

**Investigation into the circumstances surrounding the
death of a man at HMP Rye Hill
In May 2009**

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

January 2011

The man was found dead in his cell at HMP Rye Hill in May 2009, aged 60 years. The post mortem report found that he had died of ischaemic heart disease. My sincere condolences go to his family for their loss, and I must apologise for any additional distress that the delay in producing this report may have caused.

The local Primary Care Trust (PCT) is not responsible for the healthcare provided at Rye Hill and I am grateful to the Trust for undertaking an independent review of the healthcare the man received at the prison. I thank the Trust for the appointment of a clinical reviewer.

I thank the Director of Rye Hill for the time and resources that she personally gave to this investigation. Several staff were particularly helpful in liaison with the investigator appointed from my office.

Despite his complex medical history, the man had not seen a doctor for two years before his death. He reported no symptoms and, in fact, the last clinical intervention he had was in April 2007 with a psychiatrist preparing a report for his parole board. I am disappointed to discover that chronic disease management is not being delivered at Rye Hill. In this report, I examine the implication of resource issues on prisoners care and staff development. I make six wide-ranging recommendations.

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

Jane Webb
Acting Prisons and Probation Ombudsman

January 2011

CONTENTS

Summary

The Investigation Process

HMP Rye Hill

Key Events

Issues

Conclusion

Recommendations

SUMMARY

The man received a life sentence in 1979. He was transferred between nine different prisons until he was moved to a secure mental health unit for assessment following a psychotic episode. He was diagnosed with paranoid schizophrenia but would not accept his diagnosis and was returned to HMP Blakenhurst five months later. After three more prison transfers, he moved to Rye Hill shortly after the prison opened in November 2001.

When the man arrived, it was noted that he was prescribed an antidepressant and that he suffered from spondylosis (degeneration of the spine). In 2002 he refused treatment after a paranoid episode on the wing. Later that year, he agreed to take a reduced dose of his antidepressant. His medication was regularly reviewed and continued at the same dose until 2005, when a psychiatrist suggested a further reduction. He was angry at the suggestion and refused the decrease in dose, so remained on the higher dosage until his death four years later.

His final significant clinical intervention was in April 2007, when a consultant forensic psychiatrist carried out a psychiatric assessment for the Parole Board. In the record of the assessment, the psychiatrist wrote that he had “no clear evidence of mental illness” and supported the ongoing prescription of antidepressants.

There is no record of further meaningful clinical interaction, other than two dental appointments, between April 2007 and May 2009, when the man was found dead in his cell. He had not reported any symptoms and his death was sudden and unexpected. The cause of death was found to be ischaemic heart disease, (a reduced blood supply to the heart muscle usually caused by blocked arteries).

The investigation report considers the adequacy of chronic disease management and clinical governance at Rye Hill, the impact of staff shortages and a paper-based record system on the delivery of healthcare and the efforts made by the senior management team to improve healthcare services for prisoners.

