Circumstances surrounding the death of a man at HMP Stocken in July 2005

Prisons and Probation Ombudsman for England and Wales

September 2006

This is the report of an investigation into the circumstances of the death of a man at HMP Stocken in July 2005. The man had been at Stocken since 31 May and was found dead in his bed in a single cell at about 9.10am having died from natural causes. He was only 47 years old but had not been in good health, suffering from diabetes and heart disease complicated by obesity.

I would like to extend my condolences to the man's wife and young family for their very sad loss. I would also like to thank the then Governor, her secretary and the Head of Residence for their co-operation and support during my investigation.

The investigation was carried out by a qualified nurse, who works in my office. My family liaison officers made contact with the man's family and provided them with a copy of the draft report. Subsequently, the man's wife raised some concerns which we have endeavoured to address in this final report.

We would like to thank the Director of Public Health and the Prison Health Lead, at Melton, Harborough and Rutland Primary Care Trust who provided a thorough and timely clinical review of the man's health care. The quality and detail of their review enabled us to incorporate it as the main body of our report.

The clinical review found that the man had a strong family history of coronary heart disease and also significant risk factors for further cardiac events. From all the evidence available, the review concluded that appropriate actions were taken and relevant policies were adhered to following the discovery of the man's body. I have endorsed the detailed recommendations made in the clinical review as well as the good practice that was highlighted. I have also added one further recommendation about clinical practice with regard to prisoners holding their medication in their possession.

The man was found in his cell by an assistant estates manager who went there to undertake a plumbing repair. This led me to question what guidance the Prison Service gives to staff about checking that prisoners are alive and well at the start of each day. The current guidance is contained in the National Security Framework. It does not include the more detailed instruction contained in the former Security Manual (Prison Service Order 1000). I have recommended that the Prison Service reviews its guidance to staff on this matter.

STEPHEN SHAW CBE
PRISONS AND PROBATION OMBUDSMAN **September 2006**

Contents

Summary

1. The man was 47 when he was received into custody on 3 May 2005 at HMP Lincoln. He later transferred to Stocken on 31 May to serve a fourteen month prison sentence. He died in July 2005.

2. A clinical review by the local NHS Primary Care Trust found that the man had a strong family history of coronary heart disease (CHD) and also significant risk factors for further cardiac events. The clinical reviewer pointed out that good clinical practice would be the proactive management of this condition. However, the man had failed to attend appointments and there appeared to have been little action taken to follow-up his non-attendance.

3. The man was found dead in his bed in a single cell at about 9.10am. From all the evidence available, the clinical reviewer concluded that appropriate actions were taken and relevant policies were adhered to following the discovery of the man's body.

4. The clinical reviewer found that the suspension of chronic disease clinics had reduced the opportunity to provide proactive care to the man. Linked to this, there were issues in relation to the man's compliance with treatment. It was clear from the medicines found in his cell after his death that he had taken more doses of some medication than others. This may or may not have been due to confusion on the man's part. The reviewer suggested that these issues could have been addressed if the man had had access to a chronic disease management clinic or a medicines management clinic.

5. The clinical reviewer observed that circumstances surrounding the suspension of nurse-led chronic disease management clinics suggested that there was a lack of understanding among non-healthcare staff in the prison of the roles and most appropriate deployment of nursing staff who are professional practitioners.

6. Although not highlighted by the clinical reviewer, the man's wife raised a significant concern about the policy on in possession medication. There was no evidence that the man was assessed for his suitability to hold his medication in-possession nor of his compliance with his prescription.

7. A post mortem took place on at Leicester Royal Infirmary. The pathologist stated that the man had suffered at least one extensive heart attack previously, consequent to severe narrowing of the arteries supplying blood to the heart. The degree of narrowing was sufficient in the pathologist's opinion to have caused sudden and unexpected death. He concluded that the man died of natural causes: ischaemic heart disease and atheromatous stenosis of the coronary artery.

8. The fact that the man was found dead by an assistant estates manager at 9.10am has raised questions about the Prison Service guidance to staff on checking that prisoners are in their cells. The current guidance contained in the National Security Framework omits the more detailed instruction contained in the previous Security

Manual (Prison Service Order 1000). I have recommended that the Prison Service reviews its guidance to staff on this matter.

9. I have also endorsed the detailed recommendations made by the clinical reviewer and the good practice she highlighted.

