structure and improved clinical supervision. Three Band 7 nurses were recruited to act as team leaders and mentors to junior staff who now have clear lines of accountability and regular supervision to ensure good practice is followed and any training needs are identified. Clinical Governance is a standing agenda item at team meetings which are an opportunity to discuss issues that have arisen and to introduce and/or reinforce current policy. These meetings ensure two way communications with staff and shared learning.

“As a result of the review prison healthcare became fully integrated into the wider NCH&C governance framework. This allows for better joint working with the prison. There is also a new information sharing protocol which enhances communication between healthcare and prison staff. A Healthcare Integrated Governance Group was also set up to bring healthcare and prison staff together to improve patient care where joint working is particularly important. This group reports to the Prison Health Operational Forum and from there to the Prison Health Partnership Board, the membership of which includes three Prison Governors, a Director of NHS Norfolk, the Director of Clinical Governance (NCH&C) and the Independent Monitoring Board.”

94. Next, the family pointed out that “the report refers in detail to the lack of opportunity to learn from or do a root cause analysis of this incident”. They asked whether this had now been addressed.

95. NHS Norfolk replied:

“NCH&C has taken on board all the recommendations of the Clinical Reviewer and addressed each point, as shown in the action plan attached. The Serious Untoward Incident Policy was revised and re-issued in December 2009. The new policy provides clear structures for the reporting and investigation of incidents, ensures appropriate support for staff and stresses the importance of lessons learnt.”

96. The family then asked why the man was sent to the inpatient healthcare wing when there appears to be no criteria for referral and no treatment pathways in place.

97. NHS Norfolk replied:

“We understand from the PPO interviews that the man was sent to the inpatient healthcare wing to be observed and assessed by the mental health although this is subject to the evidence of the relevant witnesses at the Inquest. Since this incident the Healthcare Bed Admission/Discharge Policy has been introduced. This provides clear guidelines for the management of patients admitted to the inpatient healthcare unit. In particular an initial nursing assessment and management plan will be documented within one hour of admission.”

98. The next question the man’s family asked was whether Prison Officers have the ability to override a healthcare decision if they felt it was inappropriate. NHS Norfolk replied that Prison Officers can inform the Head of Healthcare if they are unhappy. The Head of Healthcare is able to override a nursing decision.

99. The man’s family then asked why empty packets of diclofenac and co-codamol were found in his cell when the last prescription showed that these should have been issued as “Not in possession” medication. They also asked why brufen had been found, when this had not been prescribed at all, and whether risk assessments were now in place to ensure that this situation did not arise again.

100. NHS Norfolk replied:

“The diclofenac and co-codamol were prescribed as daily “in possession”. At this time it was standard practice to use the “not in possession” part of the medicines chart also for daily “in possessions.” Medications which were strictly “not in possession” would have been documented as “in sight” meaning that they had to be given under observation of a nurse and a prison officer. A new procedure is now in place. The medication chart has been amended and “in possession” risk assessments are now undertaken as part of the secondary screening process.

“Unfortunately we are unable to confirm how brufen came to be in his cell. The man was prescribed Ibuprofen 400mg on 23 September 2008 and held this “in possession” so the packaging found in his cell could be from that occasion.

“The Medication In Possession Policy was updated in August 2009. The updated policy provides that a risk assessment must be completed before medication is given in possession.”

101. The man’s family also wanted to know why, if staff were unable to accurately take his vital signs, “the default position” was to send him to healthcare and not to hospital. They also asked whether prison officers should have used restraint techniques to help healthcare staff make further clinical observations. (These events are referred to in paragraph 51 above.)

102. NHS Norfolk replied:

“At the time of the incident it was not the default position that prisoners would be taken to the inpatient healthcare unit rather than a hospital. This was a decision for the assessing clinicians and therefore this is a question for the relevant witnesses at the inquest. ... it would not be normal practice to restrain a patient so that observations could be taken. NCH&C has received funding to provide advanced clinical assessment skills training to nursing staff. The training will emphasise the importance of establishing capacity to consent to treatment and the importance of acting in the patient’s best interest where the patient lacks capacity.”

