Investigation into the circumstances surrounding the death of a man in hospital in August 2011 whilst in the custody of HMP Cardiff

Report by the Prisons and Probation Ombudsman for England and Wales

May 2012

This is the report of an investigation into the death of a man, who died in August 2011 in hospital. He was still in the custody of HMP Cardiff when he passed away. The loss of any family member is acutely painful, but especially so whilst they are in custody. I offer my sincere condolences to his family and friends.

The investigation was conducted by an investigator from my office. I am grateful to the Healthcare Inspectorate Wales for appointing a doctor to undertake a clinical review. I would also like to thank the Governor of Cardiff and his staff for their co-operation.

The man was diagnosed with type 2 diabetes in 1978 and took regular medication to control his condition. He was first imprisoned in October 1996 and transferred to Cardiff in July 2003. In August 2011, his condition deteriorated and he was taken to hospital and diagnosed with severe pneumonia. On 16 August, he suffered a cardiac arrest. Three days later, a brain scan revealed that he had suffered brain damage caused by lack of oxygen during his cardiac arrest. After full consultation with his family, a decision was made on 20 August, to switch off his ventilator. The post mortem confirmed the cause of death as pneumonia.

The investigation found that the care which he received from the healthcare services at Cardiff was good and that every effort was made to try and control his diabetes, even though he was a reluctant patient. However, the investigation does identify the need for greater accuracy in clinical record keeping, with appropriate training on recently introduced electronic recording systems, as well as better promotion of insulin injections to patients with acute type 2 diabetes. Two recommendations are made to this effect.

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Prisons and Probation Ombudsman **May 2012**

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SUMMARY

1. The man was imprisoned for the attempted murder of his partner in November 1997 and was initially held in HMP Pentonville. He was transferred to Cardiff in July 2003. He had a history of diabetes, arthritis and, as a result of his diabetes, progressive organic brain disease.

2. The man was assessed and reviewed on numerous occasions by doctors and diabetic nurses. He was started on insulin many times. However, he never completed a trial period despite support and supervision.

3. In August 2008, he had a left sided stroke and was in hospital for a short time. After the stroke, he agreed to insulin injections and his diabetic control improved. However, he developed several complications of diabetes, including poor circulation, poor vision and nerve damage in his legs. He continued to smoke until June 2011.

4. In August 2011, the man developed a chest infection. His condition rapidly deteriorated and he was admitted to outside hospital.

5. Following his arrival at hospital by ambulance, the man had a chest x-ray which showed severe infection, causing one lung to be ineffective. He had pneumonia and multi organ failure. He then suffered a cardiac arrest. He was resuscitated, fully sedated, transferred to the intensive care unit and put onto a ventilator, to aid his breathing.

6. A brain scan confirmed damage due to a lack of oxygen. His family were informed of his condition and told that it was unlikely he would survive. He passed away in August 2011, without regaining consciousness.

7. We make two recommendations in this report to the Head of Healthcare. They concern the need for accuracy in clinical records and the promotion of insulin injections to patients with acute type 2 diabetes

THE INVESTIGATION PROCESS

8. The investigation team was notified of the man's death in August 2011. Notices announcing the investigation were supplied and displayed at the prison to staff and prisoners, who were invited to contribute any relevant information. No prisoners or staff made contact with the investigator.

9. The investigator was provided with his prison record and clinical record and statements made by staff. One of the ombudsman's family liaison officers made contact with the man's family. She discussed the purpose of the investigation and gave the family the opportunity to raise any concerns they wanted to be addressed. However, his family did not raise any concerns at the time, and did not have any comments about the draft version of this report.

10. A clinical review of his healthcare was undertaken by a doctor on behalf of the Healthcare Inspectorate Wales. The doctor was asked to determine whether the clinical care which the man received was comparable to that which he might have expected in the community.

11. The investigator informed the local Coroner about the nature and scope of the investigation and requested a copy of the post mortem report. A copy of this report will be sent to the Coroner. The post mortem report arrived in January 2012, following an inquest which was concluded on 10 January. The inquest resulted in a verdict that he had died from natural causes.

12. The investigator visited HMP Cardiff on 22 November to familiarise himself with the prison. He visited the healthcare centre where he spoke with members of staff, including two nurses and the liaison officer.

13. On 19 December, the investigator returned to Cardiff where, together with the doctor, he interviewed the healthcare manager. The interview was recorded.

14. HMP Cardiff is situated in the city centre and serves courts in Wales and south-west England. The prison holds a maximum of 814 men who are either being held on remand or who have been sentenced.

