PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the death of a man at hospital in June 2012 while in the custody of HMP Channings Wood

Report by the Prisons and Probation Ombudsman for England and Wales

January 2013

This is the report of an investigation into the death of a man, a prisoner at HMP Channings Wood. He died at hospital in June 2012, having been admitted the previous day. He was 81 years old. The cause of death, established by post mortem, was a small bowel infarction (restricted blood supply to the bowel, due to a clot causing bowel obstruction). I offer my condolences to his family and his friends.

The investigation was carried out by an investigator. A review of the man's clinical care in custody was carried out by a clinical reviewer for the local PCT. Channings Wood cooperated fully with the investigation.

The man was prescribed warfarin, to prevent the formation of blood clots, for a number of years. The investigation found that his warfarin dose and the monitoring of its effectiveness were not always optimal, although it is not possible to know whether more effective monitoring could have prevented the blood clot which led to his death.

The investigation also identified the need for Channings Wood to undertake more focussed assessment of the social care needs for prisoners like the man who have limited and deteriorating mobility. In addition, the prison also needs to improve individual risk assessments when determining whether to use restraints on hospital escorts and, similarly, when considering whether families can be allowed some privacy with a dying relative.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2013**

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SUMMARY

1. The man was 80 years old when he was sentenced to prison in October 2010 and arrived at HMP Gloucester. His health was poor and he used a walking stick and had been diagnosed with a number of chronic diseases for which he took a variety of different medications. These included warfarin (medication used to prevent blood clots forming), which his community GP's records indicated he took to treat a recurrent deep vein thrombosis (DVT, a blood clot in the veins). (The effectiveness of warfarin is monitored by regular blood tests to check the patient's international normalised ratio (INR, a measure of how fast the blood clots.)

2. In January 2011, the man transferred to HMP Channings Wood. In April, his INR was much higher than the target range and he was admitted to the inpatient unit at HMP Exeter until it stabilised. He returned to Channings Wood after four weeks.

3. The clinical reviewer comments that the man's INR was often not well controlled during his time in prison. This meant his warfarin dose was changed regularly and he had to have his blood tested much more often than is ideal. The INR range against which he was monitored was not always in line with what it should be when a DVT is being treated. Decisions about the dosage of warfarin were not always optimal.

4. In May 2012, the man reported increasing pain in his hip which affected his mobility. His friends on the wing said that, as a result, they had to help him clean his cell. There was no formal assessment of his needs and capabilities.

5. The man was taken to hospital by emergency ambulance on 27 June suffering from chest pains. Initially he was handcuffed to a prison officer. It was quickly recognised that this was inappropriate, but we think that his age, mobility and the nature of the emergency should have been considered at the outset.

6. The man's health worsened and he died on the morning of 28 June. The cause of death was established as a small bowel infarction (restricted blood supply to the bowel, due to a clot causing bowel obstruction). The clinical reviewer comments that it is possible that better control of his INR might have prevented the clot that led to his death, but it is not possible to say this with any certainty.

7. We make a number of recommendations about monitoring of INR levels, chronic disease management, support for prisoners who need help with daily tasks, appropriate risk assessment when a prisoner is taken to hospital and sensitive handling of family contact for prisoners at the end of their lives.

THE INVESTIGATION PROCESS

8. On 29 June 2012, the investigator issued notices announcing the investigation to staff and prisoners and asking anyone with relevant information to come forward. There was no response.

9. The investigator visited Channings Wood on 9 July, saw where the man had lived, and spoke to an officer on his wing and three prisoners who knew him well. He visited the healthcare centre and spoke to the healthcare manager. The investigator also met the prison's family liaison officer and spoke to the Chair of the prison's Independent Monitoring Board.

10. A clinical review of the man's time in custody was carried out by a clinical reviewer. The clinical reviewer and investigator interviewed the deputy healthcare manager and spoke to a prison doctor at Channings Wood. The investigator also interviewed the Head of the Offender Management Unit.

