Investigation into the circumstances surrounding the death of a man at hospital in July 2010 while in the custody of HMP Pentonville

Report by the Prisons and Probation Ombudsman for England and Wales

March 2011

This is a report into the death of a man at hospital in July 2010. He was 43 years old and came into HMP Pentonville on 24 May. He died from natural causes, having been admitted to hospital approximately two weeks earlier.

I offer my sincere condolences to the man's family and friends.

He had been arrested and remanded into custody for offences committed against his mother. He was already an ill man when he arrived at Pentonville and had Hepatitis C and cirrhosis of the liver. He had abused drugs and alcohol and was on the waiting list for a liver transplant.

This investigation has been conducted by a senior investigator. I would like to thank the Governor of Pentonville and his staff for their co-operation during the investigation.

The local Primary Care Trust (PCT) appointed a clinical reviewer to conduct a review of the care the man received whilst in prison. I would like to thank him for his timely contribution to the investigation.

Following the man's death, the Head of Healthcare at Pentonville conducted an interim internal management investigation which identified some of the same concerns that I have found in my own investigation. I am pleased that a number of changes have already been made and I hope that the findings in my report assist the healthcare department to make further improvements. As is often the case in investigations following a death from natural causes, I rely heavily on the findings of the clinical review. In this case, I make six recommendations concerning the appropriate level and skill mix of staff on the Integrated Drug Treatment wing (IDTS), ensuring that internal healthcare protocols are followed and the quality of record keeping.

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

Jane Webb
Acting Prisons and Probation Ombudsman **March 2011**

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SUMMARY

The man appeared at Magistrates' Court on 24 May 2010 on charges of affray and actual bodily harm, which were allegedly committed against his mother. He was subsequently remanded to HMP Pentonville.

When he arrived at Pentonville, he told healthcare staff about his history of illicit drug and alcohol abuse. He was Hepatitis C positive and had cirrhosis of the liver. He also said that he was on the National Health Service waiting list for a liver transplant. The treating hospital confirmed this and said that his liver was failing. The hospital explained that he would not be eligible for a transplant as he had not abstained from alcohol before coming into prison.

Between arriving at Pentonville and 27 June, the man was located on the Integrated Drug Treatment Service (IDTS) stabilisation wing where he was prescribed appropriate medication. However, his health deteriorated and he began to vomit. Healthcare staff conducted a number of tests and liaised with the hospital to determine his treatment plan.

The next day, 28 June, his health deteriorated further and he was taken to the accident and emergency department at the local hospital. After a slight improvement, he was transferred to the treating hospital, where it was hoped that, with further treatment, his condition might improve. Unfortunately he died in July, whilst medical staff were carrying out an endoscopy procedure.

I make six recommendations as a result of this investigation which address staffing on the Integrated Drug Treatment Service wing, following healthcare protocols and record keeping.

THE INVESTIGATION PROCESS

1. The investigation into the man's death was opened on 20 July 2010, when the investigator visited Pentonville. Notices to staff and prisoners about the investigation were sent to the prison in advance of his visit. No prisoners came forward to be interviewed.

2. The investigator met the Head of Healthcare and a governor. Copies of the man's medical records and prison files were made available. No members of the Independent Monitoring Board (IMB, who monitor the day to day life in prison and ensure standards of care and decency are maintained) or the Prison Officers' Association asked to see him. He visited the healthcare unit and toured the in-patient facility. He also visited the F wing, the Integrated Drug Treatment Service wing, where the man had lived.

3. A review of the man's medical care was commissioned by the local PCT. The investigator and the clinical reviewer from the NHS Foundation Trust, interviewed five healthcare staff and the clinical reviewer spoke separately with more staff to familiarise himself with some of the healthcare procedures.

4. One of my Family Liaison Officers contacted the man's mother and sister to tell them about the scope of my investigation and offer the opportunity to raise any questions or concerns they would like to be addressed. They have raised two concerns and I hope that the report provides them with a better understanding of his time in custody and the events leading to his death. The questions they asked were:

    - Whether he missed several hospital appointments because the prison cancelled them?

    - Whether he had refused his medication prior to being taken to hospital?