15. Cardiff provides opportunities for employment, education and training. The prison also runs various offending behaviour programmes.

16. The prison has a new healthcare centre that provides 24 hour in-patient care. The centre has 22 beds. Prisoners have access to GPs, nurses and a mental health in-reach team. The healthcare team comprises full time GPs, locum GPs from a local Cardiff surgery, a senior nurse, a practice manager, four senior healthcare officers and 26 registered nurses. The GPs offer 13 sessions each week including one on a Saturday morning. An out-of-hours service ensures that there is always a GP and a nurse on call.

17. The healthcare team offer additional services including dental treatment, a genitourinary clinic, an optician and dermatology and podiatry appointments. Healthcare emergencies and those in need of specialist care are transferred to the hospital.

Previous deaths at Cardiff

18. We have investigated the deaths of 21 prisoners at Cardiff since April 2004, when the Ombudsman became responsible for investigating all deaths in custody. Ten of these deaths occurred through natural causes. The findings in the previous investigations are not relevant to the circumstances surrounding this man's death.

Her Majesty's Inspectorate of Prisons

19. The Inspectorate carried out an unannounced short follow-up inspection of Cardiff in June 2010. In the report of the inspection, the then Deputy Chief Inspector commented on hand-written clinical records:

> "The quality of record keeping was variable and it was not always clear who had made the entry.
>
> "The quality of written entries was variable. The role and status of the signatory was not always clear. The entries we saw were respectful."

Independent Monitoring Board (IMB)

20. Each prison is monitored by an Independent Monitoring Board (IMB), members of which are drawn from the local community. They have full access to prisoners and every aspect of the establishment. In its latest annual report, covering the period from 1 September 2009 to 31 August 2010, the IMB wrote:

“The Healthcare facility at HMP Cardiff is a modern purpose built unit with excellent facilities.”

“The Independent Monitoring Board found HMP Cardiff to be a clean, safe and well managed establishment with good relations between officers and prisoners.”

KEY EVENTS

21. In 1971, the man was involved in a road traffic accident and he suffered a head injury. In 1978, he was diagnosed with Type 2 diabetes and was prescribed oral treatment for his condition. (Type 2 diabetes develops in adults. It can be treated to some degree with exercise and a change in diet. However, the patient may also need to inject insulin to ensure that their condition does not worsen.)

1996

22. The man was arrested on 12 October 1996, for the attempted murder of his partner. Following his appearance at a magistrates' court on 15 October, he was remanded into custody at HMP Pentonville to await trial. During the reception process, healthcare staff wrote in his clinical record that he suffered from arthritis and had a history of diabetes.

23. At the time of his admission to prison, he was prescribed glibenclamide and metformin (both are drugs used to control diabetes) and naprosyn (a drug used to treat arthritis and joint pains).

1997

24. Following his first appearance at the Central Criminal Court in London on 2 January 1997, the man was remanded into custody at HMP Brixton. On 10 March, he was taken to hospital for a scan which identified some brain damage.

25. It was noted in his clinical record in July, that his blood sugar levels were not controlled and that he was not keeping to a diabetic diet. This was a recurring issue throughout his time in prison. He did not always take his medication regularly and struggled to control his diabetes. Throughout his prison sentence, he underwent annual checks on the retinas in his eyes to look for any changes which might indicate that his diabetes was worsening.

26. Following his trial at the Central Criminal Court on 14 November, he was sentenced to life imprisonment with a minimum tariff of six years. He was admitted to Brixton's healthcare centre between 10 and 20 December for help in treating his diabetes.

1998

27. The man was readmitted to the healthcare centre between 7 and 13 March 1998, again for support to control his diabetes. His medication remained the same through that year.

28. On 21 October, he was transferred from Brixton to HMP Wormwood Scrubs. Between 17 and 29 December, he was again admitted to their healthcare centre for help to control his diabetes.

1999

29. From early 1999, his prescription for glibenclamide was doubled. Throughout 1999, his blood sugar and blood glucose levels were checked and found to be persistently raised. He risked developing diabetic complications, such as nerve damage, eye disease, kidney and heart disease. Entries in his clinical record state that he had frequently declined to take his medication.

30. When he started to have problems passing urine in May, he was prescribed finasteride (a drug used to help patients who have difficulty urinating), but this did not improve his symptoms. He was referred to Hammersmith Hospital where he saw a consultant urologist in August. All the test results were normal.