THE INVESTIGATION PROCESS

1. I appointed an investigator to lead the investigation into the man's death. She contacted Rye Hill and arranged for his records to be sent to her. She spoke to the Coroner's office and explained her remit. She asked for a copy of the post mortem report to be sent when it was ready. During that conversation, the Coroner's Officer confirmed that the cause of death was ischaemic heart disease.
2. Unlike public sector prisons, the local Primary Care Trust is not responsible for the delivery of healthcare at Rye Hill. It is delivered by a private company that also delivers the custodial arrangements at the prison. Nevertheless, the PCT appointed a clinical reviewer to complete a review into the clinical care that the man received during his nine years at Rye Hill. I am grateful for this appointment.
3. My Senior Family Liaison Officer wrote to the man's daughter to explain the purpose of the investigation and ask her about any concerns she would like the investigation team to explore. Although the family shared no specific concerns with us, the Liaison Officer will contact them to give them the opportunity to comment on this draft report.
4. After reviewing the paperwork, the investigator and clinical reviewer visited Rye Hill in August to meet the Head of Healthcare and the Primary Care Clinical Manager. (The Clinical Manager was then only performing the role in a temporary capacity but his position was made permanent during the course of the investigation.) The Head of Healthcare explained the management structure of healthcare delivery and the Clinical Manager described the nursing processes in more detail and showed the investigation team around the prison. While on the Hastings Unit, the unit where the man spent most of his nine years at Rye Hill, the investigator spoke to staff who knew him and those who were involved on the morning of 30 May.
5. The investigation team returned to the prison in September to conduct four interviews with staff. The investigator had also arranged to meet one of the man's friends on the Hastings Unit but unfortunately this was not possible for operational reasons. In line with normal practice, she met with the Director following the interviews to discuss her findings so far. She followed this meeting with a letter, drafted in collaboration with the clinical reviewer.
6. Upon receipt of the feedback letter, the Director requested a meeting with the investigation team which was convened for December 2009. The meeting was attended by my investigator, the clinical reviewer and an Assistant Ombudsman, overseeing the investigation on my behalf. The investigation team met the Director, the Head of Medical Services, the Offender Health Programme Lead from NHS East Midlands and the Controller at HMP Rye Hill. (A Controller monitors the prison's performance against their contract.) Following this meeting, additional

evidence was collated and sent to the investigation team. After review of the additional evidence, the clinical reviewer drafted his first clinical review and after further amendment, provided the final version, attached to this investigation report, on 15 June 2010.

7. I issued a draft version of the investigation report for consultation with the prison, the company running the prison and the man's family before it was finalised. I have reflected the Services' response to recommendations at the end of the report. In their response, the family said that, on reading the report, they were unhappy with the level of healthcare he received while in custody. The family expressed particular concern about the length of time that elapsed between his contact with a doctor, especially considering the long term conditions from which he suffered. His family were also worried by the conflicting information about his history of stroke in his medical records.

HMP RYE HILL

8. HMP Rye Hill is a Category B prison located near Rugby that accommodates up to 664 prisoners, all of whom must have received a sentence of at least four years with a minimum of 18 months left to serve. It is one of 11 prisons in England and Wales contractually managed by private companies, accommodating about 11 per cent of the national prison population. Five of the privately run prisons are run by a private company, including Rye Hill.
9. In Her Majesty's Chief Inspector of Prisons' most recent report from July 2009, she wrote that, despite previous difficulties, "the company had worked hard to ensure that the prison was now a safer place". The Chief Inspector recognised the progress the prison had made since the previous unannounced inspection in 2007, but noted "there remained much still to do".
10. In the earlier inspection in 2007, the inspection team described healthcare services as "basic". (The healthcare centre is made up of an outpatients unit and a five-bedded inpatients unit.) The delivery of chronic disease management was "limited" and the Chief Inspector recommended that it should be developed. The recommendation was repeated in the 2009 inspection report as chronic disease management was still not being delivered.
11. The delivery of healthcare in 2007 was severely affected by "significant staff shortages" and there was "little uptake" on clinical supervision. In 2009, the Chief Inspector reported that a full assessment of staff skills had been carried out in the healthcare centre and appointments made to address the staffing shortage. Unfortunately, at the time of my investigation, staffing levels were still difficult despite attempts at recruitment.
12. The 2007 inspection report recorded that nurses were trying to hold regular clinics "but without much success". At the time of the 2009 inspection, the situation had not improved and there were no clinics being run for prisoners with long term conditions.
13. The Chief Inspector also commented on the lack of services available for older prisoners in her 2007 inspection report. She recommended that a member of the health services team "should be identified as the focus for older prisoners". The most recent inspection found that a nurse had been appointed to oversee the care of older prisoners, but worked predominantly on night shifts and had little contact with older prisoners in their work. The Chief Inspector made a further recommendation that "the nurse designated as the focus for older prisoners should be easily accessible to this group of prisoners". At the time of the inspection in July 2009, 14.6% of the prison population were over 50, significantly higher than the national average which was 8.15 per cent nationally. The man was 60 years old at the time of his death.