11. One of the Ombudsman's family liaison officers telephoned the man's son and daughter-in-law, on 27 July, to explain the investigation and to ask if they had any matters they wished the investigation to take into account. The family asked whether changes to his medication some months before his death could have contributed to his death. They also said that they would have liked to have spent some time with him on their own when he was close to death, but were unable to do so due to the presence of prison officers in the room.

12. The family received a copy of the draft report as part of the consultation process. They noted the comments of the clinical reviewer and were concerned about the lack of accurate records and information regarding the man's warfarin regime and INR. They were particularly concerned by the clinical reviewer's comments that it is possible that the clot that caused his death might have been prevented with better control of his INR.

13. The report was also sent in draft to the Prison Service. Their response to the recommendations is included.

HMP CHANNINGS WOOD

14. HMP Channings Wood is a category C prison in Devon. (All prisoners are allocated a security category based on factors including their offence, risk of escape and risk to the public if they did escape. Category C prisoners are those who cannot be trusted in open conditions but who do not have the resources and will to make a determined escape attempt.) The prison holds a maximum of 731 prisoners.

15. The man lived on Weaver wing at Channings Wood which, along with the neighbouring Fleet wing, makes up Living Block Five. This is part of the prison's vulnerable prisoners' unit (VPU, for those who need to be or request to be separated from other prisoners for their own safety). Because of his age and poor mobility the man lived in a single cell at the end of a corridor near the wing office. His cell had an additional call button next to his bed.

16. Health services at Channings Wood are provided by a healthcare company. The healthcare centre is open from 7.30am to 7.45pm on Monday to Thursday, and 7.45am to 5.00pm Friday to Sunday. A healthcare service provides GPs and an out of hours service. There are GP surgeries on weekday mornings and occasionally in the afternoon. There are nurse led clinics for life long conditions and a lead nurse for older prisoners.

HM Inspectorate of Prisons (HMIP)

17. HMIP conducted a short follow up inspection of Channings Wood in July 2010. The Inspectorate found that older prisoners spent too much time locked in their cells, although there were regular meetings and activities organised which provided older men with the opportunity to comment on their care. They found that older prisoners were assessed every six months, although the prison's health needs assessment did not sufficiently reflect the needs of older prisoners. The Inspectorate also recommended that a formal prisoner carer scheme be introduced.

Independent Monitoring Board (IMB)

18. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. The IMB report for 2010-11 expressed concern about the provision of disability aids for older and disabled prisoners. The IMB commented on the excellent nurse-led healthcare, but highlighted the increasing number of prisoners' complaints about the lack of continuity in seeing GPs and the number of cancelled surgeries. The IMB concluded that these problems were predominantly due to the use of locum doctors by.

19. The Chair of the IMB told the investigator when they met on 9 July that they were still concerned about many aspects of healthcare provision and the increasing number of older prisoners. She subsequently wrote to the healthcare provider to

highlight some concerns including that the number of locum doctors resulted in unfamiliarity with some patients' medications and diagnoses.

Previous deaths at HMP Channings Wood

20. The man is the fourth of six prisoners to die at Channings Wood since September 2011. All five of the other men also died as a result of apparent natural causes. Of the three previous deaths, two also involved older prisoners, who we concluded received appropriate clinical care in prison. However, on both occasions we judged that the use of restraints in hospital was not proportionate to the risks presented by two very unwell older men.

KEY EVENTS

21. On 29 October 2010, the man was convicted of serious sexual offences committed more than 35 years previously. He was remanded to HMP Gloucester to await sentencing. He was 80 years old. This was his first time in prison. He had a many health problems. These included a quadruple heart bypass, surgically removed gall bladder, aneurysms in the groin and abdomen (aneurysms are the swelling of an artery and are most commonly found in the groin, abdomen and brain), diabetes, high blood pressure, chronic kidney disease, arthritis and chronic obstructive pulmonary disease (COPD, a term that encompasses a number of lung disease including chronic bronchitis and emphysema). He took a range of medication, including warfarin (to prevent blood clots forming). Notes from his community GP, faxed to the prison on 2 November, indicated that he took a dose of 3.5mg of warfarin per day to treat a recurrent deep vein thrombosis (DVT). (A DVT is a blood clot in the veins, usually in the leg.)