2000

31. The man was reviewed by the consultant again on 2 February 2000 and the results were again normal. He was discharged with a diagnosis of bladder neck muscle weakness.

2001

32. In 2001, he was still being prescribed metformin and glibenclamide. However, when seen again in the diabetic clinic in August, the glibenclamide was changed to gliclazide (another drug used to treat diabetes). In September his metformin prescription was increased.

33. At his first parole board review on 28 September, it was recommended he should remain in closed conditions as he was still not taking responsibility for his offence and did not think he needed to address his offending behaviour.

34. In late October, his diabetes worsened but he refused to be admitted to the healthcare centre and for the next two months refused to take his medication regularly and declined regular blood tests.

2002

35. Following a diabetic clinic review at Hammersmith Hospital on 10 September 2002, his gliclazide prescription was increased. He was diagnosed as having high blood pressure and was given aspirin to help his circulation. He was also prescribed perindopril to keep his blood pressure under control.

36. The parole board considered his case again on 3 December. They noted that he had still not accepted responsibility for his offending and had not completed any offence-related courses during his sentence. The board did not recommend his release.

2003

37. By March 2003, his gliclazide prescription had been increased again. He transferred to HMP Cardiff in July in order to complete offending behaviour programmes. A full chronic disease management (CDM) review was undertaken at Cardiff and he underwent an initial diabetic healthscreen assessment.

38. He was seen by the CDM nurse, the diabetic screening service and the podiatry service (to treat the circulation in his feet) throughout his time at Cardiff.

39. In August, he had a diabetic review at University Hospital Wales (UHW). In October, he was seen by an urologist at UHW, where it was confirmed that he had an enlargement of the prostate (this is common in men as they get older). He was given a drug called tamsulosin to treat this condition.

2004

40. The man was seen at the same clinic again in January 2004, when an improvement in his enlarged prostate was reported. He continued to improve and following a final review in July, he was discharged from UHW.

41. After he has complained of headaches between January and March, he underwent a brain scan in April. The report showed that there had been some shrinking of the brain (usually associated with age), as well as the changes which had been present on the 1997 scan, presumed to be related to his previous head injury.

2005

42. The man was prescribed insulin for his diabetes from February 2005. He struggled to cope with the twice daily injections and self administered blood tests for sugar levels. In mid-March, he refused to continue with insulin and was put back onto his previous medication.

43. He was seen by a neurologist (a specialist dealing with disorders of the nervous system) at UHW in June 2005, who diagnosed a condition known as post-traumatic headache. The following month, he failed to attend an appointment with the optician and in September, he declined routine blood tests after a review of his diabetes.

2006

44. In February 2006, the parole board again refused his possible release. They noted that he had not tried to reduce his risk.

45. When seen for review and blood tests in July, it was noted that his blood glucose levels were raised. When reviewed again in November, he was noted to have some swelling of his ankles and he was prescribed frusemide (a drug used to reduce swelling of the legs).

2007

46. The mental health in-reach team wrote in the man's clinical record in March 2007 that he was being considered for a transfer to HMP Norwich's older person's unit. However, a vacancy did not arise at Norwich and he was also reluctant to leave Cardiff.

47. At his regular CDM assessment in April, he was noted to be suffering from neuropathy (the nerves in his feet and legs were not working as a result of his diabetes). In May, he was referred to a cardiologist after complaining of chest pains and when seen in August, he stated he had experienced little pain since his referral. The cardiologist diagnosed coronary artery disease (hardening of the arteries around the heart) and decided that he was currently being prescribed the correct medication.

48. During September, he was started on gabapentin (a drug used to treat pain caused by nerve damage resulting from diabetes). In December, after being reviewed in the diabetic clinic at UHW again, he was prescribed pioglitazone (another drug to help diabetes).

2008

49. During a full CDM assessment in February 2008, healthcare staff again discussed insulin injections with the man. His blood glucose levels were checked but no changes were made to his treatment. By May, his blood glucose levels had risen, but he refused to consider insulin injections.

50. In August, he suddenly developed numbness in his left hand and had a drooping left side of his mouth. He was immediately admitted to UHW. He had suffered a stroke. The next day he underwent a brain scan which showed a small blood clot on the right side of his brain. He was immediately prescribed dipyridamole to help prevent further strokes. He was also prescribed insulin to help control his diabetes. He managed the injections well but was reluctant to check his blood sugar levels.

51. He was referred for treatment in October because he had increasing pain in his feet. In December, the parole board again decided that he had not reduced his risk and should remain in closed conditions.

