Investigation into the circumstances surrounding the death of a man, a prisoner at HMP Leicester, at hospital in October 2010

Report by the Prisons and Probation Ombudsman for England and Wales

October 2011

This is the report of an investigation into the death of a man, a prisoner at HMP Leicester. He died at hospital in October 2010, having been admitted two days earlier. He was 85 years old. The cause of death was found to be acute renal failure due to sepsis (an infection of the blood) caused by chest and urinary tract infections. I offer my sincere sympathy and condolences to his family and to all who have been affected by his loss.

The investigation was carried out by my colleagues. A review of the man's clinical care in custody was carried out by a clinical reviewer on behalf of the local Primary Care Trust. I am most grateful to him for his assistance.

I would also like to thank the Governor and staff at Leicester for their co-operation during the investigation. My particular thanks go to the Head of Safer Custody and Admissions for his work in liaising with the investigator.

When the man arrived at Leicester in June 2010, he was a wheelchair user and had a significant medical history. Caring for him was challenging and resource intensive for healthcare staff at the prison. The report makes a total of ten recommendations for areas in which practice might be improved in future. These include monitoring and acting on the results of blood tests, and the management of diabetes.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **October 2011**

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SUMMARY

1. The man was 84 years old and used a wheelchair when he was remanded into custody at HMP Leicester on 24 June 2010. He suffered with a number of chronic diseases, including insulin dependent diabetes, and took a variety of medication. He was admitted to the prison's inpatient unit on his arrival. He was sentenced to eight years imprisonment in July.

2. Throughout his time at Leicester, his blood sugar levels were checked frequently. During his last weeks, his cell was opened at night to allow his blood sugar levels to be monitored over a 24 hour period. His blood sugar levels were often erratic and his insulin dose was withheld when the levels were low. He also developed various pressure sores on his legs and recurrent urinary tract infections. On several occasions, blood and urine tests were requested but the results were not assessed. The results of a blood test taken on 31 August were not assessed for over two weeks and, although they showed that he might have renal failure, no action was taken to explore this further.

3. On the morning of 30 September, the man was unwell. An ambulance was called when an examination found that his abdomen was swollen and painful. Despite his age and very poor mobility, he was handcuffed to an officer during his first hours in hospital. He was diagnosed with acute renal (kidney) failure and was unresponsive to treatment. He died in October.

4. The clinical reviewer concludes that it is likely that he had chronic renal failure whilst at Leicester. The report makes a total of ten recommendations, many of which are taken from the clinical review. Amongst these, the recommendations concern areas including the review and assessment of blood test results and the use of restraints in hospital.

THE INVESTIGATION PROCESS

5. The investigation was opened on 5 October 2010, when the investigators issued notices announcing the investigation to staff and prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to the investigator. No one came forward as a result.

6. The investigators visited Leicester on 11 October. During the visit they met the acting Governor and the prison's family liaison officer. The investigators also visited the reception area, where they met the two officers who were on duty when the man arrived at the prison. They then visited the healthcare inpatient facility, where they saw the cell in which he lived and spoke to a healthcare officer who knew him. The investigators were provided with copies of his prison records.

7. On 18 and 21 January 2011, the investigators returned to Leicester. During these visits they interviewed five members of staff. At the conclusion of the second visit, the investigators met the Governor to feed back the initial findings of the investigation. This was subsequently followed up in writing.

8. A review of the man's clinical care in custody was carried out by a clinical reviewer on behalf of the local Primary Care Trust. He joined the investigators at Leicester during their visits in January 2011 and participated in the interviews. I am grateful to him for his assistance in this matter.

9. On 25 January, the investigator telephoned the nursing home where the man lived before being sent to prison. He spoke to the nursing manager and later received an email detailing his history at the home and a list of his medication.

10. One of the Ombudsman's family liaison officers wrote to the man's wife on 26 October 2010. She explained the purpose of the investigation and provided the opportunity for his wife to ask questions or raise any concerns that she might have. A copy of the draft report was sent to her. She subsequently telephoned the family liaison officer and explained that all of her concerns had been addressed in the report.