5. Following receipt of the draft report, the man's mother wished to note that the family were disappointed at the lack of medical information the prison had sought from external sources relating to his state of health. This included the fact they were aware he had a scheduled MRI scan in June 2010 at the treating hospital. He was also receiving treatment from a community drugs advisory service who was not contacted by the prison.

6. In summary she feels that a string of errors occurred which resulted in the man not getting the treatment he deserved. Although this report comments that the outcome would have been the same despite these errors she feels that had the appropriate steps been taken to fully investigate his medical needs he could have been hospitalised and made more comfortable sooner.

HMP PENTONVILLE

7. Pentonville is a prison serving the London courts. Built over 150 years ago. The operational capacity at the time of the man's death was 1275 prisoners.

Healthcare

8. Pentonville's healthcare department is headed by a manager, with two organisations providing health services. They are the Foundation Trust, which provides substance misuse and mental health services (including the inpatients unit) and the local PCT which provides psychiatric care and primary care services.

9. The healthcare centre is a new purpose-built building offering both inpatient beds and a day care facility for prisoners with mental health problems. There are primary care facilities on the wings, including a consulting and dispensary area. Healthcare staff are available 24 hours a day. Doctors, mental health and nurse-led clinics are available, as well as a range of more specialised services.

Previous deaths at Pentonville

10. This is the 17th death at Pentonville that my office has investigated since becoming responsible for investigating all deaths in prison custody in April 2004. There have been another three deaths since the man died which occurred between August and September 2010. The main issues in this investigation include the level and skill mix of staff on the Integrated Drug Treatment Service wing, quality of record keeping, and the following of internal healthcare protocols. I have previously made a recommendation regarding record keeping which was to ensure that all the information about a patient's care should be placed immediately onto the Electronic Patient Record.

Her Majesty's Chief Inspector of Prisons (HMCIP)

11. The most recent inspection of Pentonville was led by the then Chief Inspector of prisons in May 2009. With regard to healthcare, she wrote,

> "There had been considerable improvement in some healthcare areas, but continuing work was needed to modernise the overall service. There was excellent support from the local Primary Care Trust. Primary care services were improving slowly, but more nurse clinics were needed. There was good access to GPs and waiting lists for visiting health professionals were well managed. Dental services

were improving and pharmacy services were good. The management of external NHS appointments was commendable. The regime for inpatients was only basic and care plans were poor."

Independent Monitoring Board (IMB)

12. An IMB is appointed to each prison by the Secretary of State for Justice. Its members are independent of the Prison Service and the prison's management team. Each IMB is required to produce an annual report to the Secretary of State about the prison, highlighting good practice and areas of concern.

13. The latest IMB report covered the period from 1 April 2009 to 31 March 2010. It noted that:

> "The new Health Service provider, a consortium led by the local PCT (Primary Care Trust), started on 1 April 2009. For various reasons, they have struggled to fill a significant number of vacancies. The post of lead GP was vacant for 10 months. Agency nurses were hampered by having no keys."

KEY FINDINGS

The man's arrival at HMP Pentonville

14. The man attended Magistrates' Court on 24 May 2010, charged with actual bodily harm and affray. He was remanded to Pentonville. After going through the normal reception process interviews, he received a health screening from two nurses. Nurse A completed the initial assessment (called Grubin 1) and noted that he was under the care of the treating hospital, was Hepatitis C positive, and had a number of drug and alcohol dependencies.

15. Nurse B saw him next and took a more detailed drug and alcohol history (called a Comprehensive Short Assessment). She referred him to the reception doctor and made an appointment for him to see the Integrated Drug Treatment Service (IDTS) doctor the following day. (IDTS is a programme which seeks to expand and improve drug treatment in prisons.)

16. There is no evidence on the man's medical record of the Comprehensive Short Assessment completed by Nurse B. Each prisoner should have this assessment when they are placed on F wing. Staff informed the clinical reviewer that this was a paper based assessment that was later scanned onto the prison electronic medical patient records system (EMIS). It seems that, in this case, the assessment was not scanned onto EMIS. The paper record was provided some days after the investigation interviews took place. It noted that his drug history had been assessed, but contained no indication that it took account of any aspects of his physical health or ongoing medical difficulties.