14. The Independent Monitoring Board (IMB) is an independent organisation made up of volunteers who monitor the day-to-day life in prison. In the 2008-2009 annual report, the Chair expressed the Board's concern that "the provision of specific clinics has fallen back" and noted that "work is needed to set them up again to effectively monitor and support offenders with chronic conditions". The IMB also remarked on the impact of staff shortages on the delivery of healthcare at the prison.

KEY EVENTS

15. The man was remanded to the custody of HMP Winson Green (now HMP Birmingham) in December 1978, when he was 30 years old. He was convicted and sentenced to life imprisonment in June the following year. He remained at Birmingham for ten years after his conviction. Over the following seven years, he was transferred 18 times between nine different prisons. Unfortunately, the investigator did not have access to the medical record from the time of his remand in 1978, to the time of his discharge from the clinic in 1996.
16. In May 1996, he was transferred to Reaside Clinic, (a secure mental health unit). While at the clinic, he was diagnosed as having “paranoid schizophrenia without insight”. He responded well to medication, (150mg Amitriptyline, an antidepressant and 200mg Sulpiride, an anti-psychotic) and the decision was taken to return him to prison. During a routine search of his room before he left the clinic, staff found a sharpened knife and hastened his transfer to the more secure environment of a prison. He moved to HMP Blakenhurst (now part of HMP Hewell) on 28 October 1996.
17. After being transferred between prisons three more times, the man finally moved to Rye Hill on 22 November 2001. A “Transfer In Checklist” was completed, recording his spondylosis and prescription of Amitriptyline and Diclofenac (an anti-inflammatory drug that is also used as a painkiller). His history of stroke and glaucoma were not mentioned on the form, which also indicated that he did not have a mental health condition.
18. In 2002, the man told a custody officer that staff were trying to kill him. Upon reviewing his notes, a registered mental health nurse (RMN) realised that he had a psychotic episode on 1996. (The details of this episode have been lost with many of his records.) He was prescribed Sulpiride and referred to a forensic psychiatrist at Reaside Clinic.
19. The psychiatrist described him as “a difficult man to assess”. He “refused to consider an anti-psychotic [medication]”. The doctor continued the prescription of Amitriptyline, but recorded that he did not want any further contact with a psychiatrist. He repeated his refusal to engage with a psychiatrist during a nurse’s mental health assessment two months later, but agreed to “two weekly support visits”.
20. The man’s medication was reviewed every two months, but the dose did not alter. In October 2002, a Specialist Registrar in Psychiatry, suggested that his dose of Amitriptyline be “tapered and stopped”. The registrar reduced the dose from 150mg daily to 100mg Amitriptyline daily. He resisted an attempt to reduce his dose further in August 2005, and was recorded as “getting aggressive” at the suggestion.

21. In April 2006, the psychiatrist, then working as the visiting consultant forensic psychiatrist at Rye Hill, assessed the man. He found him “mentally well”. The psychiatrist found “no overtly psychotic symptoms”, but recorded that he would not fully engage with the assessment. Despite his reluctance to talk about his mental health, the psychiatrist described him as “cheerful and philosophical at interview”. The psychiatrist continued his medication at 100mg Amitriptyline daily and recorded his assessment in the continuous medical record.
22. One month later, in May 2006, the man’s medication was reviewed and continued at 100mg Amitriptyline. In August of the same year, a consultant psychiatrist tried to interview him. He would not engage with the assessment and became abusive to the psychiatrist, who made a brief entry to this effect in the medical record. In September 2006, the forensic psychiatrist returned to assess him and again continued his medication at the same dosage, 100mg Amitriptyline daily.
23. Two further psychiatric assessments took place on 2007, both for the purposes of the man’s parole report. One of the assessments was carried out by a forensic psychiatrist from Reaside Clinic in January 2007. The second assessment was completed by a psychiatrist in April 2007. The psychiatrist noted the ongoing prescription of 100mg of Amitriptyline. That was the last time that his medication was mentioned on record before his death more than two years later. Records show that he continued to be prescribed Amitriptyline and continued to collect his prescription over that period.
24. Between April 2007 and his death in May 2009, the man’s continuous medical record shows that he had two dental appointments and had four support visits from the counselling team. The investigator spoke to the counsellors about their entries in the continuous medical record. Three entries were made by a counsellor and one entry was made by a senior counsellor.
25. The counsellor told the investigator that she initially visited the man to support his decision to study Cognitive Behaviour Therapy. Her second contact was a follow-up appointment to check how he was getting on with his course. She made the third entry following an exchange with him. He had become irritated at the tone of a letter she had written to remind him to return a library book she had lent him during their first meeting. The senior counsellor told the investigator that her visit to him was not of a clinical nature either. She said she had been asked by another prisoner to assess whether he was able to effectively represent him at an adjudication. (An adjudication is a hearing conducted by a governor in the prison when a prisoner is alleged to have breached the Prison Rules.) Her opinion was that he was articulate and would be able to advocate for this prisoner appropriately.