HMP LEICESTER

11. HMP Leicester is a local prison for adult males, situated close to Leicester city centre. It accommodates up to 392 men, mostly in a residential unit consisting of four landings. Health services are commissioned by the local Primary Care Trust and provided by Serco Health. The healthcare centre includes an inpatient unit (known as the Enhanced Care Facility) that accommodates up to 11 men. The man lived on the inpatient unit throughout his time at Leicester.

12. HM Chief Inspector of Prisons last inspected Leicester in October 2010. This inspection was a follow up to the previous inspection of June 2008, which found good provision for older prisoners and those with physical disabilities. The previous report also commented that inpatient services were "well organised" and inpatients were involved in their own care planning. The follow up report noted that health care was the subject of a number of complaints from prisoners. However, care for prisoners with chronic conditions had been developed and there was good liaison between the disability liaison officer and healthcare staff.

13. The Independent Monitoring Board (IMB, a body of local people who independently monitor and report on the prison) annual report for 2009-10 considered bathing and showering facilities for older and infirm prisoners in healthcare to be "inadequate".

14. This is the 11th death of a prisoner at Leicester since January 2007, although it is the first since December 2009 (there have subsequently been two further deaths at the establishment). Of these deaths, two were due to natural causes. The most recent of these involved an older prisoner and commended the good practice of staff at Leicester when caring for him.

KEY EVENTS

15. On 24 June 2010, the man was convicted of a serious offence committed many years earlier. He was sent to prison to await sentencing, and arrived at HMP Leicester the same day. This was the first time that he had been in prison.

16. Prior to his imprisonment, he had lived in a nursing home. The Director of Nursing at the home told the investigator that the man was a pleasant man who did not cause any problems. She said that he used a wheelchair and required one person to help with activities such as washing and dressing. He was an insulin dependent diabetic, had congestive cardiac failure (when the heart is unable to supply sufficient blood to the body's organs) and osteomyelitis (an infection and inflammation of the bone). He had also previously been diagnosed with monocytic leukaemia (cancer of the bone marrow).

17. As a result of his various conditions, the man took a variety of different medications at the nursing home. These included three daily insulin injections, metformin (anti-diabetic medication to control blood sugar), frusemide (to reduce fluid accumulation due to congestive cardiac failure) and trimethoprim (an antibiotic for urinary tract infections).

18. On his arrival at Leicester, he was taken to the reception area of the prison. In reception, checks are carried out to ensure that the prison has the authority to hold an individual. At Leicester, prisoners usually see a nurse in a room in reception for a routine health screen. However, as he used a wheelchair, he was taken to the prison's healthcare centre for his initial health screen. The staff who were on duty in reception when he arrived recalled that he seemed to be well and was not upset or troubled about being in prison.

19. In the healthcare centre, he saw Nurse A for his health screen. She recorded the address of the nursing home in which he had lived in Ireland. She noted that he was an insulin dependent diabetic and used a catheter. He had no outstanding hospital appointments. He had brought "two large bags" of medicine with him and said he was allergic to penicillin.

20. Shortly afterwards, the man was assessed by Prison Doctor A. He told her that he was able to move from his wheelchair to the bed and back. She noted that they had not been forewarned of his arrival, but were able to put some arrangements in place for the night. He was given a single cell in the inpatient unit and an additional healthcare assistant was asked to work on the night shift.

21. Following his admission to the inpatient unit, a care plan was written to set out how staff should assist the man. It was noted that two staff should assist him to move from bed to wheelchair and that he required assistance with activities of daily living. Staff were also asked to assist him to take his insulin and blood sugar readings.

22. Later that evening, Nurse B attempted to telephone the nursing home and the pharmacy that had supplied his medication. She noted that she was unable to get through to any numbers.