17. Prison Doctor A also saw the man in reception and prescribed a variety of drugs for alcohol withdrawal and to relieve the symptoms of heroin withdrawal. The man repeated that he had a history of using illicit drugs and drinking eight to ten cans of lager a day. He again said that he was Hepatitis C positive, had cirrhosis of the liver and was awaiting a liver transplant. The doctor noted that he had tremors, stomach cramps, vomiting and joint pains. He could not remember what medication was prescribed by the hospital and so the doctor asked for the treating hospital to be contacted to follow up his care. After his reception screening, he was located onto F wing, which is the Integrated Drug Treatment Service (IDTS) stabilisation wing.

18. Pentonville's IDTS guidance notes that every patient who is allocated to the IDTS wing should have the following assessments. The fourth column indicates the extent to which the man's assessments were completed.

Day 2/ IDTS wing	2nd (full) nurse assessment (includes Grubin 2)	IDTS nurse	*Yes, but after two weeks*
Day 2/IDTS Wing	Medical review	IDTS Doctor	*Yes*
Day 5/IDTS Wing	Care plan review	Whole team	*No*
Day 1 – 5	Daily Temperature/Pulse/Blood Pressure recordings	Duty Nurses	*No*

19. On the man's second day in prison (25 May), he was seen by Prison Doctor B who completed the medical review. The doctor took a full drug and alcohol history, and explored his social circumstances and medical treatment before coming into prison. A methadone prescription for 10mg was issued to help him cope with his withdrawal symptoms.

20. Registered Mental Healthcare Nurse (RMN) A worked on F wing and he first came into contact with the man later the same day, 25 May. At interview he told the investigator that, despite looking after other detoxifying prisoners, he was "really shocked" at his appearance and described him as looking very unwell, yellow and run down.

21. Later that same day, a letter was also received from the treating hospital. This confirmed that the man had an appointment with a Professor on 9 September at 11.50am. The clinical reviewer noted that, despite healthcare being aware from his initial healthcare screening that he had a number of illnesses, there was no evidence that they contacted either his community doctor or the clinical team at the treating hospital until later when he started to become unwell.

22. Over the next couple of weeks, the man's physical appearance was said to have improved considerably. He looked better and less jaundiced than when he arrived. He was also quite optimistic that he was going to have a liver transplant which would help his condition improve. He took his prescribed medications and his medical records were frequently noted "no issues raised".

23. On 8 June, he received his secondary health assessment (known as a Grubin 2, a secondary healthcare screening tool) and the well man clinic assessment (a well man clinic specialises in men's health). The Grubin 2 was completed two weeks later than it should have been. RMN A said that Grubin 2 was not a priority on F wing and that there were insufficient staff to complete these assessments within the appropriate timescales. The investigators did not find the Grubin 2 documents in the medical records.

24. The investigator interviewed the F wing Substance Misuse Team Manager and asked her about the secondary assessment process. She said that the secondary assessment was completed as a substance misuse assessment, incorporating the questions contained within the well man assessment. This was a lengthy paper assessment (16 pages) which would be given to the doctor and scanned into the prisoner's medical record.

25. The following day, 9 June, the man was seen by Prison Doctor C. He complained of having muscle cramps and a rash, and was vomiting as result of being lactose intolerant. He was prescribed quinine sulphate tablet (which is used to treat muscle cramps) and a form was completed to arrange a special lactose-intolerant diet.

26. Between 9 and 20 June, a number of entries were made in his medical notes about his methadone prescription. His prescription for methadone was doubled from 10mg to 20mg and then further increased to 30mgs. The reason for the increases was not explained in the medical notes and RMN A said that he was unaware of the reasons. The Substance Misuse Team Manager believed that the increase was probably due to further withdrawal symptoms and finding it difficult to cope on 10 mgs, although there is no evidence recorded to support this.

27. The investigator interviewed Prison Doctor D, who also worked on F wing. The doctor said that, although she had no direct contact with the man, he was brought to her attention by a nurse on the wing on 21 June. The nurse advised her of his blood pressure (146/86, which is indicative of high blood pressure) and pulse (91 beats/minute, within the normal range) readings. He complained of vomiting blood, although there were no witnesses to support this.