22. On the evening of his arrival at Gloucester, the man saw a nurse for a reception health screen. His medical history was noted and various clinical observations were taken. He was referred to a prison doctor, and an appointment was made for the following afternoon.

23. When he saw the doctor, the man said that his solicitor had told him two days earlier that he had been diagnosed with prostate cancer. When they were obtained on 2 November, his GP notes made no mention of prostate cancer. A prison nurse telephoned the GP surgery on 4 November to see if they had any further information about this diagnosis and was told they did not. The man said that he did not recall visiting the doctor with any symptoms or having any recent investigations.

24. A detailed assessment of the man's personal and social care needs was completed on 7 November, which noted that he used a walking stick and found it difficult to walk any further than 100 metres. He also found activities of daily living, such as washing and showering, dressing himself, cleaning his cell and collecting meals, a problem. Various adjustments were recommended, including the provision of grab rails and a seat in the shower, assistance with cleaning his cell and frequent checks by staff because of his risk of falling.

25. The man's international normalised ratio (INR, a measure of how fast the blood clots and, therefore, the effectiveness of warfarin) was checked on 23 November and found to be higher than the target range[1]. As a result, his daily dose of warfarin was reduced to 3mg. The dose was reduced again six days later, to 2mg per day, as his INR remained above the target range.

[1] The clinical reviewer explains in the clinical review that INR should be maintained between 2.0 and 3.0 when a deep vein thrombosis or atrial fibrillation (irregular heart beat) is being treated. If the patient has a mechanical heart valve the INR should be maintained between 3 and 4.5.

Transfer to HMP Bristol

26. On 7 December 2010, the man was sentenced to 14 years imprisonment and transferred to HMP Bristol that day. His medical history was noted and the nurse who completed his reception assessment recommended that he be "closely and frequently monitored by the healthcare team and GP".

27. Two days after his arrival at Bristol, the man said he had vomited several times. He was prescribed anti-sickness medication. On the same day, his INR reading had fallen below the ideal range and his warfarin dose was therefore increased to 3mg per day. It was reduced to 2mg again on 14 December when his INR rose to 3.2. Just over a month later, on 20 January 2011, the dose returned to 3mg as his INR was now lower than the expected range.

Transfer to HMP Channings Wood

28. The man transferred to Channings Wood on 26 January 2011. His medical history, prescribed medication and reduced mobility were noted at a reception health screen. A prison doctor saw him the following day and recorded that he was taking warfarin for a deep vein thrombosis. He noted (incorrectly) that the INR range should be 3.0 to 3.5 and asked that his INR be kept under review.

29. Entries made in his prison records over the following two months indicate that the man had settled in well at Channings Wood and had joined a club for prisoners over 50. After a risk assessment, he was able to keep his medication in his cell to take as prescribed. He collected a supply every week.

30. The man completed a disability questionnaire on 21 February. He ticked boxes to indicate that he had reduced mobility, physical capacity and impaired vision. He said he could not climb stairs and had difficulty breathing when he exerted himself. In contrast to the assessment completed at Gloucester, he said he did not require any assistance with activities of daily living.

31. An entry in his medical record on 3 April indicated that the man's warfarin prescription had reduced to 2mg. It is not clear from the notes when this reduction was made. The lead prison doctor asked to see him on 21 April, as she was concerned that the target INR range he was being monitored against (which was 3.0 to 3.5) was unusual. He said his INR had been in this range for around ten years. He also said that he thought his INR was being checked too often and too many changes were made to his medication. She adjusted his target range to 2.5 to 3.0 and increased his warfarin prescription to 3mg per day.

