Investigation into the circumstances surrounding the death of a man in June 2009 whilst in the custody of HMP Isle of Wight - Parkhurst

Report by the Prisons and Probation Ombudsman for England and Wales

January 2010

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.

This is the report of an investigation into the death of a 70 year old man who was a prisoner at HMP Isle of Wight – Parkhurst. The man died on 19 June 2009 from natural causes. Ten days earlier, on 9 June, the man was taken from Parkhurst to HMP Brixton for his appeal against his conviction and sentence. He returned to Parkhurst during the evening of 16 June after his appeal was rejected.

I would like to add my personal condolences to those already expressed to the man's family on behalf of this office by one of the Ombudsman's Family Liaison Officers.

The investigation was conducted by one of the Ombudsman's investigators. In addition a doctor was asked by Isle of Wight Primary Care Trust to undertake a review of the man's clinical care. I am grateful for the assistance they both received from staff at HMP Isle of Wight - Parkhurst and would like to thank the Governor and his staff for their co-operation.

The clinical reviewer concluded that the man's care was equivalent to what he would have received in the wider community. However, the review raises a number of learning points that the prison health partnership will need to consider seriously. He makes two recommendations which I endorse.

Jane Webb
Deputy Prisons and Probation Ombudsman **January 2010**

SUMMARY

The man was born in 1939 and was 70 years old when he died at HMP Isle of Wight - Parkhurst on 19 June 2009. The man's death was due to natural causes as a consequence of heart disease.

The man was remanded into custody at HMP Belmarsh in May 2007. He transferred to HMP Wandsworth in July 2007. The man was sentenced at Crown Court in May 2008 to eight years imprisonment for conspiracy to kidnap. He transferred to Parkhurst on 14 August 2008.

During the man's first reception health screening interviews, it was recorded that he had a history of hypertension (high blood pressure) and a stomach ulcer. In May 2009, the man was diagnosed with blocked arteries in his legs. He was referred to vascular surgeons in Hampshire for further consideration.

The man was taken to HMP Brixton on 9 June so he could attend his appeal against his conviction. When he arrived at Brixton, it appears that a health screening interview did not take place. After his appeal was rejected, the man returned to Parkhurst on 16 June.

During the evening of 18 June, two days after his return, the man rang his cell bell and told staff that he had chest pains. Staff from the healthcare centre visited and carried out observations. As it was suspected the man had indigestion he was given Gaviscon (a non prescription medication for the treatment of heartburn and acid reflux). The man later informed staff that he felt better as he had vomited but he did ask for some paracetamol.

The man's television was still switched on around 4.00am the following morning. After staff were unable to elicit a response from him they turned off the electricity in his cell to see if he would respond. As staff thought that they could hear him breathing, no further action was taken at that time.

At around 5.30am, staff were still unable to rouse the man. He had not moved position and looked very pale, so they asked for medical assistance. Both the night orderly officer and a nurse arrived within a few minutes. They checked for signs of life and confirmed that the man had passed away.

A doctor from the out of hours general practitioner service pronounced that the man was dead at 7.10am.

After it was confirmed that the man had died, HMP Isle of Wight - Parkhurst activated its death in custody contingency plan. The police visited the prison and found no suspicious circumstances. The man's body was released to the undertakers. The Coroner's officer informed the prison that he had died from natural causes.

The clinical review carried out by a doctor and a panel of his colleagues identifies a number of issues relating to the care provided for the man. The review highlights areas of practice that could be improved, and makes two recommendations. I also suggest that there should be a review of health screening procedures at HMP

Brixton.

THE INVESTIGATION PROCESS

1. The investigation was opened on 19 June 2009 by one of the Ombudsman's investigators. He issued notices announcing the investigation to staff and prisoners. These notices included an invitation to anyone who wished to submit information relating to the man's death to make themself known. In the event no one came forward. The investigator also studied all the relevant prison records, which included the man's main prison record and his medical records.

2. The Isle of Wight Primary Care Trust commissioned a doctor to lead a panel review of the man's clinical care. I am grateful to him for undertaking such a thorough review.

3. The investigator visited HMP Isle of Wight - Parkhurst on 23 June, 29 July and 19 August 2009 and discussed aspects of the man's treatment with staff. He interviewed staff and the man's co-defendant who had previously been his cellmate when they first arrived at Parkhurst. The investigator also carried out joint interviews with the clinical reviewer. They interviewed two members of healthcare staff and the Lead General Practitioner at Parkhurst. The investigator also wrote to HMP Brixton to inform them of about the findings of the investigation.