103. The family then asked “will there be any insistence on retraining of certain individuals?”. NHS Norfolk replied:

“Any individual training needs are identified as part of the performance review process. The Head of Healthcare will attend the inquest and will, if need be, feedback to line managers if it appears that additional training is needed.”

104. The next question put by the family was:

“If nursing staff have no medical concept of one of the most basic skills ie medical/nursing observation then there is a definite requirement for retraining, would it be better to employ less qualified staff and rename this facility so that anybody with genuine or suspected health care needs are looked after in a more appropriate environment for those needs?”

105. NHS Norfolk replied:

“We accept that baseline observations should have been taken when the man was brought into the inpatient healthcare unit. The importance of this has been fed back to staff and addressed by the introduction of the Healthcare Bed Admission/Discharge Policy as detailed above. The ... Policy will be subject to audit in 2010/11 and compliance with the policy will form part of the staff performance review process. The Healthcare facility has also been subject to a

comprehensive data collection by NHS Norfolk with a view to reviewing the service as a whole in due course”.

106. The family asked why the appointment letter for the CT scan on 29 May was not included in the medical records. NHS Norfolk were unable to explain this, although they did suggest that it was possible that the appointment letter was received after the man’s death when the clinical record was sealed.

107. As mentioned in the clinical review produced as part of this investigation, “importance should be placed upon ruling out any organic cause which is more urgent to deal with before settling upon alternative causes”. The man’s family asked how this was being dealt with at HMP Norwich.

108. NHS Norfolk replied:

“As diagnosis is primarily a medical responsibility, NHS Norfolk has sought to improve the care for prisoners by putting in a place a new prison healthcare contract which will provide dedicated GPs within the prison. This will reduce the need for locums and provide for continuity of care. Also ... additional funding has been allocated to provide advanced assessment skills training to nurses.”

109. Finally, the man’s family asked what thermometer equipment was held at HMP Norwich. NHS Norfolk replied that tympanic (ear) thermometers were available in the inpatient healthcare facility, and digital thermometers were in every emergency bag located around the prison.

CONCLUSION

110. It is clear to me that when the man arrived into the prison he was committed to changing his lifestyle. He engaged with those able to help him with his drug addiction and appears to have been determined to change. He in turn wanted to give something back and so became one of the prison Listeners, something he valued and enjoyed.
111. He began to complain of headaches and, despite a number of medical examinations, his condition remained undetected. Sadly, on 26 May, his health worsened and, as he was behaving oddly, medical assistance was sought. He was later discovered on the floor of his cell, conscious but incoherent which resulted in urgent medical assistance being requested. I am satisfied that prison staff recognised his distress and summoned medical assistance.
112. Having assessed him, the nurse asked for a doctor and he arranged for the man to be admitted into the prison's healthcare department. Healthcare and the prison wings are in different buildings and he was moved in a vehicle. After being admitted, I endorse the clinical reviewer's opinion that his medical care was not well managed, with a number of fundamental gaps identified in my report.
113. A consultant neurologist said that it would be true that the earlier someone with intracranial infection is admitted into hospital, the more likely it was to have a positive outcome. I have considered the doctor's comment carefully. Whether the outcome for the man would have been any different cannot be known but, it has to be the case, it might well have been. His death is tragic. There are a number of concerns about the healthcare he received, and the evidence is that, despite specialist medical examinations, healthcare staff did not identify the seriousness of his condition.

RECOMMENDATIONS

1. The Governor must ensure that prison family liaison officers at Norwich are properly trained volunteers in line with the guidance contained within PSO 2710.