28. The doctor instructed a nurse to obtain an urgent blood sample and give him a specimen bottle so that, if he vomited again, a sample could be sent for examination. His blood samples were taken and sent to hospital on the following day, 22 June. Usually the process takes 24 hours, but on this occasion, the results were not available until 25 June. The

original samples had been incorrectly labelled and so they could not be properly processed by the hospital laboratory.

29. Prison Doctor C examined the man on 23 June. He again complained of vomiting fresh blood, had diarrhoea and felt nauseous. He was given another sample bottle to produce a specimen and a further request for blood tests was made.

30. The blood test results became available on 25 June and Prison Doctor D discussed them with the Registrar at the treating hospital. Further blood tests were requested which were completed immediately and sent to the hospital. Although she was off duty that evening, she telephoned the hospital from home at 9.00pm for the results of the test. A management plan was agreed which included repeating the blood tests on 28 June.

31. At interview, the doctor said that the treating hospital's Registrar had noted that the man's results had not changed significantly from tests he completed previously. At around 10.00pm, she telephoned the prison to discuss the results with the doctor on duty, Prison Doctor E. He was asked to review the man's condition. The doctor noted that he had vomited in his presence and the vomit contained a small amount of blood. His condition nonetheless appeared stable although he had a large bruise on his right thigh.

32. On the morning of 26 June, the man approached RMN A and complained that he was bleeding from the sites where his blood had been taken. The nurse also noted that he had extensive bruising over his body. The nurse told the investigator that he did not know how to deal with the bruising as he had never seen anything like it before. He gave him some gauze (a thin, loosely woven surgical dressing) and a clinical bag as a temporary measure to contain the blood. He also referred him to the doctor on duty. The nurse said that he had never seen someone who looked as seriously ill as the man.

33. Shortly afterwards, Prison Doctor B examined the man. He noted that blood was still oozing from the venepuncture sites (where the needles had been inserted to obtain blood samples) but the dressing was clean and dry. He also saw the bruising on his right thigh. The doctor prescribed metoclopramide for his vomiting. Soon afterwards, RMN A noted that the man continued to vomit with small amounts of blood and that the whites of his eyes were noticeably yellow.

34. On 27 June, two entries on the man's medical records were made by Nurse C. The first noted that he continued to complain of vomiting and the second that no issues or concerns were raised. RMN A said that it was busy on the wing over the weekend and he only had infrequent contact with him.

Events on Monday 28 June

35. Between 9.00am and 9.15am, following routine checks on the wing, Officer A became aware that the man was in his cell and feeling unwell. He informed Nurse D who was in the treatment room. She was the lead nurse on duty for the day. The officer said he was concerned as he had seen blood near the man and thought that he might have harmed himself.

36. Nurse D went immediately to the man's cell. He was sitting on his bed, looked confused and said he was in pain. She saw dried blood on his locker and his hand and asked if he had attempted to cut himself. He said that he had not and that the blood had come from an old wound site. She said that he looked dry around the mouth, and so she asked him if he had something to eat and drink. He replied that he had not eaten much since the previous day and so she arranged for him to have a cup of tea. She left him being observed by two officers whilst she went to find a doctor to examine him, and also agreed to collect his morning dose of methadone.

37. The nurse went to the treatment hatch upstairs on F wing together with Officer A. She explained to her colleagues who were dispensing medication, that she had come to collect the man's medication as he was unwell and could not collect it himself. As methadone is a controlled drug, she completed all the necessary checks, collected the box to transfer the medication and the drug chart was signed. The nurse and officer then returned to the cell to give him his medication.

38. The nurse noted that he was becoming more anxious and appeared increasingly unwell. She asked the officer to stay with him while she went to get a doctor. She found Prison Doctor B, who had just arrived on the wing, and explained her concerns about him. The doctor went immediately to assess him and found him in a confused state. He was irritable and mumbled that he did not want to be seen by the medical staff. He then stumbled out of his cell to the cell next door, and lay on the bed. The officer and nurse returned him back to his cell. He was still oozing blood from the venepuncture site and was jaundiced and pale.