32. A week later, on 28 April, the man's INR was very high. Because of the risk of bleeding should he fall, he was admitted to the inpatient unit at HMP Exeter until his INR stabilised. Over the following week, his INR fluctuated and corresponding changes were made to his warfarin dose. A planned return to Channings Wood on 5 May was cancelled as the level was still too high. Blood tests taken the same day showed that his kidney function had deteriorated. A prison doctor noted that this was probably hypertensive nephropathy (kidney

damage due to high blood pressure). The clinical reviewer comments that there was no evidence to support this diagnosis.

33. The man eventually returned to Channings Wood on 24 May. His INR continued to fluctuate and his warfarin prescription was increased to 4mg per day on 7 June. During June and July, his INR level remained inconsistent and, at times, very high.

34. He was diagnosed with a chest infection in early July and prescribed antibiotics. He was admitted to hospital on 12 July for further tests, and diagnosed with an exacerbation of COPD. He was prescribed a steroid and further antibiotics at the hospital.

35. An anticoagulant therapy record (known as the 'yellow book', which contains a written record of the patient's INR and warfarin dosage) was opened in September. The record contains a page to highlight why warfarin is prescribed and what the desired INR range should be. It was recorded in the man's book that he was prescribed warfarin for DVT and had a target range of 2.0 to 3.0.

36. Over the remainder of the year, the man's INR was either within the target range or slightly above or below. His warfarin dose changed whenever the reading was outside this range, before being consistently prescribed at 2mg per day from the middle of November.

37. On 20 October, a nurse carried out an assessment of the assistance the man required with daily activities. She noted that he had difficulty walking, but did not require any additional assistance with his daily activities.

2012

38. The man's INR was slightly high in late December 2011 and early January 2012, with changes made to his prescription to counteract this. From mid January his INR reading stayed consistently in the target range and the warfarin prescription therefore remained at 2mg per day. As a result, his INR was not checked as frequently and, by May, was checked once every four weeks.

39. On 6 February, the man had a routine scan of his abdominal aortic aneurysm which showed that he had a small aneurysm that needed to be monitored but did not require treatment. He had a scan of his groin, liver and kidneys on 23 February which indicated that his kidneys were shrunken and scarred and confirmed the presence of the second aneurysm in his right groin. The results were assessed by a doctor, who noted that this aneurysm had not increased in size. The doctor incorrectly recorded that the man was taking warfarin for atrial fibrillation rather than DVT.

40. The man saw a locum prison doctor on 26 April, and said he was experiencing increasing pain in his hip. The doctor diagnosed increasing arthritis and asked for an X-ray which was conducted on 30 May. It showed mild arthritis and no changes were made to his medication.

41. A follow up scan of the man's abdominal aneurysm was arranged for 9 May. Although the aneurysm was of similar size to February, the screening manager made a referral to the consultant vascular surgeon at hospital to determine whether it needed further surveillance. The man died before this appointment could take place.

42. The locum doctor saw the man on 24 May, when he told the doctor that his mobility had deteriorated on account of the pain in his hip. The doctor increased the man's dose of Athrotec (medication used to reduce pain and inflammation in arthritis) and told him it was important to try to keep as mobile as possible.

43. After remaining stable for several months, the man's INR was measured at 4.5 on 28 May. His warfarin was stopped for two days, after which the INR had returned to the normal range. During the first two weeks of June, his INR was again consistently outside the target range. Changes were made to his warfarin prescription to counteract this and his INR was checked more frequently. By 18 June, the reading had returned to the normal range. An INR check on 25 June showed the ratio as 4.2 in the man's yellow book but 4.6 in the electronic medical record (SystmOne). His warfarin prescription was reduced to 1mg per day.

44. Because of the increasing pain in his hip and the effect on his mobility, the man was given a walking frame in June to help get around his wing. He did not identify any further concerns about his health in June and, when collecting his medication, reportedly said he was well. One prisoner who knew him said his health appeared slightly worse in his last week at the prison and said he had pain in his hip and stomach.