23. The following day, a hospital bed and pressure relieving mattress were ordered for him. (They were subsequently delivered three days later.) Nurse C noted that it had been very difficult to obtain details of the nursing home, either through contact with his family or searching other sources of information.

24. On 30 June, the man was reviewed by the prison doctor. She observed that he had what appeared to be a two to three centimetre basal cell carcinoma on his chest. (Basal cell carcinoma is the most common form of skin cancer. It does not usually spread and is often treated by simply removing the growth.) She wrote a referral to a local hospital.

25. The man settled well into Leicester. He was noted to be in good spirits and spent time talking to other prisoners. Some concern was raised on 5 July about the amount of time he spent in bed and the subsequent effects this would have on his pressure areas. Nursing staff were told that they could have permission to go into his cell after the usual 7.00pm lock up time, in order to put him to bed later.

26. A physiotherapist visited on 14 July to assess the man's mobility. The physiotherapist noted that he was able to stand upright with a walking frame, but bent over if the frame was removed. He recommended that the man initially be encouraged to stand with his frame for short periods, with a view to improving his weight transference and possibly starting to take steps.

27. Two days later, the man went to court and was sentenced to eight years imprisonment. On 21 July, he saw the physiotherapist for a second time. He had shown considerable improvement since the previous assessment and was now able to stand up and take a short walk in his cell. By his next appointment one week later, he was able to walk two lengths of the corridor with his frame.

28. Blood and urine samples were taken on 29 July, following a request by Prison Doctor B. There is no indication in the medical record that the results were considered or any action taken.

29. The man's blood sugar level was checked frequently. As the clinical reviewer notes, it was "very erratic" and his insulin dose was often withheld because of low blood sugar levels. On 6 August, a diabetes specialist nurse at the hospital was contacted for advice. The nurse advised that, rather than withhold insulin when his blood sugar level was low, his regime should be reviewed by the prison doctor so that his evening dose was reduced. Nurse D later noted that the doctor (who was not named) had agreed to this change. No entry was made by the doctor.

30. Over the following week, the man reported no concerns. He continued to walk up and down the corridor with his frame and was noted as mixing well with other prisoners. On 13 August, nursing staff were called to his cell in an emergency when he was found to be unresponsive due to hypoglycaemia (meaning that blood sugar levels are very low and insufficient to provide enough energy for the body's activities). He was treated with Glucagen (a medication that stimulates the liver to release glucose into the blood) and recovered shortly afterwards.

31. Four days later, he again experienced hypoglycaemia. He was reviewed by Prison Doctor C. The doctor reduced his insulin dose on account of his blood sugar levels generally being lower in the morning and evening. In addition, he said his feet had been swollen recently. They were examined by the doctor, who concluded that the swelling was oedema (fluid retention) that could have been caused by his heart condition.

32. On the same day, he seemingly missed a hospital appointment because the lift in the healthcare centre was broken. (The inpatient unit is on the top floor of the healthcare centre.) The purpose of this appointment is not clear from his medical record.

33. The following day (18 August), an electro cardiogram (ECG, a scan to test the electrical activity of the heart) was performed at Leicester. The results showed atrial fibrillation (abnormal heart rhythm). The doctor noted that this was likely due to congestive cardiac failure and made a referral for a chest x-ray. He also requested that a blood test be taken. This happened the following day, although there is no indication of the results in the man's medical record.

34. Following the discovery of a pressure sore on his left heel on 25 August, a community tissue viability nurse (a specialist in the prevention and management of pressure wounds) was contacted for advice. Nurse E ordered a specialist pressure relieving mattress, known as an air wave mattress. She was asked to come into the prison to review him, but was unable to do so due to funding problems. On the same day, a new pressure relieving cushion was ordered for his wheelchair as the one he had was too small for the chair. A care plan was also written to advise staff when and how to change his dressing.

35. The following day Prison Doctor D wrote several referrals to the hospital. These were to the diabetic clinic, the peripheral vascular disease clinic (on account of the wound on the heel), the disabled services centre and the cardiology department.