May 2009

26. One morning in May, the man was found by a prisoner who was collecting laundry from each of the cells on Hastings Unit. He ran to the staff office to alert staff to there being something wrong. Two officers ran to the cell and discovered that he was not responding to them. A Prison Custody Officer (PCO) used her radio to call a Code One emergency call. (The investigation team was told that Code One means that someone is not breathing, or that it is a life-threatening situation.) When a Registered Mental Health Nurse (RMN) arrived at the cell, he also failed to get a response from him. The nurse could not find a pulse and he was cold to the touch. There was no record that resuscitation was attempted. The nurse waited for the paramedics to arrive who certified him death. The Coroner has since confirmed the cause of death as ischaemic heart disease.

Family liaison

27. A Family Liaison Officer (FLO) was appointed to be the main point of contact for the man's family. She was accompanied by a member of the prison's chaplaincy to go to the family's home in Birmingham on the afternoon of 30 May to break the news of his death. The man had nominated one of his daughters as his next of kin, but the FLO also spoke to his other daughter and son. She passed on the prison's condolences.
28. The following day, the FLO telephoned the man's daughter to explain that the prison would make a contribution to the funeral and that the prisoners were arranging a collection.
29. The Director of Rye Hill wrote to the man's family to express her personal condolences on 2 June. Also on that day, the man's son and daughters visited Rye Hill to collect his property and speak to staff. The FLO kept in regular touch with the family, who sent her a book of remembrance that she arranged to be circulated to staff and prisoners to record their thoughts about the man. The Head of Offender Management, who was also a trained family liaison officer, took over the liaison in this case. She arranged for the book of remembrance and the proceeds from the collection to be sent to the family in advance of the funeral in late June. She attended the funeral at the family's request.
30. I am pleased to note the sensitive and ongoing contact that the prison had with the family.

ISSUES

Findings of the prison's Significant Event report

31. Following the man's death, the prison carried out their own Significant Event report to examine the clinical care he received and identify any urgent issues that needed to be addressed. The report identified four issues, echoed by the findings of the clinical reviewer for this investigation. In some respects, the clinical reviewer's consideration of the man's medical care differs slightly from the facts set out in the Significant Event report. Nevertheless, I am pleased that the prison took prompt steps to learn the immediate lessons following the man's death and support the work identified to improve clinical care at Rye Hill.
32. Firstly, the report found that the man's medical records were not in good order, which made the analysis of his care difficult. The clinical reviewer also considers the adequacy of paper records over an electronic system to store and access medical records. The prison recommend that "HMP Rye Hill should continue to work closely with the Teaching PCT to try to expedite the implementation" of a computerised record system.
33. Secondly, the prison concluded that the man had no conditions that would have warranted his name to be placed on a chronic disease register. Nonetheless, the report acknowledged that, in view of his age, he might have benefited from treatment from an Older Persons clinic. The report went on to recommend that such a clinic is set up "as a matter of priority", given the age profile of the population in the prison. As I have said, the Chief Inspector of Prisons also commented on the adequacy of provision for Older Prisoners in her inspection reports in 2007 and repeated in 2009.
34. The third issue identified in the report is that the prison was running nurse-led clinics "on an ad hoc basis", rather than using a published timetable. The report recommended that the timetable for nurse-led clinics should be published widely.
35. Finally, the report acknowledged that there is no entry recording a review of the man's ongoing prescription. The report commented that there is no record to suggest that he was "not settled on the type or dosage of medication he was receiving". However, it acknowledges that "best practice would be for a regular face to face review of medication at a time interval identified by the managing GP". The prison report that a review did take place in April and May 2008 when a new pharmacy provider reviewed all the ongoing prescriptions in the prison, although no entry was made on his medical history to record this. The report's final recommendation was that a note should be made on a patient's medical record and medication chart "to identify when the next face to face review of medication should occur".

