

**Investigation into the circumstances surrounding the
death of a man in hospital, whilst in the custody of
HMP Pentonville on 22 September 2009**

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

February 2010

This is the report of an investigation into the death of a man who died in September 2009 in hospital whilst in the custody of HMP Pentonville. The man was 66 years old.

The man had had a coronary artery bypass graft operation on 27 August and returned to Pentonville's healthcare unit five days later. The following week he was re-admitted to hospital with low blood pressure. On 21 September, The man was diagnosed with three bleeding duodenal (stomach) ulcers. However, for religious reasons he refused a blood transfusion. Her Majesty's Coroner for Inner London did not ask for a post mortem examination into the man's death. It was noted that his death was from natural causes due to renal failure.

I extend my sincere condolences to the man's wife, family and friends.

The investigation was carried out on my behalf by one of my investigators. In addition, a review of the man's medical care was commissioned by Islington Primary Care Trust (PCT). I am grateful to the clinical reviewer for that review. I would also like to thank the then Governor of Pentonville and his staff for their assistance with this investigation. I am especially grateful to the Liaison Officer and Head of Nursing for their support.

I would also like to thank a Judge and the staff at a Crown Court for their help.

I make five recommendations for the attention of the Head of Healthcare concerning patient care, mental health assessments and medical records. Furthermore, I acknowledge two further recommendations in the clinical review relating to multi-disciplinary meetings and the use of the six in-patient beds for medical use. The support given to the man and his wife as he neared the end of his life was of a high standard. However, earlier consideration could have been given to the removal of physical restraints. I fear this latter issue is one to which I have to return in investigation after investigation.

In this final report four recommendations have been accepted and one recommendation partially accepted. The man's family have not raised any issues from the draft report.

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Prisons and Probation Ombudsman

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SUMMARY

The man was bailed to appear at Crown Court in June 2009 for alleged sexual offences. In 24 June 2009, prior to his court appearance, he attended the accident and emergency department at hospital after taking an overdose of paracetamol and experiencing chest pain. He told doctors that his overdose was as a result of anxiety regarding his forthcoming court appearance, but he denied any intention of self harm. His chest pain was noted and, following tests, the doctors referred the man to a chest pain clinic.

On 28 June, the man was taken from his home to hospital after complaining of chest pain. Against medical advice he discharged himself the following day and went to Crown Court for the first day of his trial, but arriving late. His failure to attend court on time had already prompted the Judge to issue an arrest warrant, and the man was remanded into custody at Pentonville.

The man was taken back to court on 30 June and the Judge asked for a report into his health. A court doctor deemed the man unfit to stand trial and he was returned to Pentonville. The following day he was seen by a doctor at the prison who then reported to the Judge that the man was unwell and waiting for medical investigations for a potential serious heart condition. The Judge adjourned the trial and remanded The man into custody for pre-sentencing reports.

The doctor at Pentonville made an urgent referral for the man to be seen at hospital. However, because of a lack of escort staff an out-patient appointment was cancelled on 14 July. The man was seen at the hospital on 31 July, and the doctor's diagnosed angina (narrowing of the artery) and advised the man to remain in hospital for an urgent heart by-pass operation. The man discharged himself and returned to Pentonville.

Following a discussion with his wife, the man agreed to the surgery and he was escorted to hospital on 13 August. There his condition was stabilised in preparation for the by-pass surgery on 27 August.

The man returned to Pentonville on 1 September and was admitted to the healthcare unit for observation. He was advised on self-administration of insulin for his diabetes, and to take gentle exercise on the unit to ensure he did not develop a deep vein thrombosis. Whilst being cared for, nurses also applied dressings to a seeping wound on his leg.

On 9 September 2009, the man's health deteriorated and he was admitted to hospital. Following medical tests he was diagnosed with three bleeding stomach ulcers. The man refused a blood transfusion on religious grounds, and was transferred to the intensive care unit. He died on 22 September, with his wife at his bedside. He was no longer restrained and officers were respectfully situated away from his bedside.