The Prison Service has accepted the recommendation and commented:

It is not a mandatory requirement within PSO 2710 for Family Liaison Officers to attend the training course. Locally, at Norwich, no untrained Family Liaison Officer will be asked to carry out these duties”

For healthcare provider and commissioner

2. The provider should ensure that only experienced staff with the appropriate skills and training should undertake reception screening. Those staff would require specific training in relation to the various elements of the screening programme which includes substance misuse and mental health assessment where appropriate.

NHS Norfolk has responded:

“The Primary care team responsible for reception screening have received additional training in the competencies listed within the Reception Screening Policy. Also, all new staff receive Reception Training as part of their induction.

“The reception screening assessment template has also been improved. See answer 3 below.”

3. The provider should ensure that the local guidelines for reception screening (June 2005) are reviewed and updated to meet the national standards.

NHS Norfolk has responded:

“The reception Screening Policy was updated in October 2009 to meet national standards.

“To improve the reception process we have also made significant improvements to the Clinical information System (SystemOne)

“Between August 2009 and March 2010 Suffolk Support Services contracted to undertake a complete review of SystemOne (the Clinical Information System). This project included the complete reconfiguration of the system with the development of safe and effective assessment templates, retraining of all staff including Super-users (who receive additional training) to support less experienced staff, and improved reporting.

“The system now includes the National Reception Screening Tool, the Depression and anxiety assessment templates which are used by GPs in the community, the Opiate withdrawal screening tool, the alcohol screening tool and the threshold assessment grid (TAG) risk assessment tool which identifies the risk of suicide and self-harm.

It is also standard practice to seek the consent of prisoners to the release of their medical records from their GP as part of the reception process.”

4. The provider should put in place a regular audit programme which ensures that all areas of the screening assessment are competently completed and correct care pathways are followed.

NHS Norfolk has responded:

“We have completed a number of audits:

“Record Keeping Audit September 2009

“Reception Screening Process Audit November 2009

“Alcohol Screening and Intervention Audit March 2010

“Consent Audit (see answer to point 7 below) September 2009

“The audit programme 2009/10 demonstrated a high level of compliance with the policies.”

5. The provider should ensure training for all healthcare staff be undertaken around mental health assessment and the management of substance misuse, to ensure that care provided offers the most appropriate treatment regimes for the conditions of patients and maintains their safety.

NHS Norfolk has responded:

“We have met this recommendation through both formal training and also effective clinical supervision of staff.

“There are now Band 7 clinical leads in place for Primary Care, IDTS and Inpatients. The band 7 clinical leads act as mentors or delegate this responsibility to other senior nurses. Mentors for new staff are identified on the induction checklist.

Group supervision bimonthly and informal supervision is established. Staff have the option of additional individual supervision and this can be made mandatory at line manager discretion.

“Specific to mental health – A mental health rota ensures that there is always support available from an RMN. Additional funding has now been

allocated to provide mental health awareness training for all healthcare staff.

“Specific to substance misuse, the staff were initially trained by TADS (Trust Alcohol and Drug Service, part of NWMHFT). Now that IDTS is fully implemented, the training for staff on the new A wing is provided in a number of ways including attendance at courses, supervision by the IDTS lead, shadowing opportunities and ongoing appraisal and continuous professional development.”

6. The provider should ensure that treatment plans and the rationale for decisions made are clearly documented within SystmOne clinical records to enable continuity of care.

NHS Norfolk has responded:

“There is now a care plan template within SystmOne which ensures that all prisoners with complex health needs have a clear care plan. The Continuity of care Audit undertaken within Healthcare in March 2010 demonstrated a high level of compliance. The NCH&C audit facilitator reported “Overall the results at HMP Norwich were exemplary””.

7. The provider should ensure that requests for community medical records are routinely made as soon as possible in order to inform better healthcare assessments and outline current needs. There should be an administrative process in place to facilitate this, and regular audit process to monitor effectiveness and response.