4. The investigator contacted Her Majesty's Coroner to inform him of the nature and scope of the investigation and to request a copy of the post mortem report. Upon completion, this report will be sent to the Coroner to assist in his enquiries into the man's death.

6. One of the Ombudsman's Family Liaisons Officers contacted the man's family. This gave them the opportunity to discuss the purpose of the investigation and raise any concerns or questions that they wanted to be addressed. They chose not to raise any concerns at that time. I hope that this report provides them with a better understanding of the events leading up to the man's death.

HMP ISLE OF WIGHT - PARKHURST

8. HMP Isle of Wight was inaugurated on 1st April 2009. It is the organisational amalgamation of the former Albany, Camp Hill and Parkhurst prisons. HMP Isle of Wight holds approximately 1,700 prisoners on the three sites. The prison is governed by Mr Barry Greenberry, who took up post following the amalgamation. Each site has its own Director, who reports to Governor Greenberry.

9. The Camp Hill site is a category C training prison and Albany is a category B training prison for sex offenders. Parkhurst was a high security prison until the mid 1990s when it was converted to its current role. It now caters for long-term and life sentence category B prisoners and remands from the Isle of Wight courts. Parkhurst has five wings. All the cells have in cell power and integral sanitation. A and D wings hold vulnerable prisoners. F wing is for prisoners on remand and is the induction wing.

10. After the evening roll call to confirm prisoners are all accounted for, the prison enters what is called patrol state. This is defined as follows: 'Prisoners are locked up and staff numbers are reduced to the minimum needed to patrol. The main role of staff at this time is to maintain the security of the prison.'

11. When the night patrol officer arrives on the wing, a hand-over is given by the officer on evening duty and a sealed packet containing keys is passed from one to the other. The keys in the sealed packet are only to be opened in an emergency. When the officer on duty the next day arrives, he or she receives a hand-over from the night patrol officer and another roll check is carried out before the night patrol officer leaves the wing. When staff were unable to rouse the man on the morning of 19 June 2009 and had to enter his cell, the prison was in patrol state.

12. Health services at HMP Isle of Wight are commissioned by the Isle of Wight Primary Care Trust (PCT) and healthcare is clustered with both Albany and Camp Hill. A new inpatient unit was completed earlier this year and is situated at Albany. There are three nurses on duty at Parkhurst from 7.30am to 6.00pm from Monday to Friday. General Practitioners (GPs) from a local community practice attend Parkhurst for four three-hour sessions each week. Evenings and weekends are covered by on call GPs from the same community practice. Prisoners with more serious conditions or clinical needs are referred to the local hospital.

5. During 2009, there was one other death from natural causes at Parkhurst but this investigation has not been completed. The investigator reviewed reports from earlier years but found no common factor between the circumstances surrounding this investigation and those into previous deaths.

Independent Monitoring Board

6. Each prison has an Independent Monitoring Board (IMB). IMB members are independent and unpaid. They monitor day-to-day life in their prison and ensure that proper standards of care and decency are maintained. Each IMB produces an annual report. The report for Parkhurst for the year 2007/08 has a section on healthcare provision in the prison. It highlights the constraints under which healthcare staff worked during this period:

> "Throughout the year there have been administrative problems and lack of staff who are practiced in dealing with the health care demands peculiar to the prison community, in both mental and physical conditions. The few established staff have worked excess hours and are dedicated to deliver a reasonable level of health care. However, there have been a number of areas of concern with peripheral medical services that have spasmodic problems in delivery."

Her Majesty's Chief Inspector of Prisons' report

7. The most recent inspection by Her Majesty's Chief Inspector of Prisons, Dame Anne Owers, was an unannounced inspection carried out in December 2008. In her report, Dame Anne wrote that:

> "Staff-prisoner relationships were distant and there was no meaningful personal officer scheme. Too many issues that ought to have been resolved informally by staff were the subject of formal complaints … In many ways, Parkhurst is a failing prison: prisoners feel unsafe and poorly treated, and neither the environment nor the regime are suited to the role of a modern training prison. Matters are compounded by a demanding population, many of whom resent being housed in what they view as an isolated establishment with little to offer them."

8. Dame Anne also wrote that:

> "Staffing levels in primary [health] care and inpatients were minimal, and there were vacancies across the cluster. This resulted in a limited health service for prisoners. There was only one member of the health services team on duty at night, based on the inpatient unit [a new inpatient unit has now opened at Albany], who was expected to attend to incidents at Parkhurst and provide telephone advice to staff at Albany and Camp Hill. Staff did not have easy access to ongoing training or support to maintain their professional registration. There was no lead nurse for older prisoners, despite the age profile of the population."