THE INVESTIGATION PROCESS

1. The investigation into the man's death was opened on 5 October 2009 when my investigator visited Pentonville. Notices of the Ombudsman's terms of reference and notices to staff and prisoners had been sent to the prison in advance of her visit. Up to the date of circulation of this report no members of staff or prisoners have responded to the notices of investigation.
2. My investigator met with Head of Nursing and the Liaison Officer. Copies of the man's medical records and prison files were available for her to take away. No members of the Independent Monitoring Board (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 my investigator. Pentonville has previous experience of deaths in custody and both the IMB and the union are aware of the investigation process.
3. My investigator visited the healthcare unit, and toured the in-patient facility. On the unit she visited a cell and spoke to a Listener (Listeners are prisoners trained by the Samaritans to provide confidential support to other prisoners in times of crisis.)
4. One of my Family Liaison Officers contacted the man's wife to tell her about the scope of my inquiries and to offer the family the opportunity to raise any questions or concerns they would like addressed as part of the investigation. At the time of issuing this draft report the family had not raised any concerns directly with my office. However, I hope the report provides them with an understanding of the man's time in custody and the events leading to his death.
5. A review of the man's medical care was commissioned by Islington PCT. On 19 October, my investigator telephoned the Crown Court to make enquiries regarding the man's appearance at the court in June. The Judge sent her a full chronology of the man's court appearances on 9 November.
6. Also on 9 November, my investigator and the clinical reviewer interviewed healthcare staff at Pentonville.

HMP PENTONVILLE

7. Pentonville is a local prison, predominately holding prisoners on remand and serving courts in north east London. At the time of the investigation, it could hold up to 1,152 prisoners. The accommodation comprises five residential units, a vulnerable prisoner wing, a segregation unit, a first night centre, and a healthcare unit with 24 hour nursing care. Healthcare at Pentonville is provided by the Islington Primary Care Trust and has beds for up to 22 in-patients.

8. The establishment was last inspected by Her Majesty's Chief Inspector of Prisons in June 2006. In her report of that inspection, the Chief Inspector pointed to improvements in some areas since her previous visit in 2005 and wrote:

“Progress in healthcare had been slow. A new management structure had been put in place and the aim was to ensure safety before developing services. Some good clinical audits were undertaken. Prisoners were not seen in private in reception but this was being addressed. GP clinic arrangements had improved but waiting list management and follow-up arrangements for these and other clinics were poor. Primary care services were basic and there were no chronic disease management or formal discharge clinics and little health promotion work. All healthcare staff had recently undertaken a drugs assessment but improvement in administration was needed. The number of in-patient beds had reduced from 32 to 22 and all in-patients had care plans. A full-time staff grade psychiatrist was in post. The mental health in reach team had expanded but saw only patients with severe and enduring illness and there were no primary mental health services. A day care service had recently begun.”

9. The 2009 Annual Report of the Independent Monitoring Board at Pentonville noted that:

“A Health Service provider tender specification was produced and a new provider was selected. The transfer to the new provider, a consortium led by Islington PCT, took place on 1st April 2009. The impact on health care services during the reporting year just ended before the new contract came into effect was to continue with the inadequately high levels of nursing and paramedic vacancies including physiotherapy. It is envisaged that more nursing staff will be deployed under the new contract. It is hoped this will reduce the future need for patients to visit outside clinics, with the resulting added costs of hospital escorts... There were good examples during the year of the professionalism and dedication of healthcare staff when faced with emergencies and acute cases.”

10. There had been four previous deaths due to natural causes at Pentonville since my office started investigating all deaths in prison custody in 2004. None of my reports into those deaths raised issues similar to those arising in respect of the man.

KEY FINDINGS

11. The man was born in East London in 1946 and was married. He was unemployed and a Jehovah's Witness by religion. In December 2008, he appeared at Magistrates' Court to face charges of sexual assault dating back to the 1970s. He was bailed to appear at Crown Court in June 2009.
12. On 24 June 2009, the man was seen in the accident and emergency department of a hospital. He had been referred there by his doctor after telling him he had taken too many paracetamol tablets and was experiencing chest pain. No treatment was needed for the paracetamol overdose and the man saw a member of the psychiatric liaison team. He denied any ideas of self harm, but was anxious about his forthcoming court appearance and was given written information about support in the community. However, following a physical examination and an Electrocardiograph (ECG) some abnormalities were identified. (An ECG machine traces the heart rate and rhythms.) The hospital doctor made a referral to The man's doctor for him to be seen at the a chest pain clinic on 27 June.
13. The man's solicitor asked the doctor for a medical report to be presented to the Crown Court outlining the man's current medical condition and whether he would be fit to stand trial. The doctor completed the report and forwarded this to the solicitor, recommending that the man's case be postponed until his heart problems had been investigated.
14. On 28 June, the man was seen in the emergency unit of a hospital, having been taken there by an emergency ambulance from his home. The following day, the man discharged himself from hospital and signed an irregular discharge certificate. (An irregular discharge certificate notes that a patient wishes to leave hospital against medical advice.)
15. At Crown Court at 2.38pm on 29 June, the Judge issued an arrest warrant for the man for his failure to attend court. In fact, the man made his way to the court and was taken before the Judge at 3.49pm. The Judge remanded the man into custody at 4.16pm to appear before the court the following day.
16. On arrival at HMP Pentonville, The man was seen in reception by a nurse who noted his present medication and took a verbal medical history that included type two diabetes. The man told the nurse he had no thoughts of self harm and he confirmed this when he saw the doctor. The following day, the man was taken to Crown Court.
17. The Judge asked that the man be examined to ascertain whether he was fit for trial, and a doctor was called to the court cells. Additionally, at 11.40am a member of Pentonville's healthcare staff received a