Chronic Disease Management

36. Chronic disease management is defined by the National Health Service (NHS) as “a system of coordinated healthcare interventions ... for populations with long-term conditions in which patient self-care is significant”. It is often associated with older people, who may suffer from more than one condition at a time. The Department of Health outlines the three core elements of chronic disease management as Registration (recording patients’ conditions), Recall (use of reminders to ensure care needs are addressed) and Review (to assist the ongoing management of their condition).
37. In the Significant Event report, the prison wrote that the man did not suffer from any conditions that would warrant him to be listed on a chronic disease register. After a review of his medical records, the clinical reviewer reports that he had suffered from a “stroke or intracranial lesion [caused by pressure in the skull]” in 2000. The clinical reviewer also noted his “long-term underlying mental health problem, psychotic in nature”. He considers that both of these health problems required the structured approach to care that a chronic disease register would have provided.
38. During the course of the investigation, the investigation team spoke to the Primary Care Clinical Manager about the lack of chronic disease registers at the prison. He showed the team a number of “lists” of prisoners with certain conditions that had just been set up. He explained that prisoners’ medical records had been manually searched and their name added to a spreadsheet to record that they suffered from a particular condition. When asked whether the man was on the stroke register, he suggested that it was likely he would have “fallen through our net”, because staff were reliant on their own knowledge of the prisoner and the stroke had happened several years ago.
39. I understand the difficulty of setting up a chronic disease register, especially when medical records are not held electronically (a matter I consider later). However, the man’s stroke episode was recorded in his medical record. I am concerned that he was not identified when the chronic disease registers were set up.

The Head of Healthcare should review all prisoners’ medical records to ensure that prisoners are recorded on appropriate chronic disease registers.

40. The Clinical Manager showed the investigation team the chronic disease registers, or “lists” as he referred to them, but acknowledged that they were in need of development. As the clinical reviewer notes in his review, the lists “appeared new and had insufficient areas of monitoring within them”. When asked how a prisoner would be recalled or his condition reviewed, the Clinical Manager confirmed that prisoners were not being recalled “at the moment”.

41. The Clinical Manager explained to the investigation team that only prisoners who had been admitted to the inpatients' unit qualified for a care plan. A bank nurse (an alternative to an agency nurse) who has worked at Rye Hill for seven years explained that some outpatients have care plans when their conditions become acute. However, there was no evidence of a system of regular review or care planning for prisoners with long term conditions.
42. Despite his medical history, the man was not examined by a healthcare professional for more than two years. Rye Hill accommodates prisoners with long sentences, therefore a significant number of older prisoners. In their Serious Event Report, the company running the prison acknowledges the importance of care for elderly prisoners. I share the clinical reviewer's concerns about the lack of clarity surrounding chronic disease management at Rye Hill. I acknowledge that the appropriate management of his medical conditions may have had no bearing on the outcome in this case. Nevertheless, I strongly echo the clinical reviewer's recommendation:

The Director and Head of Healthcare must ensure that delivery of chronic disease management is reviewed in line with the Quality and Outcome Framework and the other associated service orders.