KEY EVENTS

13. On 4 May 2007, the man was remanded into custody at HMP Belmarsh. This was not the man's first experience of prison. He transferred to HMP Wandsworth on 27 July 2007. The man was sentenced at Crown Court on 2 May 2008 to eight years imprisonment for conspiracy to kidnap. On 14 August 2008, the man moved to HMP Isle of Wight - Parkhurst.

14. During the man's first reception health screening interviews, it was recorded that he had a stomach ulcer and a history of hypertension (high blood pressure). He received medication for his blood pressure (ramipril) and stomach problems (lansoprazole). The man was allowed to keep his medication in his own possession.

15. In a letter dated 11 May 2007, the National Offender Management Service Directorate of High Security informed Belmarsh that the man was re-categorised as a category B prisoner. (All adult male prisoners are classified on reception into prison and put into one of four security categories based on the likelihood of escape and the risk to the public if they did escape. The categories are: Category A: prisoners who would be highly dangerous to the public, police or national security if they were to escape. Category B: prisoners for whom the highest security conditions are not necessary, but for whom escape needs to be made very difficult. Category C: prisoners who cannot be trusted in open conditions but who are unlikely to make a determined escape attempt. Category D: open conditions, prisoners who can be trusted not to try and escape.)

16. On 16 March 2008, it was noted in the man's prison record that he had been given enhanced prisoner status. (The Incentives and Earned Privileged Scheme (IEPS) is a scheme that is designed to encourage and reward good behaviour in prisons. There are three tiers – Basic, Standard and Enhanced. Incentives include access to in-cell televisions, more money to spend, wearing their own clothes, more time out of the cell and community visits.)

17. In a letter dated 22 July, the Border and Immigrations Agency (now known as UK Borders Agency) confirmed that deportation action would not be taken against the man.

18. The man was assessed by a prison doctor on 24 February 2009 as he had a rash all along one side of his body. The doctor diagnosed the rash as shingles (this is a reactivation of the virus which causes chickenpox) and she prescribed Aciclovir (an antiviral medication).

19. On 30 March, the man's personal officer (each prisoner is allocated a personal officer, who is the first point of contact for them) made the following entry in his prison record:

> "Is one of the more senior members of B wing and this shows in his behaviour and attitude towards staff and other prisoners. He has never

shown any concerns from staff regarding his behaviour and adheres to all rules set out to him."

20. When he was interviewed as part of this investigation, the personal officer said:

> "The man was far from a difficult prisoner. He was polite to everybody, polite to staff, polite to prisoners. He was very popular on the wing with everybody because of that you know, and he was, he was a real pleasure he really was, very polite man. The man was employed in the Picta workshop which was a workshop designated to people who wish to learn how to use computers. During that time he was asked on several occasions if he would be interested in being a wing cleaner which is a very trusted job, but obviously he was enjoying his work in the workshop he was in. Once he had finished his course in the workshop we did actually take him on as a wing cleaner."

21. The man attended an appointment with a visiting chiropodist on 1 May. The chiropodist noted that the man appeared to suffering from claudication (this is the name given to pain in the leg caused by "furred up" or blocked arteries). Two weeks later, on 15 May, after the man saw the prison doctor, a referral was made to the Vascular Surgery Department at a local hospital. The man passed away before he was able to attend the appointment at the hospital. The prison doctor also prescribed simvastatin (a drug commonly known as a statin which is used for lowering control cholesterol levels and preventing cardiovascular disease).

22. On 1 June, the following entry was made by an Offender Supervisor in the man's prison record:

> "The man showed me some paperwork he received to say his case will be heard at the Court of Appeal on 12th June 09. He was extremely happy about this and feeling positive about a good result."

23. Just over a week later, on 8 June, the man transferred to HMP Brixton for his appeal against his conviction and sentence.

24. Prison Service Order (PSO) 3050 Continuity of Healthcare for Prisoners outlines a prison's responsibility when a prisoner is transferred between establishments. It is not clear what clinical action was taken by Parkhurst to facilitate the man's move to Brixton whilst he attended his appeal. A record of continuation of care did not exist for him. The man's co-defendant was interviewed as part of this investigation. He had shared a cell with the man at Brixton and confirmed that they both took their medication with them when they moved prisons.