The investigation

10. The investigation began when my investigator contacted the Governor of Stocken. Notices were issued to staff and prisoners announcing the investigation and inviting anyone with information relevant to the man's death to contact my investigator. The Governor arranged for a copy of The man's prison record and medical record to be posted to this office.

11. One of my family liaison officers (FLOs) tried to contact the man's wife by telephone. On 15 August, my FLO wrote explaining the role of my office and offering the services of the FLO including a home visit if that was what the man's wife would wish.

12. Arrangements were made through Stocken's Residential Manager for interviews to take place when my investigator visited Stocken on 30 and 31 August. She familiarised herself with the prison, including the health care centre and met staff and prisoners. She met with the Chair and Secretary of the local branch of the Prison Officers' Association (POA) who raised no issues. She also spoke with a representative of the Independent Monitoring Board (IMB). She interviewed three staff formally and three in a more informal conversation. Records of the formal interviews and two of the informal conversations were forwarded to Stocken for staff to check, amend as necessary and sign.

13. My investigator liaised closely with the Prison Health Lead at Melton, Harborough and Rutland Primary Care Trust who was acting on behalf of the Director of Public Health, in respect of the clinical review. They provided a thorough and timely clinical review of the man's health care which forms the body of this report

14. The investigation was completed on 20 October 2005. Unfortunately, due to a number of eventualities, the man's wife and children did not see the draft report until May 2006. The man's wife raised a number of questions about the report with my FLO. These were addressed as far as was possible by my investigator and the clinical review team from the PCT and included in this final report in June 2006.

HMP Stocken

15. Stocken prison was built in 1985 and has been expanded on four occasions. It now accommodates over 600 convicted adult men. The emphasis is on training and resettlement.

16. Stocken was last inspected by Her Majesty's Chief Inspector of Prisons in October 2002 on a brief unannounced inspection. Given the pace of change, that report was not relevant to this investigation. The Prison Service's Standards Audit Team was conducting an audit at the time of my investigator's visit.

Clinical Review

17. The majority of the remainder of this report is the Clinical Review provided by the Director of Public Health, Melton Rutland and Harborough Primary Care Trust, with the assistance of the Prison Healthcare Development Manager at the Trust.

Review process

18. As part of the review process the following staff at Stocken were spoken with or interviewed:

- the Clinical Nurse Manager
- three Staff Nurses
- the Head of Residence
- the governor with responsibility for health care*
- the Practice Manager*

19. The following documentation has been examined:

- Prisoner Medical Record (PMR)
- Departmental Diary, Healthcare HMP Stocken
- GP Clinic Lists, Healthcare HMP Stocken
- Post-mortem examination report

Clinical care of the man

Background

20. The man was a 47-year-old man who was first received into custody on 3 May 2005 at HMP Lincoln. On reception, his medical problems were recorded as diabetes (non insulin dependent) and left ventricular failure. He had a strong family history of coronary heart disease (CHD) with both his parents and his brother suffering myocardial infarctions (MI, heart attacks) at relatively young ages. His brother died following an MI, aged 40. Previous investigations had shown that the man had himself suffered an MI in the past and was in heart failure. He had been referred to a cardiologist in 2004, but failed to attend. On arrival at HMP Lincoln he was taking the following medication:

- Frusemide 80 mg daily
- Metformin 500 mg bd
- Aspirin 75 mg daily
- Ramipril 75 mg daily
- Simvastatin 40mg daily
- Paracetamol 1 gm daily
- Dihydrocodeine 60 mg daily

21. As a result of shortness of breath, the man spent his first night in the healthcare inpatient unit. On the second day his BP was 150/95 and pulse 100 bpm. At that stage he was transferred to his cell with no documented changes in treatment.

22. On 24 May 2005 the man was transferred to HMP Nottingham via court and then on 31 May 2005 to HMP Stocken. On assessment at reception at HMP Stocken, the following were recorded:

- Diabetic with LVF (left ventricular failure)
- History of depression
- No history of smoking, drug or alcohol abuse
- Weight 137 kg, height 5'11"

23. At this stage, the man was referred to the nurse-led diabetic clinic but he did not wish to see a doctor the following day so no appointment was made. The medication which the man had 'in-possession' on arrival from HMP Nottingham and his HMP Nottingham treatment chart were checked by nursing staff. He kept the prescribed medication he had in his possession. The staff nurse carrying out the reception assessment completed a new prescription for the doctor to sign the following day. It is not common practice for nurses to write out prescriptions for doctors.