Prescription review

43. At the time of his death, the man was taking 100 milligrams (mg) of Amitriptyline (a commonly prescribed antidepressant) daily as treatment for depression. From the medical records made available to the investigation team, he had been taking the same dose of Amitriptyline since 2002, when the dose was reduced from 150mg daily to 100mg daily. He became angry at the suggestion of a further reduction in dose in 2005 and stayed on the same dose until his death.
44. The forensic psychiatrist carried out a psychiatric report for a parole hearing on 23 April 2008. He noted the ongoing prescription of Amitriptyline. That is the last entry in the man's medical record that refers to his medication. Nonetheless, it is clear from his prescription charts that he took his antidepressants until his death.
45. Medication reviews are undertaken by the locum GP at the prison. One doctor worked as a locum GP every other month at Rye Hill. He explained to the clinical reviewer that part of his role is to carry out routine medication reviews. The locum GP said that he "reviews a patient's notes and does not see them in person", although he may well have previously treated those prisoners in his surgery.
46. It is good practice for medication to be reviewed with the patient present at least once a year. The man was prescribed the usual adult dose for depression and there were no recorded indications that he had an

adverse reaction to the treatment or the dose. However, there is no record that he was examined by a healthcare professional for more than two years before his death. Therefore, it cannot be possible to determine whether the continued prescription remained appropriate. I agree with the clinical reviewer's recommendation:

The Director and the Head of Healthcare should strengthen procedures for repeat prescribing within the prison.

Medical Information Technology (IT) system

47. At Rye Hill, all the prisoners' medical records are held in paper files in a locked filing room in the healthcare centre. All publicly funded prisons now have an electronic medical information system (SystemOne), which enables prisoners' records to be retrieved and searched efficiently. It also means that a prisoner's medical information is available between prisons to ensure continuity of care when they are transferred.
48. When the investigation team met with the Director, Medical Director and the Offender Health Lead for NHS East Midlands in December 2009, the Teaching PCT had agreed to fund the installation of SystemOne at Rye Hill. However, the project had not started because the matter of funding the ongoing maintenance of the system had yet to be resolved.
49. During that meeting, the Director of Rye Hill acknowledged that the installation of an electronic system to hold medical records was "central" to the effective delivery of healthcare. Such a system could provide automatic prompts when a prisoner is due to be reviewed or their prescription repeated. I agree with the Director that the introduction of a medical IT system could help staff to deliver effective clinical care.

The Teaching PCT and prison should prioritise the implementation of a computerised medical information system.

Clinical Governance

50. Clinical governance is the framework through which healthcare providers are accountable for continuously improving the quality of their services. In their policy documentation, provided to the investigation team, the prison recognises that

"Directors have responsibility for the overall performance of the health care in the secure environment, whilst members of the healthcare team are responsible for individual clinical performance".

The expectations set out by the prison are that the healthcare manager should report to the senior management team each month and there should be a quarterly review by the Head of Medical Services in the prison.

51. During his interview for this investigation team in September 2009, the newly appointed Primary Care Clinical Manager said that the clinical governance team had not met since July 2009, and that meeting was to set the terms of reference. He said that the healthcare team meet each month and information should be fed into quarterly clinical governance meetings.
52. At the meeting with the investigation team in December 2009, the Head of Medical Services outlined the clinical governance structures in place at Rye Hill. She explained that there is a quarterly meeting chaired by the Director at the prison, attended by her, which feeds into an overarching meeting regarding healthcare provision throughout the Justice Services which is held every two months.
53. Following the meeting in December 2009, the Director arranged for more information about clinical governance to be collated and sent to my investigator. The clinical reviewer considers these documents at length in the clinical review. I agree with the clinical reviewer that the evidence demonstrates the commitment of the Head of Medical Services and the Director to delivering clinical governance. However, I share his concern that the Head of Healthcare and Primary Care Clinical Manager were unaware of the clinical governance structures in place.

The Director should work with the Head of Healthcare to promote their understanding of the clinical governance framework to operational staff and ensure that it is used to improve healthcare provided for prisoners.