36. He was reviewed by Prison Doctor E on 28 August. The doctor assessed the wound on his ankle and prescribed a course of flucloxacillin (an antibiotic) to treat the wound infection. As I have noted in paragraph 19, above, he had told nursing staff on his first day at Leicester that he was allergic to penicillin (flucloxacillin is a type of penicillin). At interview, the

doctor told the investigator and clinical reviewer that he was not aware of this at the time and had not noticed the reference to his allergy in the notes.

37. That evening, nursing staff noticed the mistake and contacted the out of hours doctor, who advised them to stop the prescription. He had not yet been given any flucloxacillin. The out of hours doctor suggested that erythromycin (a different antibiotic) be prescribed as an alternative, but this was not stocked at the prison and was not therefore available over the bank holiday weekend. In addition, his blood sugar level was low and the out of hours doctor therefore advised that it be monitored hourly overnight. As a result, permission was granted for his cell door to remain unlocked during the night. For the remainder of his time at Leicester, staff checked the man's blood sugar levels regularly during the day and night. During this time the door was locked, but nursing staff were able to gain access via the night orderly officer (the member of staff in charge of the prison at night).

38. His blood sugar levels fluctuated over the weekend, and the out of hours doctor was contacted on several occasions for advice. He was given his first dose of erythromycin on 30 August. A blood test was taken the following day, although it is not clear from the notes who requested this.

39. On 1 September, the diabetes specialist nurse was contacted for advice. She recommended a reduction to his evening dose of insulin. Later that day, a tissue viability nurse visited to assess his pressure areas and the wound to his heel. She concluded that the wound was not infected and made recommendations about changes to the dressing. The tissue viability nurse also said she would follow up the air wave mattress that had been ordered a week previously.

40. The physiotherapist visited the man on 8 September for his weekly assessment. He noted that the wound on the man's heel was healing and he was able to manage short walks with his frame. The following day, an unnamed prison doctor reviewed him at the request of Nurse D on account of his continued fluctuating diabetes. The doctor told the nurse that they should continue the current regime and omit insulin as necessary. However, the doctor did not record this in the medical record.

41. The man went to the dermatology clinic at hospital on 10 September. The basal cell carcinoma identified by Prison Doctor A on 30 June was removed, and he returned to the prison the same day. Each time that a prisoner is escorted outside the prison to hospital, a risk assessment considers the risk to the public, potential for escape and likelihood of outside assistance. The assessment informs the decision about the number of escorting officers and the type of restraint to be used. The risk assessment determined that the man should be accompanied by two officers and handcuffed to one of them by means of an escort chain (a long chain with a handcuff at each end). In addition, his hands would be

cuffed together by a standard set of handcuffs. This combination of two sets of restraints is known as 'double cuffs'.

42. On 13 September, Nurse F made an entry in which he said he was cleaning the man's commode when he asked him for a drink. The nurse wrote that he asked him to wait until he had finished cleaning and that he therefore said that he would make a complaint.

43. The results of the blood test taken on 31 August were assessed by Prison Doctor B on 15 September. The doctor noted that the blood test showed that the man's thyroid stimulating hormone (TSH, a test of how well the thyroid is working) was high. (A high TSH indicates that the thyroid gland is underactive and not producing enough thyroxine. This causes some of the body's function to slow down and can lead to symptoms such as tiredness and weight gain.) He prescribed the medication L-Thyroxine (to replace the thyroxine that they thyroid gland is not producing).

44. The blood results also showed a high levels of urea and creatinine, which can indicate that the kidneys are not working properly. The doctor did not make an entry with regard to these results. At interview he told the investigator and clinical reviewer that this result showed "a degree of renal failure". He went on to say that "in an ideal world" he would have taken steps to repeat the test, but this was delayed by the man's infections and subsequent admission to hospital.