2009

52. By January 2009, the man's blood glucose levels had dropped following his stroke, and by November that year they had dropped further. During this time, he had regular Chronic Disease Management Reviews, diabetic screening and podiatry sessions. After dry gangrene (tissue in the toe which had lost its circulation and died) was diagnosed in December, the doctor referred him to a vascular surgeon (a specialist dealing with diseases of the arteries and veins).

2010

53. The man was seen by a consultant at Cardiff's regional vascular clinic in February 2010, where a scan of the arteries in his legs showed some hardening but no significant problems.

54. During his parole board review in May, the recommendation for a transfer to the elderly lifer unit at Norwich was noted, but Norwich made it clear that few prisoners transferred out of their unit and spaces only became available when one of the men died. The panel maintained that his risk was too high to be safely managed in less secure conditions.

55. In June, his mobility was decreasing and by July he was unable to climb the stairs. He was referred for an x-ray which showed no problems with his hips but minor wear and tear to his lower lumbar spine.

56. He underwent a CDM review in December.

2011

57. In March 2011, his blood pressure was found to be raised. He was prescribed amlodipine to lower his blood pressure.

58. In early June, he was prescribed amoxicillin (a penicillin antibiotic) for a chest infection. In early July, his medications were:

- pregabalin 300mg twice a day for nerve damage caused by diabetes
- finasteride 5mg daily for his enlarged prostate
- omeprazole 20mg daily for stomach problems
- co-codamol 500mg twice daily pain relief for joint problems
- simvastatin 20mg daily to lower cholesterol
- amlodipine 5mg daily for high blood pressure
- frusemide 40mg daily to reduce swelling in his legs
- metformin 850mg three times a day for diabetes
- amytryptiline 75mg at night to help with nerve damage
- lisinopril 10mg daily for high blood pressure
- aspirin 75mg daily for circulation
- ferrous fumarate 305mg daily iron tablet to help blood
- insulin by pen injection twice daily for diabetes

59. At his blood pressure and diabetes review undertaken on 2 August, it was noted that he had stopped smoking during the summer. His blood pressure was also under control. On 13 August, wing staff became concerned that he was finding it increasingly difficult to cope. His mobility had become severely limited and he had become incontinent on several occasions. He was transferred to the healthcare centre.

60. At 10.15pm that night, he was found on the floor of his cell. He was given a cup of tea, had his observations checked and then recovered. No injuries were noted. He was regularly monitored overnight and slept for long periods.

61. The following morning, 14 August, he remained frail and slightly confused and at 12.05pm he was noted to have a low oxygen saturation level (the level of oxygen in the blood). The duty doctor was called. He had a raised temperature of 38 degrees celsius and his chest was congested. The doctor diagnosed him with a lower respiratory tract infection and prescribed antibiotics. At 9.00pm his condition had deteriorated again. The doctor arranged for an ambulance and he was taken to UHW.

62. He was escorted to hospital by two prison officers. He was not handcuffed due to his age and because he was slightly confused. The escort officers recorded his time in hospital in a bedwatch log. He had a chest x-ray at 1.00am on 15 August, which confirmed a diagnosis of severe pneumonia (the condition was worse in his right lung). He underwent a number of investigations and continued to be given antibiotics and intravenous fluids.

63. At 7.30am that morning, the escort officers were told by a doctor that he might have tuberculosis. He was then put into an isolation ward and underwent further tests. He was also checked for legionella and HIV infections. The escort officers remained outside the isolation room.

64. At 8.10am on 16 August, he was found by a physiopherapist, who realised that he had suffered a heart attack and raised the alarm. He had no pulse and was not breathing. Hospital staff resuscitated him. They gave him an adrenaline injection and his heart was restarted by a machine called a defibrillator (which gives an electric shock to reset the heart rhythm).

65. One of the escort officers telephoned the prison control room to ask for information about his next of kin. Cardiff provided a contact telephone number for his sister, who was contacted by nursing staff at the hospital. The healthcare manager at Cardiff visited UHW with the man's prison clinical record. Meanwhile, staff at Cardiff began preparing to request his emergency release on compassionate grounds.

66. He was transferred to the intensive care unit. He was unconscious and intubated (a tube was inserted into his throat to keep him breathing). Only one escort officer remained with him after 3.30pm.

67. On 18 August, a scan of his stomach showed no major problems, but the next day, a scan of his brain showed extensive brain damage caused by oxygen starvation during his cardiac arrest. There was no sign of brain activity.