25. The Court of Appeal considered the man's case on 12 June and refused his appeal application. The man returned to B wing at Parkhurst four days later, on 16 June (at 9.30pm after leaving Brixton at 2.30pm).

26. In his interview with the investigator, the personal officer said:

> "While I was away on leave the man and his co-defendant did actually travel up for a court appeal. They were very positive that they were going to have a good outcome for it, before leaving, although I didn't really have a proper chance to have a conversation with the co-defendant or the man about it. The co-dependant was upbeat when I spoke to him. I never had the opportunity to speak to the man. It could have raised the stress levels a little bit I would imagine."

27. In his interview, the co-defendant said that he thought the stress of their appeal failure may have led to the man's death. He said:

> " … we were told that we were getting out on appeal because our appeal was that strong and we were expecting to get out. Our legal teams and all were expecting us to get out. They told us there was no problem and we were expecting to get out and we got up there and it didn't happen. I think the man was badly stressed about it. I was myself too you know what I mean but I am not 70 years of age and I think that is what it was."

28. The co-defendant also said:

> "I know it was the Court of Appeal that he [the man] had this problem and I think it was the shock on the way we were treated and he shouldn't have been in prison at all. We were both expecting to get out and it didn't happen. We were just ignored. I won't go into it now but we are going to fight it on you know. And actually the day before he died we were both talking about our next appeals and what we were going to do and how we were going to appeal. And he was into that in a big way and he was pretty annoyed about the way we were treated."

29. Around 8.15pm on 18 June, the man rang his cell (B2-09) bell and complained of chest pains (after being locked up for the night prisoners use their cell bell when they need to ask staff for help). Staff on the wing contacted healthcare and asked for their assistance. A general nurse immediately came to the wing. He carried out observations and, as he suspected the man had indigestion, gave him some Gaviscon (a non prescription medication for the treatment of heartburn and acid reflux).

30. When interviewed as part of this investigation, the general nurse said:

> "As I entered the cell he [the man] stood up and came towards me which I didn't expect … I asked him to sit down and I then asked him to explain his chest pain. I said have you got that pain now, he said no. I said can you explain what it was, he said he had not had it before and I just ran through and said just describe what it is, where it was. He explained that it was a pain in his chest, I then went on and said was it radiating anywhere, did he have any other pains, how did he feel. He

was still sat on the bed, he was moving and just talking normally. His blood pressure I took which was raised but he had a history of hypertension as far as I can recall. He was not unduly distressed or agitated so I talked to him and he wasn't sweating or anything like that."

31. The general nurse then re-checked the man's symptoms:

> "Then I just went back to his chest pain and asked him to go over it again just to confirm what he had said originally. He again said that it was in the centre, he hadn't got it now but then he did say that it actually came when he was laying down and I said oh. So I said well what happened when you sat up and he said it went. I said have you got the pain now and he said no, how do you feel, I feel fine. I grabbed hold of his hands and said can you just squeeze me. I was aware of his age but he looked for a man of that age quite fit. He talked all the time without any break or pause for breath even. Basically I had got some Gaviscon with me because my thoughts were that it was a sort of epigastric [the epigastrium is the area of central abdomen lying just below the sternum] or something like that where he was lying down and then when he said up it was gone."

32. At around 9.20pm whilst patrolling the wing, an Operational Support Grade (OSG) checked on the man and he told her that he had vomited and now felt okay. Around 10.00pm, the man asked the OSG for some paracetamol. She telephoned a staff nurse who confirmed that the man could be given the paracetamol.

33. When interviewed as part of this investigation, the staff nurse said:

> "I had a phone call at about ten past ten I think something like that I think it was saying that he has requested paracetamol for a headache. I said that is fine because they have paracetamol on the wing, because Oscar 1 [radio call sign for the Night Orderly Officer] the first line in command will say don't come across they have got it. I will check that he has got no allergies, if he has not had any during the day has not overdosed or anything like that, and that is fine. I said how is he in himself and the Operational Support Grade who was working on the wing said he gave me two thumbs up and said he is feeling a lot better and I thought great that is good but phone me if there is a problem."

34. Around 4.00am on 19 June, the OSG contacted an officer on a neighbouring wing as the man had not moved and his television was still switched on. The officer came over to B wing and, as she was unable to elicit a response from the man, rang the staff nurse to seek advice on next steps. The staff nurse advised her to switch off the electricity in the cell and see if there was any response. After they did this, both the officer and OSG thought that they could hear the man breathing.