24. Also on reception the man discussed his wish to lose weight and was given advice and booklets providing relevant information to support him.

25. On 3 June 2005, results from the man's blood samples taken in HMP Nottingham arrived at HMP Stocken. It is documented that the doctor checked the results and asked for tests to be repeated in July.

26. On 6 June, the man was seen in the nurse-led diabetic clinic where an initial assessment of his disease was undertaken. Findings on examination were:

- Blood pressure (BP) 141/89
- Pulse 78 bpm
- Blood glucose 4.7 mmols/l
- Possible fungal infection on left big toe

27. The man was asked to attend to have blood samples taken for Hba1c[1], fasting lipids and glucose on 9 June. He did not attend for this appointment but he was recalled on 10 June when a nurse did take a blood sample. The man also had a GP clinic appointment on 10 June but he appears not to have attended this. There is no documentation of any immediate actions taken following his non-attendance and no follow-up was organised to attend the diabetic clinic.

28. The results of blood tests, all within normal limits, were seen by the doctor and it is recorded that no further action was required. It is not documented

[1] A blood test relevant to the management of diabetes mellitus

whether the man was ever given the results of blood tests, nor is there an audit trail to show whether prisoners actually get their nurse clinic appointment slips.

29. On 20 June, the man had another appointment to see the doctor but again did not appear for this appointment.

30. On 21 June, all nurse-led chronic disease management clinics at HMP Stocken were suspended. As a result, the man could not be called for a second diabetic clinic appointment. It had been proposed that nurses would not be on duty in the evenings, thus freeing up capacity to provide a full nursing service during the day, including the running of chronic disease management clinics. In addition, this would have allowed nursing staff to attend relevant clinical training sessions, essential to development of nurses' skills and to improve standards of service delivery. However, it is understood that both the Governor and the local POA branch took the view that a nursing presence in the evening was essential. Since there was insufficient nursing capacity to maintain this level of service, the governor with responsibility for health care made the decision to suspend all nurse-led clinics.

31. On 22 June, the man was seen by healthcare staff complaining of feeling unwell. He stated that he was trying to lose weight. Nil of note was found on examination, the nurse gave dietary advice and no follow up was arranged.

32. On 23 June, the man attended the diabetic retinopathy clinic held in the prison. Suspected eye disease was detected and an appointment for further examination at Leicester Royal Infirmary was arranged.

33. On 1 July, the man collected the medicines listed:

- Frusemide 40 mg od (daily)
- Metformin 500 mg bd
- Aspirin 75 mg od
- Ramipril 75 mg od
- Simvastatin 40 mg od

34. On 6 July, the man was due to attend the nurse phlebotomy clinic for repeat blood tests but he failed to attend.

35. Following his death a significant amount of medication was found in the man's cell. This included varying amounts of the above drugs, as shown in the following table. Additionally, 14 tablets of aspirin 300mg. There is no record of him ever having been prescribed or given these aspirin tablets by the approved 'over the counter medication' access route.

	Medicines collected by the man on 1 July 2005	Medicines removed from cell after the man's death	Number of tablets missing
Frusemide 40 mg od	56 tablets	30 tablets	26
Metformin 500 mg bd	56 tablets	44 tablets	12
Aspirin 75 mg od	28 tablets	21 tablets	7
Ramipril 75 mg od	28 tablets	22 tablets	6
Simvastatin 40 mg od	28 tablets	24 tablets	4

Findings

36. In relation to the Prisoner Medical Records (PMRs), on some sheets of the records dates are incorrect, signatures are illegible and the name and status of individuals making entries is not recorded. In addition, some relevant information, ascertained through interviews with staff, was not detailed in the records.

37. Prescriptions were written, dispensed and administered from inadequately completely prescription charts which omitted information required for safe use of medicines. In addition, the staff nurse carrying out the reception assessment completed a new prescription chart for the doctor to sign the following day. It is not appropriate for nurses to write out prescriptions for doctors.

38. The man had a strong family history of CHD and also significant risk factors for further cardiac events. In such a case, proactive management of his condition would have been good clinical practice. However, he regularly failed to attend appointments and there appears to have been little action taken to follow-up his non-attendance. The suspension of chronic disease clinics further reduced the opportunity to provide proactive care to the man.