68. In the early afternoon of 20 August, the man's sister, brother, daughter and nephew came to the hospital and were informed of his situation by medical staff. All present agreed to switch off the machine keeping him alive. A 'Withdrawal of life prolonging treatment' form was completed by the consultant

69. The police, the Governor of Cardiff, the Coroner, the IMB and this office were informed of the man's death. The escort officers were offered support and prisoners and staff at Cardiff were notified. A debrief meeting was held at the prison to ensure that any immediate issues were identified.

70. The prison's family liaison officer liaised with the man's relatives. The family were invited to visit the prison to see where he had lived before he became ill. The prison also offered financial assistance towards the cost of the funeral.

71. A post mortem examination was carried out on 23 August by a consultant pathologist. The cause of death was confirmed as pneumonia. The consultant pathologist commented, "Pneumonia when severe is known to be fatal especially in the frail and elderly."

72. His nephew wrote to Cardiff on behalf of his family, commenting that his uncle had received all the care and support necessary. He added that the care he received had caused him to be upbeat and optimistic for the most part. The family were especially grateful to the medical and welfare staff, who they thought had acted with care and kindness. They thanked all the staff who had contributed to making his later life tolerable.

ISSUES

Clinical Care

73. The Clinical Reviewer completed a review of his clinical care. His findings are worth repeating in detail:

> 'The care the man received from the medical services at HMP Cardiff was good and every effort was made to try and control his diabetes. He was a reluctant patient and continued to smoke until two months prior to his death, often missed his medication and frequently declined his regular blood tests to monitor his diabetes.
>
> 'However, the medical records reviewed are medico-legally unsafe because:
>
> - The entries in the CCR [clinical record] are often illegible
> - The signatures of most of the entries are illegible
> - Incorrect diagnoses were being used, e.g. cancer of the prostate
> - There was no summary card or sheet which accurately detailed all his past history
> - Correspondence received by HMP Cardiff is not date stamped with the date of receipt
> - No attempt was made to obtain his previous GP records to confirm his complicated past history and medication.
> - Referrals were made and the letters not written for several weeks
> - No co-ordination took place to chase up letters from consultants or full discharge summaries e.g. after his admission in August 2008
> - Some of the actions taken by the doctors are not written in the CCR, e.g. referral to urologist (a specialist who treats the diseases of the pelvic region) and haematologist (a specialist who deals with disorders of the blood).
>
> 'Throughout much of his time at HMP Cardiff, he was advised that his diabetes would have been better controlled on insulin injections. In the community a great deal of support and education would have taken place to ensure that the conversion to insulin was achieved.
>
> *'Was the care he received equitable with what he could have expected to receive in the community?*
>
> 'Yes with one exception. He had regular and detailed chronic disease management (CDM) checks throughout his imprisonment. The CDM checks done at HMP Cardiff are very good, they are recorded legibly and are thorough – this is very good practice. His diabetes was poorly controlled on oral treatment and in the community every effort would have been made to convert him to insulin injections. This conversion is a frequent occurrence in the community and like him; patients are

reluctant to accept the change. Community staff are specially trained in supporting patients through this conversion and if necessary at the start the injections are given by a nurse until the patient has confidence in being able to give themselves the insulin injection.

‘There is no process in the HMP Cardiff healthcare centre to ensure that a correct medical summary is generated when a new prisoner arrives which reflects accurately the records and hospital letters. In General Practice it is normal practice to check any records of a new patient to ensure they accurately reflect the letters and records.

‘Was his death preventable?

‘No. Better diabetic control would not have prevented his death.

‘Was it foreseeable?

‘No. Patients with uncontrolled diabetes are more susceptible to infection. In spite of the poor control of his diabetes, he had few infections during his time in prison. Often patients with uncontrolled diabetes have frequent chest infections or infections of the legs (cellulitis).

‘Was the level of care provided to him appropriate and timely?

‘Yes. He had regular CDM checks, regular blood checks for his diabetes (when he agreed to having a blood test), regular diabetic eye checks, regular podiatry checks and was given an annual flu vaccination. On 14th August 2011, the duty doctor could have been alerted earlier that he was experiencing problems.

‘Was his diagnosis made appropriately?

‘Yes. Throughout his time in prison he was correctly referred to the various specialists and he was frequently given adequate information about his problems – he often did not heed that advice.

‘Were his treatments and appointments conducted appropriately?