45. The man submitted a complaint form on 17 September, in which he said that Nurse F was "nasty" to him. He also said that the nurse did not clean him properly after he had been to the toilet. The healthcare manager replied to him four days later. He said that he would have to conduct a full investigation as the complaint was directed at a specific member of staff. He told him that this would involve an interview in order to obtain a full statement from him. However, he told the investigator and clinical reviewer that he did not have the opportunity to conduct this interview before he was admitted to hospital. An investigation into the nurse's conduct after the man's death found that he had referred to him in a derogatory manner. The nurse was later dismissed on account of an unrelated disciplinary matter.

46. Concerns were raised about the man's mobility on 19 September, and over the following days. Nurse A noted that he now required assistance to stand up from a sitting position and was not moving very well on his bed. On 20 September, he ate little and said he had no appetite as he was not feeling well. He did not take his daily walk as he said he did not feel "stable" enough. A food chart was started to monitor his intake.

47. On the following morning, he passed a large amount of blood in his urine. He was reviewed by Prison Doctor B later that day, who requested a urine test. A sample was taken the same day, with the results available on 22 September. There is no indication that the results were considered. On

the same day, he received a new air wave mattress after his previous mattress had begun to deflate.

48. The man's blood sugar levels fluctuated on 25 September, and his morning insulin was subsequently omitted. The wound on his heel was noted to be healing gradually. His urine was now noted to contain white pus (known as pyuria). He saw a prison doctor about this. Although no entry was made by the doctor, he reportedly advised that a urine sample be taken for testing. There is no indication that a sample was taken or of what the results might have been.

49. On 28 September, the man was due to go to hospital for an x-ray. (Although it is not clear from the notes, it is likely that this was the x-ray requested on 18 August.) However, he said he felt too unwell to attend and therefore declined to go to the appointment. That evening, his blood sugar was low and his third dose of insulin was therefore omitted.

50. The following day, the man had an appointment at the diabetic clinic at the hospital. His insulin regime was changed from three doses per day to two per day. Advice was also given with regard to managing his pressure sores. On this occasion, he was accompanied by two officers and cuffed to one of them by an escort chain only. On his return to prison, he was able to walk a few yards with the aid of his frame.

51. Prison Doctor B was asked to assess the man on the morning of 30 September, as he appeared unwell. On examination, his abdomen was swollen and painful. The doctor arranged for him to be admitted to hospital for assessment. An ambulance was called at 10.30am, and arrived 25 minutes later. At around 11.15am, whilst being taken to the ambulance, the man lost consciousness and briefly stopped breathing. He was given oxygen and recovered within one minute.

52. As previously, the man was accompanied by two officers and cuffed to one by an escort chain. However, at around 5.00pm the escorting staff were told that he was very unwell and "might not make it through the night". They contacted the duty governor, who authorised the removal of the escort chain. The Roman Catholic chaplain made contact with the man's wife to tell her of his condition. She and her two daughters and son-in-law visited that evening.

53. The man was diagnosed with acute renal failure and was unresponsive to all treatment. He died at 4.40am with his wife and daughter at his side. The cause of death was acute renal failure due to sepsis (an infection of the blood) caused by chest and urinary tract infections.

54. Following his death, the man's wife and daughters visited the prison on 9 October. During their visit they saw the cell in which he lived and prayed with the chaplain. The man's funeral was held on 22 October and was attended by the chaplain and the acting Governor. The full costs of the funeral were met by HMP Leicester.

ISSUES

55. The man spent the whole of his time at Leicester living in the healthcare inpatient unit. During this time, a lot of thought was put into helping him. A hospital bed and specialist mattress were ordered for him after his arrival and staff were allowed to go into his cell after the normal lock up time in order to help him to bed later. A physiotherapist visited on a weekly advice and his recommendations saw an improvement in his mobility for a short while. In addition, in his final weeks at the prison, nursing staff were able to take his blood sugar levels throughout the normal lock up period overnight.