39. Linked to this, there were issues in relation to the man's compliance with treatment. It is clear from the medicines found in his cell after his death that he had taken more doses of some of his medication than of others. In the nine days before his death, it appears that he took far more frusemide and half as much simvastatin as had been prescribed. This may or may not have been due to confusion. These issues could have been addressed if the man had received adequate care through a chronic disease management clinic or had attended a medicines management clinic. There is no record that he attended either despite the fact that he was taking a number of different medicines.

40. The fact that unaccounted for tablets of aspirin were found in the man's cell after his death gives cause for concern. It is not clear from where the man obtained the tablets.

41. Circumstances surrounding the suspension of nurse-led chronic disease management clinics suggest that there is a lack of understanding among non-healthcare staff in the prison of the roles and most appropriate

deployment of nursing staff, who are highly trained professionals. The provision of quality healthcare services within the prison is a priority.

42. Areas of good practice include the use of pathology laboratory results action forms to ensure that all investigation results are checked and acted upon as necessary by healthcare staff. In addition, at reception at HMP Stocken, the man expressed a wish to lose weight. He was given both verbal and written advice and support.

Chronology

43. At weekends, cells are unlocked at approximately 8.00am. The man was observed to be in bed at this time but it was not until 9.10am, when an Assistant Estates Manager entered his unlocked cell to carry out a repair, that anything untoward was noticed. The Assistant Estates Manager thought initially that the man was asleep. He spoke to him in a raised voice and put on the light but once he entered the cell he could see that the man was dead. He did not touch him but raised the alarm with the wing staff. They in turn looked at the man for themselves before raising the alarm. The prison's contingency plan instructs staff to initiate resuscitation unless rigor mortis is present and defines rigor mortis.

44. An emergency call was immediately put out and the staff nurse on duty and the duty governor responded. On their arrival, they found the man in bed. He was clearly dead, with fixed dilated pupils, absent carotid pulses, no response to painful stimuli and no visible breathing. No attempt was made at cardio-pulmonary resuscitation (CPR) and there is no record in the prisoner's medical record (PMR) of any discussion.

45. At interview, the staff nurse concerned confirmed that she did not initiate CPR because rigor mortis was present. She was confident that she was responsible for the decision not to resuscitate and the duty governor present agreed with her professional judgement. Having worked in medical wards, she was familiar with death. The discipline staff took no active role in the decision. The staff nurse in question had last received a CPR update in October 2004.

46. The on-call doctor was called at 9.30am and certified the death at 10.45am. He was recorded as attending at 10.20am in the incident log.

47. A post-mortem examination was carried out at Leicester Royal Infirmary. The main findings of the examination were that the man had suffered from ischaemic heart disease and the severe narrowing of the blood vessels that supply oxygen to the heart was sufficient to have caused sudden and unexpected death. Cause of death was reported as:

    1a Ischaemic heart disease
    1b Atheromatous stenosis of the coronary artery

Findings

48. From all the evidence available, it appears that appropriate actions were taken and relevant policies were adhered to, following the discovery of the man's body.

Recommendations

49. Detailed, informative, contemporaneous and legible records are essential, to support communication between staff and improve patient care. There is a need to reiterate this to all healthcare staff and stress that the Prisoner Medical Records are legal documents and all entries must be dated and signed legibly and that all relevant information should be recorded.

50. Policies in relation to the writing of prescriptions and the dispensing and administration of medicines, both prescription and non-prescription ('over the counter medicines') need to be clear and adhered to by staff.

51. Chronic disease management nurse-led clinics need to be re-established. These clinics, together with the maintenance of chronic disease registers are essential elements of the National Service Frameworks (NSFs). On reception screening, patients requiring chronic disease management should be identified and referred to appropriate clinics and an appropriate audit trail established.

52. Clinical Information Technology systems are essential to support the effective implementation of NSFs, to facilitate organisation and management of clinics, to identify patients on multiple medicines requiring regular medication review or attendance at medicines management clinics and to flag up non-attendance requiring follow-up.