telephone call from a court officer and asked if the prison doctor could also confirm that the man was fit for trial. The doctor was unavailable at that time and said he would contact the court later. The Judge received a medical report from the court doctor to the effect that The man was unfit to stand trial. The Judge remanded him back into custody at 12.33pm and the man returned to Pentonville.

18. On 1 July, the man's barrister told the Judge that the man was unwell. The Judge called the escorting officer into the court to confirm that she had been told that morning by the nurse at Pentonville that the man had been given all of his medication for angina and diabetes. The trial was then started with the man present. At the end of the day, the Judge suggested to the man's barrister, and their medical advisers, that they carry out any medical examinations they wished. The man returned to Pentonville.
19. The man was seen on 2 July by a nurse who recorded his full medical history. The nurse took his blood pressure (which was 157/82; a normal reading for blood pressure would be 130/80), measured a pulse rate of 80 beats per minute (a normal pulse rate would be between 60-100 beats per minute), and recorded a normal temperature of 36.6 degrees. The nurse noted the man's recent visit to hospital and referred him to see the prison doctor.
20. A doctor examined the man and wrote that he had not told the reception doctor about his chest pain and recent hospital admission when he had been examined two days previously. Nevertheless, it was noted that the man had not had any chest pain whilst in prison. After reviewing medical correspondence, the doctor made a urgent referral for the man to see a chest specialist and deemed him unfit to appear in court. A letter was faxed to Crown Court for the attention of the Judge, outlining the man's present medical condition and saying that in the doctor's opinion he was not fit to stand trial.
21. The Judge reviewed doctor's medical report the following day, remanded the man into custody in his absence, and asked for pre-sentence reports to be prepared. The man was moved to Pentonville's vulnerable prisoner unit...
22. The man was referred to the mental health team on 8 July, following an assessment by a psychiatrist who had visited him at the request of his solicitors.
23. On 11 July, the man was seen again by a nurse who recorded his blood pressure as 134/71, a pulse rate of 73 beats per minute and a temperature of 35.6. The man's blood glucose level was recorded as 13.8 mmol/l after his breakfast. (Blood glucose levels average at 4 to 7mmol/l before meals, less than 10mmol/l 90 minutes after meals and around 8mmol/l at bedtime). The nurse noted that the man's blood glucose levels would be checked the following day.

24. The man refused his medication from a nurse on 13 July and said he had not been allowed a telephone call for nearly a week. (There is nothing noted in the man's personal file as to why he had not been able to telephone his wife; it may be that he had no credit left on his Pinphone.) The nurse tried to persuade him to take his medication and said that his health would be affected. The man was adamant that he would not take his medication, and the nurse informed the senior officer on the wing.
25. The next day, the man's appointment at a hospital was cancelled by a charge nurse. At a pre-assessment meeting earlier in the week all the out-patient appointments had been graded as to their urgency. The man's appointment had been assessed as of lower priority than that of other patients and, because of a shortage in the number of available escort staff, his appointment was cancelled. Later, he was seen by a doctor who wrote that the man had pain in his thumb. The doctor prescribed paracetamol and some cream to rub into the affected area.
26. On 21 July, the man was seen by a member of the mental health care team. However, there are no notes as to the outcome of that consultation.
27. The man went to a hospital for an out-patient appointment on 31 July. As a result of the appointment, the doctor wrote that he had received a telephone call from the hospital and that the man's tests confirmed that he had unstable angina (a narrowing of the coronary artery restricting blood supply to the heart). The doctor added that he was unhappy that the previous appointment had been cancelled. The doctor reviewed the man's medication and noted that, should the man experience any chest pain, it should be taken seriously by healthcare staff.
28. An entry in the man's medical notes said that he had returned a prescribed medication of Bisoporal (for angina) on 5 August. Two days later, a nurse wrote that the man had now agreed to take the Bisoporal.
29. On 10 August, the man was escorted to hospital for an angiogram. (An angiogram is a procedure where a catheter is inserted into an artery or vein to check the flow of blood to the heart.) Following the result of the procedure, doctors advised the man that he should stay, as an in patient, for a coronary by-pass operation. However, the man declined the operation, saying he wanted to speak to his wife before agreeing to surgery. He discharged himself from hospital and returned to Pentonville the following day.
30. On his return to Pentonville, the man saw a doctor whom he told about his decision regarding the by-pass surgery. He also told the doctor that he was a Jehovah's Witness and would not want any blood products, or transfusions, and that he had told the hospital doctor of this decision. However, on 12 August the man wrote to the doctors at Pentonville