Training and recruitment

54. All of the healthcare professionals interviewed as part of the investigation described the significant impact of staffing shortage on the delivery of healthcare. During my investigator's feedback to the Director, she acknowledged the difficulty recruiting full time permanent members of staff.
55. During the course of the investigation, the prison provided a nurse recruitment timeline, in which were recorded clear efforts to recruit additional nursing staff. Nevertheless, there were still three nursing positions vacant at the end of January 2010 despite two recruitment campaigns. A nurse explained the "frustration" that results from working at such a low level of staffing. He said that there was "not enough time in the day" to carry out the duties that he required. He explained that there should be at least three nurses on duty, but the current staffing level is one general nurse and one mental health nurse working during a day shift.
56. There are clear concerns about the delivery of healthcare, for example the impact on nurse-led clinics as discussed above. It also means that

there is less time available for staff to undertake the required training because it is harder to spare them from their operational duties. For example, at the time of this investigation, the Clinical Manager told the team that there were a number of healthcare staff who had not received mandatory basic life support training. I am pleased to note from the additional evidence provided to the investigation team that all healthcare staff had received basic life support training by October 2009.

57. I appreciate the challenge of managing the constant healthcare needs of a prison population with a stretched, ever-changing team. Nevertheless, to continue to offer healthcare without sufficiently qualified staff recruited in sufficient numbers, may result in an inability to give prisoners the treatment they need. From the evidence provided to the investigation team, it is clear that efforts have been made to address staff's training requirements through action planning and the skill mix review noted by the Chief Inspector in her 2009 report. Nevertheless, I agree with the clinical reviewer's recommendation:

The Management Board should recruit appropriately trained and experienced healthcare staff to provide structured healthcare, including chronic disease management, to the prisoners of Rye Hill.

CONCLUSION

58. The man's death from ischaemic heart disease may not have been foreseeable, even if he had more contact with healthcare services. I accept that prisoners must take some responsibility for their own health, as they would in the community. He did not seek medical assistance or advice, beyond receiving his prescription, during his time at the prison. Nevertheless, I do not think it is acceptable that he had no meaningful clinical contacts for more than two years before his death even though he was taking antidepressant medication.
59. I am concerned at the lack of structured chronic disease management and care planning available to prisoners at Rye Hill. I agree with the clinical reviewer that such gaps in healthcare mean that Rye Hill does not provide care equitable to that in the community. I acknowledge the commitment of the management team to developing healthcare delivery to redress this and I am pleased to note work that has already begun to address it.

RECOMMENDATIONS

The prison accepted all of my recommendations and I have included the actions identified in response to each recommendation.

1. The Head of Healthcare should review all prisoners' medical records to ensure that prisoners are recorded on appropriate chronic disease registers.

We have now reviewed all patient records and their pharmacy records to bring the disease registers up to date.

2. The Director and Head of Healthcare must ensure that delivery of chronic disease management is reviewed in line with the Quality and Outcome Framework and the other associated service orders.

We have worked with the GP to review all our chronic disease pathways and ensure they meet evidence based best practice. These will be reviewed on an annual basis or more frequently if new guidelines are issued.

3. The Director and the Head of Healthcare should strengthen procedures for repeat prescribing within the prison.

The new pharmacy provider and the healthcare team have a much more robust approach to repeat prescribing which is auditable.

4. The Teaching PCT and prison should prioritise the implementation of a computerised medical information system.

The installation of the electronic medical system is underway. We are awaiting BT to finish the installation of the N3 connection and will then be live within days as all the cabling has been completed and the hardware is ready for installation.

5. The Director should work with the Head of Healthcare to promote their understanding of the clinical governance framework to operational staff and ensure that it is used to improve healthcare provided for prisoners.

The Healthcare team including the operational manager have received training on Clinical Governance. All establishment Directors have also received training on Clinical Governance. There are regular Clinical Governance Meetings with the PCT which they have commented are of good quality.

6. The Management Board should recruit appropriately trained and experienced healthcare staff to provide structured healthcare, including chronic disease management, to the prisoners of Rye Hill.

We have now recruited a variety of RMNs and RNs to all vacant posts to enable us to deliver a range of interventions and chronic disease management. We only use bank nurses in the event of needing additional support, all of whom have significant experience of working in secure environments.