53. Action is required to increase understanding of all staff in the prison, including management staff, as to the importance of providing appropriate standards of healthcare within the prison. This requires that healthcare staff are deployed appropriately, maximising use of their professional clinical skills. It may not be best use of nursing staff time to maintain a presence in the evenings to the detriment of providing treatment and care to those who require it. There needs to be discussion with prison staff as to what function they feel a nursing presence in the evening fulfils. It may be that the function can be fulfilled through alternative arrangements.

54. Within the healthcare service, there needs to be an audit trail in place to demonstrate that prisoners receive information about their condition, including results of investigations and that they receive information concerning booked appointments.

55. Of particular relevance to the man, consider establishing a care pathway for morbidly obese patients trying to lose weight. Recording the BMI, or other obesity index, of prisoners on reception would aid with the monitoring of the condition.

The Family's Concerns

56. During the original investigation, my FLO received no formal response from the man's family. However when the man's wife read the draft report she raised a number of concerns. These are listed below and addressed where possible:

a) The man had a history of depression which had not been highlighted in the report to her satisfaction.
When the man was assessed on reception at Stocken the nurse noted that he had a history of depression. This was not elaborated on and never followed up. There was no evidence from the man's various appointments with medical and nursing staff that he expressed any concern about his state of mind nor were any relevant signs or symptoms noted.

b) Why wasn't the man kept in the hospital wing?
The man spent his first night in custody at Lincoln in the health care centre because he had been found to be short of breath when examined in reception. The next morning he was discharged to a residential wing with the same prescribed medication as he had brought in from home. The doctor who discharged him did not elaborate on the reason for discharging him. Stocken does not have an inpatient unit.

c) What time did the man die and how long was it before he was found?
This investigation was unable to establish the answers to these questions but the Coroner's inquest may be able to offer some more information.

d) Why were there not more regular checks made upon the man?
The clinical review report found a lack of proactive management of the man's heart condition. The reviewer commented further that the man failed to attend some appointments. However there was little or no action taken to follow-up his non-attendance. The suspension of chronic disease clinics further reduced the opportunity to provide proactive care to the man.

e) When was the decision taken not to resuscitate the man, by whom and on what grounds?
The staff nurse on duty and the duty governor found the man in bed with fixed dilated pupils, absent carotid pulses, no response to painful stimuli and no visible breathing. At interview, the staff nurse concerned confirmed that she did not attempt resuscitation because rigor mortis was present. Having worked in medical wards, she was familiar with death and had last received a resuscitation update in October 2004.. She was confident that she was responsible for the decision not to resuscitate and the duty governor present agreed with her professional judgement. The prison's contingency plan instructs staff to initiate resuscitation unless rigor mortis is present and defines rigor mortis.

f) Why was the man allowed to have his own medication given his history of depression?
Prison Service and Department of Health policies on medication are built on a presumption of the prisoner having personal responsibility to hold his or her medication in possession[2]. Stocken is a training prison, preparing prisoners to return to life in the community where managing one's own medication would be the norm. However the duty of care on an institution such as a prison can be best implemented by routinely undertaking a risk assessment of all prisoners before allowing medication in possession.

g) The man was never prescribed Aspirin so where did the Aspirin found in the cell come from?
Investigations before he came into prison had shown that the man had suffered a heart attack in the past and had been in heart failure. He also had a strong family history of coronary heart disease (CHD) and significant risk of further heart problems, such as obesity. A low dose of aspirin is used as an antiplatelet drug[3] for the secondary prevention of brain and heart disease caused by blood clots. The treatment is aspirin 75mg daily which is what was prescribed for the man. The Aspirin tablets found in the cell were 300mg each. This form of the drug is used in the treatment of pain. The investigation was unable to establish how the man had come by these tablets.

h) Did the post mortem show any abnormal amounts of any substances that might have led to the man's death?
Nothing untoward was reported to my investigator. However this matter may be further explored at the Coroner's inquest.

i) Do we know when the heart attack that was identified in post mortem occurred?
No, that has not been established during the investigation. Again however this matter may be further explored at the Coroner's inquest.

j) What are the rules about prisoners being allowed to keep medication in their cells?
The answer to this is similar to that given to concern (f) above.

k) The prison did not really seem to bother about the man's welfare. Was this the view of the investigator.
The investigator and clinical reviewer's conclusions are set out in the next section and recommendations for changes in practice follow with the intention of improving the prevention of similar events in future.