‘Yes. There were however gaps in his care. For example after his stroke in August 2008, he should have had an ECHO (echocardiogram) and carotid artery scan (this is the artery which supplies blood to the head and neck) – Healthcare Inspectorate Wales could not find any evidence that these scans had been undertaken. Several referrals to hospital were made but no record of these referrals were made in the CCR (clinical record) e.g. referral to a urologist in 2009.

‘There is evidence from the CCR (clinical record) that over the years at HMP Cardiff, he [was] referred to various departments at UHW and

most of the time there are referral letters, but frequently there are no letters back from UHW. There appears to be a lack of communication [about] who is responsible for co-ordinating the referral process so that the doctors know whom he should be seeing and when.

'Was he provided with appropriate pain relief and/or medication?

'Yes. He had problems with diabetic neuropathy (nerve damage) in his legs and various joint pains. All the appropriate drugs were used.

'Was he given full information about their condition, care and treatment?

'Yes there is adequate evidence that he was told many times about his diabetic treatment. In his final days, his relatives were kept fully informed by UHW about his condition, his progress and the decisions made about his treatment.

'Were appropriate decisions made about the most suitable location for him?

'There are some references in the CCR (clinical record) about a possible move to HMP Norwich but the final decision about this transfer is not in the CCR.'

74. The Clinical Reviewer adds:

'HMP Cardiff has changed from written records to electronic records in November 2011. The Healthcare Centre will be using SystmOne™ software for the electronic record – this is the software used by all prisons in Wales and England. It will allow for electronic transfer of records [between prisons]. There may be a view that the introduction of the electronic record will solve some of the problems [in this case]. To some extent that is true, the records will be legible and the person entering the data will be clearly identified. However systems and processes need to be put in place with good training for all staff.'

75. We make the following recommendation in light of the Clinical Reviewer 's findings:

The Head of Healthcare should ensure that clinical staff are provided with appropriate systems and training to ensure that clinical records are accurately completed.

76. The man's diabetes was poorly controlled and he was advised that it would be better controlled with insulin injections. He was started on insulin on numerous occasions and reviewed regularly by doctors and diabetic nurses. However, after being in prison for more than a decade, he had never made it through a trial period, despite support and supervision. The Clinical Reviewer further comments:

> ‘Health Promotion in HMP Cardiff was well organised and very good, however for long-term prisoners there seems to be no incentive to change their life style. Improving the way in which patients with out-of-control Type 2 diabetes are converted to insulin would be a major learning point of this review.’

77. We make the following recommendation based on his findings to ensure that the learning from the investigation can be taken forward. We would encourage the Head of Healthcare to consider good practice in other nearby prisons in Wales;

    The Head of Healthcare should implement new methods of health promotion to encourage the conversion of patients with out-of-control Type 2 diabetes to insulin injections.

78. The Clinical Reviewer concludes:

> ‘The man presented… what will be an increasing challenge to the prison service – how to provide good diabetic care to long term prisoners, often of low IQ, who are not interested in health promotion. The health promotion would include good diabetic diet, taking adequate exercise and stopping smoking.
>
> ‘He inevitably suffered the complications of poor diabetic control - poor circulation, stroke, deteriorating vision and susceptibility to infection.’

Use of restraints

79. The man was obviously very ill when he was taken to hospital on 14 August. Because of this, handcuffs were not used during the escort or while he was in hospital. We believe this decision was appropriate and demonstrates a good understanding of risk assessment.

CONCLUSION

80. The Clinical Reviewer believes that the care the man received was good. He considers that every effort was made to control his diabetes. However, despite regular checks, he was a reluctant patient. He frequently declined tests to monitor his diabetes, ignored advice and did not complete the transition to insulin. Nonetheless, the Clinical Reviewer found that better diabetic control would not have prevented his death.

81. At the end of his life, his relatives were kept informed by hospital staff about his condition and were involved in decisions about his treatment. We hope that the investigation has helped his family to better understand his time in custody and the treatment he was offered.

RECOMMENDATIONS

1. **The Head of Healthcare should ensure that clinical staff are provided with appropriate systems and training to ensure that clinical records are accurately completed.**

   NOMS accepted this recommendation. In their response they said: "Since November 2011 we have introduced System One (Clinical IT). All staff have had training In the system and there is ongoing support provided through the ULHB. Managers have access to reports to monitor entries and ensure Records are completed correctly"

2. **The Head of Healthcare should implement new methods of health promotion to encourage the conversion of patients with out-of-control Type 2 diabetes to insulin injections.**

   NOMS accepted this recommendation. In their response they said: "The new Head of Health Care (when selected) will take this recommendation forward as a matter of urgency."