agreeing to the by-pass surgery after discussing this procedure with his wife. On receipt of this information the doctor contacted the hospital to arrange the man's admission.

31. The following day it was noted in the man's medical notes that he had slept on the floor of his cell rather than his bed. No reason was offered as to why he had done this.
32. On 3 September, a nurse wrote that the man's surgical wound dressings had been changed and he had been assisted with his personal hygiene. The nurse encouraged the man to take gentle exercise by walking on the unit during association. (This had been advised by the duty doctor to prevent a deep vein thrombosis [blood clot] forming.) The following day, a doctor noted that the man would need assistance with understanding his diabetes and insulin injections (medication for diabetes) before he could be sent back to the wing.
33. Four days later, a nurse wrote that the man was now able to check his own blood glucose levels and would be soon ready for discharge to his wing. On 8 September, a nurse noted that one of the man's surgical wounds was 'weeping'. A clean dressing was applied and the man was again encouraged to take more exercise.
34. Later that day, a nurse noted that the man needed to be prompted to look after himself and his cell. The nurse further wrote that the man did not sleep in his bed, preferring to sleep in a chair with his feet on the ground. This was against the advice of healthcare staff who had told him to sleep with his legs elevated. The nurse ended her entry by noting that the man had not taken his evening meal.
35. On 9 September, a nurse recorded that the man's surgical wound was still oozing fluid whilst she applied a clean dressing, although he said it was not painful. The man was now self-administering his insulin but was slow in taking his exercise.
36. Later, a doctor saw the man and noted that he was pale, tired and seemed unwell. The doctor spoke to a specialist at a hospital to discuss the man's present medical condition. It was agreed that he should be admitted to hospital. At 2.15pm, the man was taken to hospital, escorted by two officers and on an escort chain. He was admitted to a ward for treatment and observation. (A security risk assessment noted that restraints should be removed for appropriate medical investigations and any surgical procedures.)
37. Three days later, the man was transferred to the intensive therapy unit (ITU) as his renal (kidney) function was causing concern. On 14 September, the man was moved to a side room and his wife was allowed to visit her husband daily.

38. The man was transferred to a high dependency ward on 18 September. At 11.05pm, his condition deteriorated and hospital staff advised that the man's wife should be contacted and return to the hospital. An ECG procedure was carried out and doctor asked the man if he would agree to a blood transfusion. He refused.
39. The following morning at 00.40am, the man was moved to the intensive care unit. His wife had arrived at the hospital and remained at her husband's bedside. An endoscope procedure was undertaken at 00.50am (a tube with a camera attached is passed down the throat to examine the stomach). The doctors advised that the restraints should be removed as the man was now seriously ill. The bed watch officers made contact with the prison and informed them that they had removed the restraints.
40. The bed watch notes record that a stomach bleed had been controlled at 3.20am. However, the man was now on a ventilator and his wife stayed with him until later that morning. A governor agreed that restraints should not be re-applied unless there was a positive change in the man's condition. In addition, the governor gave permission for the bed watch officers to sit in a side room, away from the man's bedside, whilst maintaining observation. On 20 September at 6.45pm, the bed watch notes record that, for religious reasons, the man again said he did not want a blood transfusion. The man's wife told the escort officers that her husband's condition was continuing to deteriorate.
41. Head of Nursing Care visited the ITU on 21 September. He spoke to a senior doctor and was told that several days previously the endoscope procedure had indicated that the man had three bleeding duodenal ulcers which had now been controlled. Nevertheless, the man's refusal to accept a blood transfusion meant that his blood levels had dropped to a dangerously low level. He was now in renal failure and the prognosis was that he would die within the next 24 hours.
42. At 11.45am, a governor made contact with the bed watch officers to check on their welfare and that of the man's visitors. Later, the man's wife told the bed watch officers that her husband was in the final hours of his life and thanked them for their support and help. A governor visited the hospital at 4.15pm in his role as family liaison officer. He ensured that officers were on duty at a discreet distance from the man's bedside whilst still able to observe him, and that they were comfortable with the situation. The governor introduced himself to the man's wife and offered her any assistance she might need.
43. The man received a visit from his religious minister at 7.30pm. At 11.15pm, the man's wife left her husband's bedside and went to the family rest room. Less than an hour later a nurse asked her to return to her husband's bedside. The man's wife told the escort officer that her