45. One morning towards the end of June, the man told one of the officers on his wing that he had chest pain and felt unwell. A nurse was called to the wing to assess him. He told the nurse that his chest pain was "off and on" and he felt sick. The nurse took clinical observations, which showed that the man's oxygen saturation level (a measure of the amount of oxygen in the blood) was low. Because of this and his ongoing chest pain, the nurse asked that an emergency ambulance be called. The call was made at 12.20pm and the ambulance arrived at 12.35pm. The man was admitted to hospital.

46. When the ambulance was called an escort risk assessment was completed. The man's risk to the public was assessed as normal (on a scale of low, normal, high) and his risk of escape was low. The healthcare assessment section was completed by a healthcare administrator, who recorded that there were no medical objections to the use of restraints. The risk assessment was agreed by the duty governor, who authorised a two officer escort and that the man should be handcuffed to one of the officers.

47. The ambulance arrived at hospital at 1.30pm. Around an hour later, the man became more unwell and was taken for a CT scan. The handcuffs were removed for the scan and, while it was taking place, one of the escorting officers telephoned the prison and asked for permission not to reapply the handcuffs as the man's condition was worsening. The officer spoke to another operational manager, who agreed that the handcuffs should not be reapplied.

48. During the afternoon, the operational manager tried unsuccessfully to contact the man's son, his nominated next of kin. The duty governor was able to contact the man's daughter-in-law by telephone at around 5.30pm and told her that her father-in-law had been admitted to hospital. The man's son and daughter-in-law visited him in hospital that evening.

49. The man's condition continued to worsen overnight. He died the following morning with his son and daughter-in-law present. A family liaison officer was appointed and visited the hospital to meet the family, but found they had left. She telephoned the family that afternoon to introduce herself. The family liaison officer spoke to them fully the following day. The duty governor and a prison chaplain visited the hospital after the man's death to support the escorting officers.

50. The news of the man's death was broken individually to his friends on Weaver wing by members of staff. A memorial service was held the following day. Prisoners who were subject to suicide and self-harm monitoring were reviewed by staff to check they had not been adversely affected by the news of his death.

51. The man's family visited the prison on 6 July and collected his property. The funeral was held in July. He had paid for his funeral in full some years before he was sent to prison. Channings Wood met the cost of transporting his body to his home town.

ISSUES

Anticoagulation control

52. Friends of the man at Channings Wood said that he told them that frequent changes to his warfarin prescription made him feel unwell and that he did not know why his dose kept changing. The man's family also expressed concern about the changes to his medication, and asked if this would have contributed to his death.

53. The man's community GP records, obtained by HMP Gloucester, indicate that he was prescribed 3.5mg of warfarin a day before being sent to prison. It was recorded that this was to treat a recurrent DVT, with a target INR ratio of 2.5. The records show that in the six months before his imprisonment, his INR consistently measured between 1.8 and 3.0, and there was no change to his prescription. The clinical reviewer explains that INR should be maintained between 2.0 and 3.0 when warfarin is being used to treat DVT and when INR is well controlled it is possible to space blood tests at up to 12 weeks.

54. During his time in prison, there was some inconsistency with the man's warfarin management. Although it was usually noted that he was being treated for recurrent DVT, on some occasions it was incorrectly recorded that he was being treated for atrial fibrillation or a mechanical heart valve. There was also inconsistency in his target INR range. Shortly after his arrival at Channings Wood, the ideal range was recorded as 3.0 to 3.5. It was then amended to 2.5 to 3.0 and, later, to 2.0 to 3.0.