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[2] '*A Pharmacy Service for Prisoners*' published Department of Health 2003

[3] Antiplatelet drugs decrease platelet aggregation and may inhibit thrombus formation in the arterial circulation, where anticoagulants have little effect.

Key Findings and Conclusions

57. The post mortem concluded that the man died of natural causes: ischaemic heart disease and atheromatous stenosis of the coronary artery. The pathologist found that the man had suffered at least one extensive attack previously, consequent to severe narrowing of the arteries supplying blood to the heart. The degree of narrowing was sufficient in the pathologist's opinion to have caused sudden and unexpected death.

58. The man had a strong family history of coronary heart disease and also significant risk factors for further cardiac events. The clinical reviewer pointed out that proactive management of his condition would have been good clinical practice. She noted however, that he had failed to attend appointments and there appeared to have been little action taken to follow-up his non-attendance.

59. The clinical reviewer found that the suspension of chronic disease clinics had reduced the opportunity to provide proactive care to the man. There was other evidence of the man's unpredictable compliance with treatment. For example, the medicines found in his cell after his death indicated that for whatever reason he had taken more doses of some medication than others. The reviewer suggested that these issues could have been addressed if the man had had access to a chronic disease management clinic or a medicines management clinic.

60. The clinical reviewer observed that circumstances surrounding the suspension of nurse-led chronic disease management clinics suggested that there was a lack of understanding among non-healthcare staff in the prison of the roles and most appropriate deployment of nursing staff. My investigator learned from the Head of Regimes that there was tension over the interpretation in practice of the first aid requirement within the Health and Safety at Work Act. For example, plans for nurses' development and training had been restricted because of a requirement to provide 'first aid' cover in the evenings for which the nursing team was not resourced.

61. Although not highlighted by the clinical reviewer, this case raises a significant concern about the policy on in possession medication. There was no evidence that the man was assessed for his suitability to hold his medication in possession nor of his compliance with his prescription.

62. The man was found dead by an Assistant Estates Manager at 9.10am and that has raised questions about the Prison Service guidance to staff on checking that prisoners are safe and well in their cells. The new National Security Framework (NSF) makes no mention at all of what staff should look for when counting the roll. In contrast, the Security Manual (Prison Service Order 1000) stated in the section on 'Checking the roll':

"Para 26.9 Prison management must issue written instructions to staff to ensure roll checks at least four times every 24 hours as follows:

i. before morning unlock
ii. at lunch time:
iii. at tea time:
iv. after lock up at night"

"Para 26.10 When checking the roll, staff must assure themselves that prisoners are in cells, dormitories or cubicles by obtaining a clear view of their face, if necessary by waking them."

63. The Governor of Stocken confirmed that, as she understood it, the NSF had superseded PSO 1000. And in terms of respect and decency, historic practices whereby prisoners were woken, perhaps by banging on the cell door, are no longer acceptable. Likewise, offering respect and decency means that adult male prisoners are not checked whether they have got up for, or eaten, their breakfast. However, once the core day of the prison is in progress, it is not appropriate for the whereabouts or well being of prisoners to be unknown. It was quite by chance that a member of staff entered the man's cell in order to carry out a repair to his sink at 9.10am. If this had not happened, the man could have remained unfound for another couple of hours, probably until lunchtime. The issue raises questions about what guidance, if any, is currently given on this aspect of prison officers' work. It is a matter that requires further consideration by the Prison Service.

Recommendations

I recommend that the Governor works with the Melton Harborough and Rutland Primary Care Trust to implement all the recommendations made in the clinical review.

I recommend that the Melton Harborough and Rutland Primary Care Trust works with the pharmacy and health care managers at Stocken to improve the management of medication, undertaking a routine risk assessment of prisoners for holding their medication in possession and monitoring compliance.

I recommend that the Prison Service reviews the instruction it gives to governors and staff regarding the checking of prisoners in their cells. The guidance must ensure there is an acceptable balance between obtaining assurance that prisoners are safe and well in their cells, dormitories or cubicles and the requirement to treat prisoners with decency and respect.

Good practice

I endorse the good practice identified in the clinical review. Namely:

- the use of pathology laboratory results action forms to ensure that all investigation results are checked and acted upon as necessary by healthcare staff;

- the practice of giving both verbal and written advice and support to prisoners who express a wish to lose weight to improve their health, as in the man's case.