39. The doctor telephoned the treating hospital for advice and it was agreed that the man should be taken to the accident and emergency department. An ambulance was called but, when the paramedics arrived, he insisted that he did not want to go to hospital but wanted to be left alone.

40. Together with the paramedics, the doctor agreed that the man did not have the mental capacity to make a rational decision to refuse treatment. His condition was deemed to be life threatening and so he was taken on a stretcher from his cell to the ambulance. Two officers accompanied him to the hospital. He was not handcuffed by the escorting staff. The officers were informed to monitor the situation and, should his health

improve, a risk assessment would be carried out to decide whether cuffs or escorting chain should be applied.

41. At 12.15pm, whilst on the way to the hospital, the man's condition worsened and the paramedics decided to take him to the local hospital's Accident and Emergency department which is nearer. On arrival, he was drifting in and out of consciousness. He was transferred to the resuscitation unit followed by a move to the Intensive Therapy Unit (ITU), where another medical team attended to him. Prison Doctor D telephoned the ITU unit and was told that he had had a cardiac arrest but was now stable.

42. The man was assessed by the hospital doctor at 4.15pm. The doctor informed the prison officers that his condition was critical and his next of kin should be informed. His sister was listed as his next of kin and she subsequently arrived at the hospital at about 5.35pm.

43. The prison's healthcare staff contacted the local hospital regularly to obtain updates on the man's condition. On 1 July, they were informed that he was conscious but remained agitated and confused. Over the coming days his condition remained unchanged. Hospital staff planned to arrange a transfer to the treating hospital once the medical team there were satisfied that his condition was stable enough to do so.

44. On 10 July, he was transferred to the treating hospital. His condition had become more stable and he was conscious, although still quite unwell. Over the next couple of days, he received blood transfusions. His mobility improved a little and he was able sit up in a chair. Following the improvement in his health, a risk assessment was carried out and the decision was taken that a single cuff escort chain should be applied. (An escort chain is approximately 1.5 metres long and is attached to the prisoner and the officer.)

45. As he was alleged to have harmed his mother, he was not allowed to have any contact with her. She contacted the prison to see if she could visit her son in hospital. Wanting to ascertain if they could allow this, the prison initially contacted the hospital doctor in charge of the man's care. The doctor confirmed that his condition was critical and life threatening and he would not physically be a threat to anyone who visited him. The information was passed on to the police so that they could authorise a visit.

46. The man remained in hospital and, on the morning of 14 July, healthcare staff contacted the treating hospital again noting that "Spoke to ward. Having endoscopy today. No plans for discharge today".

47. At around 10.55am, he was taken to surgery for an endoscopy procedure to be carried out (an endoscopy is a procedure in which a camera is used to allow an internal examination). The escort chain was removed whilst the procedure took place.

48. In the course of the procedure, he started to bleed internally which led to a cardiac arrest. Medical staff attempted to stabilise his condition but were unsuccessful. He was pronounced dead by the hospital doctor at 3.40pm. Whilst some hospital staff tried to resuscitate him, others contacted his sister to ask her to come immediately to the hospital.

49. Later that day, and after he died, the prison and the police agreed that, on compassionate grounds, his mother could visit him.

After the man's death

50. The prison escort staff contacted the prison to inform them of the man's death and the death in custody contingency plan was initiated. His family were informed of his death by his sister. A governor was appointed as the prison's liaison officer and he immediately went to the hospital to meet with the family. He spoke with the family about what would happen next and provided the information and contact details required to arrange the funeral. He remained in contact with the family throughout and offered financial assistance to the family.

51. Notices informing staff and prisoners of the man's death were issued. The prison care team were deployed and offered support to the staff who cared for him. Prisoners were also offered support.

52. A post mortem examination took place on 16 July. It was recorded that the cause of his death was oesophageal varical haemorrhage (swollen veins in the oesophagus which start to bleed), decompensated liver cirrhosis (which means there are complications associated with the cirrhosis) and Hepatitis C.

ISSUES

Clinical care

53. The clinical review was conducted by a clinical reviewer and is annexed to this report. All the recommendations relate to healthcare matters and are directed to the Head of Healthcare and the Primary Care Trusts.