husband had passed away at 00.15am the following day. This was confirmed by a hospital doctor at 00.40am.

44. A governor remained in contact with the man's wife and offered her any support she might need. The prison offered financial assistance for the man's funeral.

ISSUES

Clinical Care

45. A review of the man's medical care was undertaken by an Acting Director of Nursing in the National Health Service. The clinical reviewer and my own investigator, interviewed medical staff at Pentonville as part of the review process. The clinical reviewer noted the chronology of the man's interventions with healthcare staff and his medical care.

Mental Health

46. The man was referred to the mental health team on 8 July following an assessment by a psychiatrist acting on behalf of the man's solicitor. He was seen by a member of the mental health care team on 21 July. Notes from that consultation were absent and the clinician who undertook the assessment was unavailable for interview. The Deputy Manager of the Mental Health Team described the outcome of the assessment, noting that it was not felt that the man had either a depressive or a psychotic illness and he was not suicidal. Any symptoms were due to anxiety about being in custody. They planned to follow up with the psychiatrist, but there is no record of this happening and no interventions were made available to help the man manage his anxiety.
47. The clinical reviewer was concerned over the length of time from referral to assessment and the lack of documentation available to other clinicians regarding the outcome of this assessment. In his review he comments:

"In the recent inspection by the Chief Inspector of Prisons the report noted that primary mental health needs were clearly not well served. This case would appear to confirm that view."

I endorse the following recommendations from the clinical review:

The mental health team should review access to Primary Mental Health Care Services.

The mental health team should review its policies for recording assessments and interventions in the primary healthcare record (EMIS) to ensure availability of information for clinicians.

Cancelled out-patient appointment

48. The man's first appointment at a chest pain clinic was scheduled for 14 July. This was cancelled due to a lack of escorts being available. The

nurse who cancelled the hospital appointment described to my investigator the system for cancelling hospital appointments based on risk. High risk appointments are graded red, medium amber, and low green. The decision to cancel the man's appointment clearly annoyed a doctor who noted on 31 July that he was unhappy that the out-patient appointment on 14 July had not gone ahead. The doctor judged the man's referral as urgent. The clinical reviewer comments:

"The recent prison inspectorate report describes the management of external hospital appointments as exemplary, and noted that no appointments had been cancelled due to a lack of escorts. This case is an exception to this and the panel would urge the healthcare services to look in some detail as to the reasons why it happened. "

I endorse this further recommendation from the clinical review:

The Head of Healthcare should review the cancelled appointment in this case to understand why this slipped through what was recently described as an exemplary system.

Care plans

49. On the man's return to Pentonville on 1 September, he was admitted to the healthcare unit for post-operative care and observation. He was seen by a doctor, and further medical reviews were held on 3 and 4 September, and then again three days later. However, while a care plan was supplied to the clinical reviewer on the day of the interviews, this gives little guidance to nursing staff on what was required. The clinical reviewer writes:

"Daily entries make no reference to it and it would also appear that the man preferred to sleep either on the floor or in his chair at night. No attempt seems to have been made to understand this or any implications of this explored, rather each evening the relevant nurse was left to find the best solution for him."

I endorse these recommendations from the clinical review:

The Head of Healthcare should ensure that in-patients have clear plans of care that are referred to by individual nurses on a day to day basis.

In-patient notes should be subject to regular audit and recommendations made and acted upon. As a minimum this should be three monthly.

50. The inpatient unit has 22 beds, nominally split between 16 beds for mental health patients and six for people with physical healthcare needs. Nursing staff are predominately from Camden and Islington

Foundation Trust and mental health nurses. The clinical reviewer comments:

“It is understood that there are currently a number of vacancies within the nursing team. The GP input is via a weekly rota with each of the GPs offering input for a week at a time. Thus there is little continuity of care or consistent oversight of formulation of treatment and care plans and implantation of the same. The panel were of the view that the input both medical and nursing into the in-patient unit and specifically the beds for those patients with physical healthcare needs should be reviewed.”