55. The clinical reviewer comments that the man's INR was often not well controlled, which meant that he often had to have his blood tested every few days. There were some periods, such as in spring 2012, when his INR was better controlled and he was able to go for up to four weeks between tests. During many of the periods when his INR was higher or lower than the target range, The man's warfarin dose was changed to compensate. The clinical reviewer comments that different prison doctors made varying decisions about the warfarin dose, although there are documented examples of the reasoning behind these decisions. The clinical reviewer notes the advantages of computer software that assists in the management of patients on warfarin and helps ensure consistency in dosage, which the Head of Healthcare at Channings Wood will wish to consider.

56. In summary the clinical reviewer comments:

> "It is possible that better control of his anticoagulation could have prevented the clot that led to the man's death, but it is not possible to say this with certainty."

The Head of Healthcare at HMP Channings Wood should ensure that the target INR and reason for warfarin treatment are clearly recorded and available to GPs when making dosage decisions to enable consistency of treatment.

Chronic disease management

57. The man had a number of long term conditions before he was sent to prison, including diabetes, high blood pressure, chronic kidney disease and COPD. He took a variety of different medications to manage these.

58. National Institute for Health and Clinical Excellence (NICE) guidelines state that patients being treated for diabetes and high blood pressure (and other chronic diseases) should be offered a review each year. The man did not have a diabetes or blood pressure review in prison, although the clinical reviewer notes that his respiratory disease was monitored appropriately.

59. The deputy healthcare manager at Channings Wood told the investigator and clinical reviewer that they have clinics and employ lead nurses for chronic diseases. Reviews are expected to be held annually (or more regularly if the patient's needs require it), but she said that, due to current staffing problems, some clinics are not held as regularly as they should be. We note that at the time of his death the man had been at Channings Wood for eighteen months without a formal annual review of his chronic conditions.

The Head of Healthcare should ensure that clinics for life long conditions are held annually, in line with NICE guidelines.

Provision of personal and social care

60. The man was 80 years old when he was sent to prison in October 2010. He used a walking stick and struggled to walk further than 100 metres. An assessment of his personal and social care needs at Gloucester recorded that he had difficulty with some activities of daily living. Various adjustments were recommended to help him, including assistance with cleaning his cell.

61. When he moved to Channings Wood in January 2011, the man said that he did not need any help with daily living tasks. A further assessment on 20 October 2011 indicated that he continued to have difficulty walking but did not need additional assistance. After his mobility deteriorated further in May 2012, because of mild arthritis affecting both of his hips, there was no reassessment of his personal and social care needs.

62. An officer who works on Weaver unit and knew the man agreed that his mobility had deteriorated in the last few months of his life, but believed that he was able to look after himself without help. A prisoner, who lived in a cell close to the man, told the investigator that the man struggled to walk up and down the corridor and sometimes had to be helped back to his cell. He added that other prisoners helped him to clean his cell. Another prisoner said that he helped the man clean his cell about once a week.

63. In June, the man was given a walking frame to help him move around the unit. It is apparent that his mobility deteriorated in the last few weeks or months of his life. While he remained mostly independent, he relied on the help of friends to

clean his cell. We conclude that this should have been recognised and a further assessment of his personal and social care needs carried out. We note that the Inspectorate recommended in 2010 that a formal prisoner carer scheme should be introduced, but this recommendation had not been implemented.

The Governor and Head of Healthcare should ensure that an assessment of a prisoner's personal and social care needs takes place when the prisoner experiences a significant reduction in mobility and that appropriate support is provided.

Use of restraints

64. A risk assessment was completed before the man's hospital admission in June. He was assessed as normal (medium) risk to the public and low risk of escaping (on a scale of low, normal, high). The manager who authorised the risk assessment told the investigator that it would be standard practice to assess someone who had committed offences such as the man as medium risk to the public. The medical information section of the risk assessment was completed by a healthcare administrator and contained no mention of his mobility problems, general health, or the nature of the emergency admission.

65. The manager authorised a two officer escort and that the man should be handcuffed to one of the officers. The manager said he would not usually see the prisoner before completing the risk assessment and a standard risk assessment is therefore completed. The assessment will be considered again once the prisoner is at hospital, to take into account their individual circumstances such as age and mobility. The manager added that he would only authorise no restraints to be used if it was apparent that loss of life was imminent.