The prison's response

Stocken's management has produced a response to the recommendations in this report in the form of an action plan. They welcomed the identification of two examples of good practice. The response can be summarised as follows:

1. I recommend that the Governor works with the Melton Harborough and Rutland Primary Care Trust to implement all the recommendations made in the clinical review.

   Accepted subject to the comments made against paragraphs 2 – 8 below.

2. Detailed, informative, contemporaneous and legible records are essential, to support communication between staff and improve patient care. There is a need to reiterate this to all healthcare staff and stress that the Prisoner Medical Records are legal documents and all entries must be dated and signed legibly and that all relevant information should be recorded.

   Accepted – The requirement will be incorporated in all staff performance and development records and be an agenda item at healthcare meetings.

3. Policies in relation to the writing of prescriptions and the dispensing and administration of medicines, both prescription and non-prescription (over the counter medicines) need to be clear and adhered to by staff.

   Accepted – All relevant policies will now be reviewed to ensure that procedures are clear and understandable. All staff will sign that they have read and understood the requirements. New staff will do this as part of their induction.

4. Chronic disease management nurse-led clinics need to be re-established. These clinics, together with the maintenance of chronic disease registers are essential elements of the National Service Frameworks (NSFs). On reception screening, patients requiring chronic disease management should be identified and referred to appropriate clinics and an appropriate audit trail established.

   Accepted locally – Clinics will be re-established. Reception screening will be reviewed to ensure compliance.

5. Clinical Information Technology systems are essential to support the effective implementation of NSFs, to facilitate organisation and management of clinics, to identify patients on multiple medicines requiring regular medication review or attendance at medicines management clinics and to flag up non-attendance requiring follow-up.

   Not accepted by the prison because it falls under the remit of the PCT

6. Action is required to increase understanding of all staff in the prison, including management staff, as to the importance of providing appropriate standards of healthcare within the prison. This requires that healthcare staff are deployed appropriately, maximising use of their professional clinical skills. It may not be best use of nursing staff time to maintain a presence in the evenings to the detriment of providing treatment and care to those who require it. There needs to be discussion with prison staff as to what function they feel a nursing presence in the evening fulfils. It may be that the function can be fulfilled through alternative arrangements.

   Accepted – Full review/consultation to take place.

7. Within the healthcare service, there needs to be an audit trail in place to demonstrate that prisoners receive information about their condition, including results of investigations and that they receive information concerning booked appointments.

   Accepted for review – A full review will take place taking account of the recommendations made.

8. Of particular relevance to the man, consider establishing a care pathway for morbidly obese patients trying to lose weight. Recording the BMI, or other

obesity index, of prisoners on reception would aid with the monitoring of the condition.

Partially accepted locally – In order to implement this it will be necessary to identify additional nurse time. A full review will be undertaken to establish feasibility. See also recommendation 5.

9. I recommend that the Melton Harborough and Rutland Primary Care Trust works with the pharmacy and health care managers at Stocken to improve the management of medication, undertaking a routine risk assessment of prisoners for holding their medication in possession and monitoring compliance.

   The prison is engaged in a tendering process for a new pharmacy provider and will seek to introduce revised risk assessments with the new provider. Monitoring checks are carried out on prisoners with in-possession medication to ensure compliance.

10. I recommend that the Prison Service reviews the instruction it gives to governors and staff regarding the checking of prisoners in their cells. The guidance must ensure there is an acceptable balance between obtaining assurance that prisoners are safe and well in their cells, dormitories or cubicles and the requirement to treat prisoners with decency and respect.

    Accepted for review – This recommendation has now been reviewed by the Security Policy Group of the Prison Service. Previous historical practices involving the frequent disturbance of sleeping prisoners whilst checking the roll have been discontinued on decency grounds. The previous policy was amended with the introduction of the National Security Framework to allow individual establishments to develop practises and procedures that firstly met the mandatory outcomes of the National Security Framework (i.e. 4 roll checks within any 24 hour period), and, secondly allowed a degree of local discretion as to how and when these checks would be made. It would be physically impossible for staff to individually check all prisoners on normal allocation without some degree of disturbance, entering individual cells and/or potential physical contact. To do so regularly would undoubtedly cause unrest and resentment amongst prisoners. We believe that the current risk assessed based discretional policy is a proportionate response to the number of deaths through natural causes currently experienced across the prison estate.