54. The clinical reviewer states that it was evident that aspects of the man's care were not completed in accordance with the protocols in operation in healthcare at the time. He considers that the main reasons were that staff were unaware of the relevant protocols, and some staff deliberately did not follow them and whilst others had insufficient training to carry out the tasks. He comments that the healthcare team relies heavily on temporary staffing from the staff bank and agencies which substantially increases the burden on the permanent staff and the team's budget.

55. Despite his concerns, the clinical reviewer does not believe that the actions and oversights had a material effect on the outcome for the man. He makes eight recommendations and I refer to several below. It is also worthy to note that there were some individual areas of good practice, which are also highlighted below.

Reception screening

56. The man received the requisite Comprehensive Short Assessment from healthcare staff. However, it was not recorded on his electronic medical records (Pentonville uses a system called EMIS). When the assessment document was retrieved for the investigator, it showed that his drug history had been fully assessed. However there was no indication that any aspects of his physical health or ongoing medical difficulties were taken into account.

57. The man also appeared to receive a secondary health screen (Grubin 2) although it was undertaken nearly two weeks after he came into prison. The prison healthcare protocols require that the screen should have taken place within 24 hours of admission. Although Nurse B noted on his medical records that the Grubin 2 and well man assessment were completed, a copy was not available to the clinical team caring for him. At interview, another nurse said that the Grubin 2 was not a priority and there were insufficient staff to complete them in a timely fashion.

58. The initial assessments which should be completed when an individual is placed on the IDTS wing are of the utmost importance for considering their immediate needs and determining how their care and treatment should be delivered. If the assessments are not completed properly, subsequent decisions will not be as informed or effective.

The Head of Healthcare should ensure that staff complete the required assessments according to the healthcare protocols. This should be regularly subject to audit to ensure compliance.

All clinical records should be made available to the entire clinical team by using EMIS as the core record.

Retrieving previous medical information

59. A letter was received on 25 May 2010 from the treating hospital noting that the man's next appointment with the Professor was on 9 September. (This was the only evidence that he had a hospital appointment.) Although he had told reception healthcare staff about his medical conditions, no contact was made with either his community doctor or the clinical team at the treating hospital until he started to become unwell on 25 June. It is important that information about the prisoner's medical history is gathered in order to ensure continuity of treatment.

The Head of Healthcare should ensure that information about a prisoner's previous treatment should be obtained at the earliest opportunity.

Monitoring the man

60. For 15 days between 24 May and 8 June, the nursing entries in the man's medical record refer to 'no issues raised'. The clinical reviewer noted that there was no evidence that the Trust's own protocols for daily clinical observations of temperature, pulse and blood pressure were followed. These omissions are even more striking given that RMN A had described him looking very ill when he came into custody. As well, there is no evidence that the day five care plan review was undertaken as required by the healthcare protocol. Had it been carried out, it might have offered the opportunity to ensure that the earlier parts of the protocol were completed.

The Trust should ensure that clinical observations are completed according to their protocol. The Service Manager and Head of Healthcare should be able to assure themselves that they are being completed.

Prescribing methadone

61. Methadone is a painkilling drug, used to treat heroin addiction. In the course of 11 days between 9 June and 20 June, the man's methadone prescription was doubled from 10mg to 20mg and then further increased to 30mgs. It was not possible to ascertain the reason for this from the medical notes, although the Substance Misuse Team Manager surmised that he might have been experiencing further symptoms of withdrawal. Whatever the reason for increasing the dosage, it is essential that it is

recorded in the clinical notes to ensure that the entire clinical team are aware of changes and the rationale behind them.

The Head of Healthcare should remind staff that all changes in a patient's clinical care and treatment should be recorded in the clinical record.

62. Under the healthcare controlled drugs protocol, which includes methadone, two nurses should be present when a controlled drug is given to a prisoner. Only Nurse D was present in his cell when the man was given methadone on 28 June. I am sure that this was done with the best of intentions to give the medication as quickly as possible. The Substance Misuse and Inpatient Manager told the investigation team that she was aware of this error and the nurses had been reminded of the implications of not following the correct process. The error has been managed as a performance management issue for all three nurses involved and I therefore make no recommendation on this matter.