I note the recommendation in the clinical review relating to the six physical healthcare beds.

Primary care

51. In interview a number of those spoken to during this investigation referred to the meetings held between the wing staff, mental health team and primary care nursing staff. It was noted that there were mixed views about the purpose of these meetings and their function. What is clear is that the man was discussed on three occasions: 23 July, 6 and 13 August, with notes as follows:

Date	Clinical record
23rd July	No concerns from staff on the wings. No meds
6th Aug	No nurse from G1, no officers present, therefore unable to update
13th Aug	Not known to nursing staff on main G wing nor known to officer.

52. Whilst the clinical reviewer views this as a model of localised primary care for discussing patients, he would like the function of these meetings to be specified and a renewed commitment from all partners ensuring that they attend, have the right information available, and that the meetings have the right membership. The Head of Healthcare should clearly define the purpose of the wing based clinical meetings and ensure that staff are committed to ensuring that they function as intended.

Bed watch

53. Officers escorting the man on 19 September were told by hospital staff that restraints were inappropriate when the man's condition deteriorated following the diagnosis of three bleeding duodenal ulcers. The officers immediately removed the restraints and notified the prison of their actions. Risk assessments had indicated that restraints should be removed for appropriate medical investigations and at the request of

hospital consultants. However, I believe an earlier risk assessment for removal of restraints should have been considered.

54. A governor went to the hospital later on 19 September. He asked the escorting officers to sit away from the man's bedside, thereby offering him and his family privacy and dignity. On 21 September, a governor spoke to the bed watch officers to check that they were comfortable with the situation and that the man's wife and his visitors were being cared for.
55. During the afternoon, a governor again visited the hospital and spoke to the man's wife. He introduced himself as the family liaison officer and offered support any assistance she might need. This support continued following her husband's death. She was noted as thanking the bed watch officers for their support shortly before her husband died.
56. The help and care shown by the staff who visited the hospital, or acted as bed watch escort, was of a high professional standard. I note the good practice of discipline officers and managers in supporting the man and his family during this very difficult time.

CONCLUSION

57. The man was promptly referred to hospital when the doctor at Pentonville became aware of his potentially serious heart condition. However, because of a shortage of escort staff, the man's first appointment was cancelled. When he did attend the hospital and doctors advised him to have urgent heart surgery, he refused until he had spoken to his wife. When he made the decision to have the surgery he was immediately admitted to hospital.
58. The man's health deteriorated whilst being cared for in the healthcare unit. On grounds of his religious beliefs, the man refused a blood transfusion when he was admitted to hospital.
59. The clinical reviewer has made recommendations for the attention of the Head of Healthcare that I endorse. However, I do not feel the man's death could have been prevented by clinical or uniformed staff.
60. Managers and escort staff were supportive in their care of the man whilst he was an in-patient. Indeed, I have identified this as an example of good practice. However, an earlier removal of restraints should have been considered.

RECOMMENDATIONS

Head of Healthcare

1. The mental health team should review access to Primary Mental Health Care Services.

Accepted – “Reviews currently in progress, taking elements of inter disciplinary coordination to improve referral process, and timeline delivery on appropriate actions. The head of healthcare leading review.”

2. The mental health team should review its policies for recording assessments and interventions in the primary healthcare record (EMIS) to ensure availability of information for clinicians.

Accepted – “Regular audit of record keeping standards 3 monthly. To be led by MH in line with FT policy.”

3. The Head of Healthcare should review the cancelled appointment in this case to understand why this slipped through what was recently described as an exemplary system.

Partially Accepted – “Work with the prison in partnership to ensure the appropriate availability of escorts to secondary care services. Agree new working protocol at Safer Custody/Governance.”

4. The Head of Healthcare should ensure that in-patients have clear plans of care that are referred to by individual nurses on a day to day basis.

Accepted – “Review as part of the Record Keeping Audit. Expectation of FT, all patients will have individual care plans that are used to assess, implement and monitor patient care. These to be utilised/monitored during the weekly ward round.”

5. In-patient notes should be subject to regular audit and recommendations made and acted upon. As a minimum this should be three monthly.

Accepted – “As above, regular audits to be carried out at 3 monthly intervals, utilising recommendations and timelined.”