66. Around an hour after he arrived at hospital, the man's health quickly deteriorated and he was taken for a scan. The handcuffs were removed before the scan and were not reapplied. We are satisfied that the officers accompanying him acted correctly in seeking permission to removed the handcuffs and an appropriate decision was made to allow this.

67. We acknowledge that, in an urgent situation, it will not always be possible to have all the necessary information before a full risk assessment can be completed. However, in this case an assessment was completed and it is apparent that the relevant factors about risk were not properly taken into account to match the individual circumstances. It appears that the prison operates on a default position of using restraints. However, the man was 81 years old and required the assistance of a frame to walk. He was suffering from chest pains and was very ill. His offences were committed over 35 years previously and the circumstances would not suggest that he was any current risk to the general public. A quick assessment should have been able to establish that given his age, health and mobility, an escort of two officers without restraints should have been sufficient.

The Governor should ensure that the use of restraints for hospital escorts accurately reflects the prisoner's actual risk at the time.

Privacy in the last hours of the man's life

68. The man's family said they would have liked to have spent some time alone with him when he was close to death, but were unable to do so due to the presence of prison officers in the room.

69. It is apparent from the prison's bedwatch and decision logs that it was clear that the man was likely to die very soon. His family arrived at the hospital at around 10.20am and were told this news by a consultant. The man died around an hour and a half later.

70. There is no indication from the bedwatch records that the family asked the escorting officers for privacy and it is understandable if this was a question they might not think they can ask of prison staff. We think it is right and decent to offer the family of a dying prisoner time alone with them when they are close to death, unless there is any significant evidence to suggest that such an offer would present a risk to the prisoner or have other security implications. We are unaware of that there was any such evidence in this case.

The Governor should ensure, subject to an appropriate risk assessment, that the family of a dying prisoner are offered time alone with them when they are close to death.

CONCLUSION

71. The man had frequent blood tests and changes to his warfarin prescription. It is apparent from our investigation that his INR was not always well controlled and there was some inconsistency with its target range. We agree with the clinical reviewer's conclusion that some dosage decisions might have been made differently, and this (and other aspects of chronic disease management) meant that he did not always receive the highest standard of care. However, it is not possible to know whether more effective monitoring would have prevented his death. The investigation has identified a need for more focussed assessment of social care needs at the prison and better individual risk assessments for escorts to hospital to ensure that restraints are not used unnecessarily.

RECOMMENDATIONS

1. The Head of Healthcare at HMP Channings Wood should ensure that the target INR and reason for warfarin treatment are clearly recorded and available to GPs when making dosage decisions to enable consistency of treatment.

   Accepted – The patient's anticoagulant therapy book will be completed to ensure that details are recorded for why the patient is receiving anticoagulation and what the INR target range is.

2. The Head of Healthcare should ensure that clinics for life long conditions are held annually, in line with NICE guidelines.

   Accepted – Patients with chronic disease management will be reviewed annually in line with NICE guidelines.

3. The Governor and Head of Healthcare should ensure that an assessment of a prisoner's personal and social care needs takes place when the prisoner experiences a significant reduction in mobility and that appropriate support is provided.

   Accepted – Healthcare staff will work collaboratively with the prison social inclusion officer to assess on-going personal/social care needs.

4. The Governor should ensure that the use of restraints for hospital escorts accurately reflects the prisoner's actual risk at the time.

   Accepted – We have reviewed the use of restraints on prisoners who do not pose a risk to the public or of escape and will ensure that the use of restraints for hospital escorts accurately reflects the prisoner's actual risk at the time.

5. The Governor should ensure, subject to an appropriate risk assessment, that the family of a dying prisoner are offered time alone with them when they are close to death.

   Accepted – All duty governors are instructed to ensure this is facilitated in all future cases.