NHS Norfolk has responded:

“The Reception Screening Policy states that the member of staff undertaking the reception screen will send a written request to any relevant healthcare providers for past medical history, having gained patient consent to do so.

“A Consent Audit was completed in September 2009. This demonstrated a high level of compliance with this aspect of the policy. Of the 66 patients that had a GP that could be contacted, 65 of them (98%) had given the prison consent to contact their GP.”

8. The provider should ensure there is clear guidance on drug detoxification available and followed, with appropriate and timely prescribing in order to palliate the wide range of withdrawal symptoms patients’ experience. They should ensure that all healthcare staff are competent to assess and respond to this.

NHS Norfolk has responded:

“The Integrated Drug Treatment System (IDTS) has now been implemented in line with National Guidance. This increases the range of

available treatment options, and in particular supports substitute prescribing to enable stabilisation, maintenance and detoxification from opiates within a safe environment. Specifically, methadone may now be prescribed from reception into the prison, where this is indicated by clinical need.

“All prisoners with an active substance misuse history are located on the new A wing where the healthcare staff are all appropriately trained and experienced in the management of substance misuse. The staff are able to provide immediate symptom relief through the use of Patient Group Directions (PGDs). The nursing staff are supported by GPs working until 8pm Monday-Friday and 4pm on Saturdays which allows for substitute prescribing on the first night of custody, supported by the availability of an emergency stock of medication.”

9. The commissioners should seek assurances from the providers that all relevant staff are aware of the local Lofexidine management policy and guidance, and that they comply with the policy. Additionally, there should be a regular audit carried out to ensure compliance.

NHS Norfolk has responded:

“A revised protocol for the Clinical Management of Patients Administered Lofexidine was published in May 2009. Following an audit in July 2009 an action plan was developed and implemented. Re-audit in November 2009 demonstrated significant improvement. In 100% of cases the Substance Misuse Screening Tool had been used, baseline observations (including urine screening) were recorded, and prescribing, administration and ongoing care were in line with policy.”

10. The commissioners should seek assurances from the provider that all those carrying out reception health screening, substance misuse management and mental health screening have received proper training. Additionally, they should ensure appropriate services have been put into place to safeguard patients via these assessments, with regular audit embedded to monitor standards.

NHS Norfolk has responded:

“The Commissioner has requested and received copies of the relevant training logs and audit reports.

“The review of action plans now forms part of the contract monitoring process undertaken by NHS Norfolk of its providers.”

11. The commissioner should ensure there is a clear criteria for admission to the healthcare centre and expectations around a minimum level of baseline clinical assessment should be developed and made available for providers to implement. Additionally, the commissioner should seek assurances and evidence that the criteria is being followed.

NHS Norfolk has responded:

“Please see 10.3.2 and 10.3.3 below [these relate to recommendations made in the clinical review – “10.3.2 - The healthcare Bed Admission and Discharge Policy, April 2010 clarifies admission and exclusion criteria, admission procedures (including the requirement for observations), and procedures for transfer to secondary care. This will be the subject of audit during 2010/11. 10.3.3 – Section 3.5 of the Healthcare Bed Admission and Discharge Policy, April 2010, specifies the admission procedure which includes an initial nursing assessment and management plan which must be documented within 1 hour of admission. This will be the subject of audit during 2010/11].

“A new policy is now in place and this will be subject to audit in due course.

“NHS Norfolk are also in the process of gathering data on the healthcare unit to allow for an evaluation of the service.”

12. The commissioner should ensure that the services for specialist nursing for those prisoners with blood borne virus (hepatitis B & C, HIV) is reviewed to reflect best practice in the community and meets the needs of prisoners.

NHS Norfolk has responded:

“A new provider of healthcare will take over at HMP Norwich from 1 October 2010. The provision of specialist nursing for prisoners with blood borne viruses is a key performance indicator for the new provider and we expect a competency review to be undertaken as part of the implementation plan.”