Nursing the man

63. RMN A was honest in that he was unsure how to deal with the man's physical ailments, such as the bruising which was brought to his attention on 26 June. The nurse is a registered mental health nurse with extensive experience within the IDTS wing, but he does not appear to have the appropriate knowledge from either experience or training to understand what may have caused his bruising. Staff with the correct skills set should be available for patients, such as those on the IDTS wing, with complex needs.

64. This issue was identified in the Healthcare Interim Internal Management Investigation conducted after the man's death. The Head of Healthcare told the investigator that he has to address a disparity in the number of mental health nurses and registered general nurses on the IDTS wing. As this work is already in progress, I do not make a recommendation on this issue.

Clinical observations

65. On Sunday 27 June, two entries on the man's medical records were made by Nurse C. The first noted that he continued to complain of vomiting and the second that no issues or concerns were raised. There appeared to be genuine concern about his health. However, at no time during the week before he was admitted to hospital by which time he had clearly deteriorated, were increased clinical observations requested by any of the doctors or nurses.

66. The clinical reviewer notes that this may well be because there were large numbers of temporary staff who are unaware of the treatment protocols. Nonetheless, even temporary staff should have realised that it was essential to monitor any changes in a patient's condition. The

Service Manager estimated that 40per cent of shifts are covered by either bank or agency nurses. The Head of Healthcare confirmed that the level of clinical observations "simply weren't good enough" and they would learn from these omissions. The clinical reviewer makes a recommendation about the vacancy rate on the IDTS wing, which I do not repeat here but which the PCT will wish to address. He also makes a recommendation about the competence of staff to take and understand clinical observations.

The Head of Healthcare should ensure that staff in the Integrated Drug Treatment Service wing understand the importance of taking basic clinical observations.

Good practice

67. The commitment of Prison Doctor D, who coordinated much of the care after hours from her home, was noteworthy and exceptional. Additionally, healthcare staff made regular contact with both hospitals which was also good practice.

68. The use of restraints or handcuffs is normal practice when escorting prisoners to and from prisons. I note that in this case, careful consideration was given to this issue whilst the man was in hospital. I believe that the prison acted appropriately by not using restraints initially and then risk assessing his condition as time went on. The restraints were removed for the endoscopy to be performed which was when, unexpectedly, that he died.

CONCLUSION

69. The man was already an ill man when he came into prison. He told reception staff that he had several illnesses as well as drug and alcohol problems. After he was located on the Integrated Drug Treatment Service wing, certain parts of the medical protocols were not followed including the necessary assessments, obtaining his previous medical records and making accurate records of his treatment in prison.

70. When he was taken ill on 28 June, staff acted appropriately and I am pleased that restraints were not used at this time. Staff continued to liaise effectively with both hospitals until he died.

71. Given that he was very ill when he arrived in prison, I do not believe that his death was preventable. However, there are improvements that can be made in healthcare provision at Pentonville, and I have made recommendations to ensure that these are made. In particular I am concerned that he was not assessed as required by the protocols and clinical observations were not made as expected.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that staff complete the required assessments according to the healthcare protocols. This should be regularly subject to audit to ensure compliance.

   The Prison Service has accepted this recommendation.

2. All clinical records should be made available to the entire clinical team by using EMIS as the core record.

   The Prison Service has accepted this recommendation.

3. The Head of Healthcare should ensure that information about a prisoner's previous treatment should be obtained at the earliest opportunity.

   The Prison Service has accepted this recommendation.

4. The Trust should ensure that clinical observations are completed according to their protocol. The Service Manager and Head of Healthcare should be able to assure themselves that they are being completed.

   The Prison Service has accepted this recommendation.

5. The Head of Healthcare should remind staff that all changes in a patient's clinical care and treatment should be recorded in the clinical record.

   The Prison Service has accepted this recommendation.

6. The Head of Healthcare should ensure that staff in the Integrated Drug Treatment wing understand the importance of taking basic clinical observations.

   The Prison Service has accepted this recommendation.