35. When interviewed as part of this investigation, the officer said:

> "So we got the electric keys, switched the electric off, did call him, knocked on the door, no response but I could hear a breathing which I was adamant was from his cell, obviously it wasn't. The OSG also listened at the door and she thought it was coming from him as well. Throughout the rest of the night she continued to monitor him."

36. Around 5.30am, after she had carried out the roll call on the wing, the OSG was contacted by the officer. They checked on the man who had not moved position. They were still unable to rouse him and, as there was now more natural light, they saw that his skin was very pale and there was no chest movement. They requested medical assistance and the Night Orderly Officer (radio call sign Oscar 1) who was in charge of the prison during the early hours of 19 June, and the staff nurse arrived on the wing within a few minutes. The Night Orderly Officer opened the man's cell and both he and the staff nurse checked for signs of life. They were unable to find any signs of life and confirmed that the man had died.

37. The officer told the Ombudsman's investigator:

> "At six o'clock in the morning after I had done my roll check on Charlie Wing I went in to B and G wing where the OSG was working and asked her if she had done her roll check. She said she had and I asked if the man was still in the same position and she said he was but she could still hear him breathing. I went back up to the door and had a check and although I could still hear the breathing it was really quite deep breathing and I couldn't see any movement. We could actually see at six o'clock in the morning because it was then light I could see there was no movement from his shoulders or his chest or anything, his left hand looked purple and his face was very white. So I actually had my suspicions that he had actually died. We then contacted Oscar 1 who immediately attended, opened the door, called the man's name, no response. I believe he actually touched his neck. It was either his neck or his wrist I can't really remember but looked at me and said he has gone."

38. In his statement to the Governor, the Night Orderly Officer wrote:

> "I phoned B & G [wing], the OSG answered the phone and informed me that she had concerns about a prisoner on B wing and not being able to get a response. I asked is it the same one you mentioned earlier, she said yes. I went straight to B wing looked through the observation glass and saw the man laying fully clothed on the top of the bed as if asleep. I unlocked the door called the man, felt the man's arm which was cold and from the blueness of his extremities concluded he had died."

39. Parkhurst contacted the out of hours general practitioners' service and a doctor attended. He pronounced that the man was dead at 7.10am.

40. A Principal Officer was appointed as the prison family liaison officer. The man was a widower and his next of kin was one of his nephews who lived abroad. Parkhurst asked the foreign police service during the morning of 19 June to notify the family of the man's death.

41. The man's nephew rang the prison later that day to confirm the circumstances of his uncle's death. Another of the man's nephews and his wife came over to the Isle of Wight on 23 June to collect the man's belongings and view his body. They were met by the Principal Officer but they declined an invitation to visit Parkhurst. The Principal Officer maintained contact with the family and assisted with the funeral arrangements. Parkhurst also offered financial assistance with the costs of the repatriation of the man's body and his funeral. The man's funeral took place on 29 June and a memorial service was held at the prison. After the man's death the prisoners on B wing collected over £50 in his memory. This is to be used to purchase a memorial plaque to be placed on a bench in the grounds of the prison.

42. A fellow prisoner wrote the following in a letter to a national magazine for prisoners:

> "For all who knew the man, our friend passed away in his sleep on 19th June. He will be sorely missed as he was a kind and friendly guy and one of the nicest people you'll ever meet. He was a popular guy here on B wing at Parkhurst and he's going to be missed by me and many others. God be with you. RIP."

43. The post mortem report records the man's death as being due to natural causes, as a consequence of hypertensive and ischaemic heart disease. The report says:

> "The death of the man was clearly the result of natural disease. The heart muscle had become enlarged as a result of the excess work thrown upon it by a sustained spontaneous increase in systemic blood pressure [hypertensive heart disease]. This would have had the effect of increasing the demand of the heart muscle for blood. However, the heart muscle had in addition been starved of blood over a long period of time as the result of degenerative narrowing of the coronary arteries supplying it (ischaemic heart disease). These two disease processes, which are interdependent, would together have brought about a state of affairs in which sudden unexpected defects in heart rhythm or pumping efficiency could be expected to arise, with a high likelihood of death. In the case of The man, sudden death could have occurred at any time without any obvious precipitating factor, and it is clear in hindsight that the chest pain of which he complained on the night of his death was angina pectoris, the cramp of inadequate cardiac perfusion. Though the treatment offered [that is Gavison] was inappropriate for angina, it is by no means certain, in view of The man's age and the

severity of his heart disease, that correct treatment would have altered the fatal outcome."

ISSUES CONSIDERED

Clinical care

44. As noted above, a review of the man's medical care was undertaken on behalf of the Isle of Wight Primary Care Trust by doctor who convened a review panel. The panel met on 24 September 2009 and the investigator attended their meeting.

45. It was noted that the man had suffered from significant long-term chronic diseases. From the medical records, it was clear to the panel that the man was seen regularly by healthcare staff and, when necessary, referred to secondary care services.

46. The man was seen by a prison doctor following a referral by the chiropodist. The circulation in the man's legs was highlighted as a problem and an appropriate referral was made. He had not complained of chest pains at that time.

47. However, the panel found that the standard of record keeping needed to be improved. This had been raised as an area of concern in previous investigations into deaths at Parkhurst. It was felt that the introduction of the new electronic system (SystmOne) would help this to be achieved, and the panel made the following recommendation, which I endorse:

    The Head of Prison Healthcare at HMP Isle of Wight should review the policies and procedures regarding prisoner's medical records and arrange appropriate staff training where necessary to improve the accuracy and consistency of record keeping.

48. Prison Service Order (PSO) 3050 on Continuity of Healthcare for Prisoners was issued in February 2006. Chapter 5 of the PSO is devoted to Transfer of Prisoners and says at 5.3: ''Current healthcare needs [must be] assessed and continuity of care ensured when prisoners are transferred between establishments.''

49. Chapter 5.12 of the PSO points out that ''patients with more complex health care needs may require more detailed planning such as communicating directly with the receiving health care team in advance of transfer''.

50. The panel recommended that prior to a prisoner's discharge or transfer, a pro forma should be completed to summarise their health care needs. This should include additional information on the prisoner (medication, problems, outstanding referrals and key medical conditions). The panel felt that this action will lead to improvements to the quality of transfer of information going to the prison which is receiving the prisoner.

    The Head of Prison Healthcare at HMP Isle of Wight should ensure that when a prisoner is transferred/discharged that staff complete a summary of their health care needs.

51. Chapter 5.25 of PSO 3050 sets out the responsibilities of the prison receiving newly transferred prisoners. It is expected that the healthcare team will ‘’make such enquiries and undertake such examinations as appear to be appropriate in all the circumstances as set out in the General Medical Service contract.” Both the review panel and the investigator could find no record of a health screening interview taking place after the man transferred to HMP Brixton for his appeal hearing. As mentioned previously, the man’s co-defendant and cell mate at Brixton, confirmed that they both brought their in-possession medication with them to Brixton. The Head of Psychology and Suicide Prevention at Brixton confirmed that when the man moved to Brixton his medical records from Parkhurst accompanied him. As healthcare staff at Brixton were able to see the man’s medical records, and as no issues had been highlighted before his move, no further action was taken. I suggest that systems are reviewed at Brixton in light of the information discovered during this investigation.

CONCLUSION

52. The man arrived in HMP Isle of Wight - Parkhurst in August 2008 with a history of health problems which included high blood pressure and a stomach ulcer. He died of natural causes in June 2009.

53. In the light of the clinical reviewer's findings, I judge that the man's care was equivalent to what he would have received in the wider community. Indeed, in his review the reviewer wrote: "The man received a high standard of care". The findings of the clinical review and this investigation highlight that there is a need for some improvements to record keeping and transfer arrangements at HMP Isle of Wight and HMP Brixton.

RECOMMENDATIONS

1. The Head of Prison Healthcare at HMP Isle of Wight should ensure that when a prisoner is transferred/discharged staff complete a summary of their health care needs.

   Accepted - If Prison Healthcare staff are advised of a prisoner's transfer to another establishment they will ensure that the receiving prison is provided with sufficient information to enable the safe and effective continuation of any inputs to his healthcare needs. This may be via SystmOne (where the receiving prison uses SystmOne) or via a secure e mail/hard copy. This expectation has been articulated to the Primary Healthcare Manager and the Team Leaders of all the clinical areas within HMP Isle of Wight.

2. The Head of Prison Healthcare at HMP Isle of Wight should review the policies and procedures regarding prisoner's medical records and arrange appropriate staff training where necessary to improve the accuracy and consistency of record keeping.

   Accepted - Training has been available during 2009 and is being provided by the Isle of Wight NHS Primary Care Trust PCT to Prison Healthcare Nursing staff in respect of record keeping and Information Governance. A further programme of training is already included in the Continuing and Vocational Education (CVE) plans agreed with the University of Southampton for 2010/11. An expectation that quality record keeping also features in staff appraisals had also been made clear to Team Leaders.