56. I consider these actions to be creditable. However, there are some areas of his management that might have been improved. I discuss these in more detail below.

Location in Enhanced Care Facility

57. On his arrival at Leicester on 24 June 2010, he was admitted to the inpatient unit (known as the Enhanced Care Facility) on account of his disability and general poor health. He lived in a single cell on the unit for the remainder of his time in prison.

58. The healthcare manager told the investigator and clinical reviewer that he thought Leicester had the facilities and amenities needed to care for the man. However, he went on to say that the physical environment created barriers to delivering this care:

> "It's a very confined space … [the man's] reduced mobility coupled with the fact that he was on the top floor of a three storey building made it difficult to … get him to other parts of the prison."

59. I note that on one occasion, he was unable to attend a planned hospital appointment because the lift in the healthcare centre was broken. The healthcare manager said that it might have been possible to transfer him to a more suitable prison, but he was unsure where that might have been on account of the "intense input" that he required.

    The healthcare manager should seek to transfer inpatients for whom the facilities at Leicester are not suitable.

60. The clinical reviewer comments that it was "appropriate" to place the man in the inpatient unit. However, he comments on its suitability as follows:

> "[The Enhanced Care Facility] may be appropriate for the treatment of prisoners with acute, short term illnesses, but it may not be the most appropriate setting for people with chronic, long term illnesses and, especially, those in the last few years of their life."

61. The clinical reviewer recommends that a review is held of prison inpatient units, to determine whether there is a greater need to allocate prisoners to the specific facilities in specific prisons. Balanced against this, however, is the limited number of inpatient beds and the need to consider the prisoner's distance from home and family. Nevertheless, he considers that not all inpatient units are suitable for all patients and I agree with his view that, in principle, patients should be allocated to units with facilities that best match their need.

Staffing issues

62. The healthcare manager told the investigator and clinical reviewer that there is a total of 29 healthcare staff at Leicester. This includes general and mental health nurses, healthcare assistants and pharmacy staff. He described the difficulties they face in recruiting and retaining nursing staff and a permanent prison doctor. For some time Leicester was reliant on a number of short-term locum doctors, although a permanent doctor was recruited in February 2011. In addition, he is the fourth healthcare manager in post in four years.

63. He also explained that there is a "very basic" induction package for doctors new to Leicester. There is no formal handover of patients and he said that a doctor would receive an informal handover from a nurse if he had to see a patient on the inpatient facility. Prison Doctor B told the investigator and clinical reviewer that he did not get a handover of patients when he started at Leicester and did not receive an induction pack. Prison Doctor E said that when he started he was able to talk with Prison Doctor A, who was then working full time at the prison.

64. The clinical reviewer comments as follows:

> "There are significant recruitment and retention problems in the healthcare service in HMP Leicester … The reliance upon locum doctors means that there is a lack of continuity of care for prisoners who need ongoing medical attention and there is no one to take individual responsibility for the medical care of prisoners with ongoing problems … It appears that the staffing levels, in terms of healthcare staff, on the Enhanced Care Facility, are variable and are sometimes inadequate"

The local Primary Care Trust should review its contract with Serco Health to ensure that staffing levels on the Enhanced Care Facility are adequate.

The healthcare manager should develop a comprehensive induction pack for doctors newly employed at HMP Leicester.

The healthcare manager should ensure that a formal handover is available to doctors working on the Enhanced Care Facility at the start of each shift.

65. There are a number of occasions in which prison doctors did not record actions they had taken or recommended. There are also many occasions in which doctors made entries under the log in of other members of staff. It appears that some staff, particularly locum doctors who work on short term contracts, do not have their own log in identities. This is important, as it is then clear in the records who has made a decision or taken an action. The clinical reviewer makes the following recommendation, which I endorse:

    Every member of healthcare staff who needs access to the computer should be given a personal log in identity so that the author of every entry can be quickly and accurately identified. Doctors should always record interactions with patients and should be reminded that failure to do so is a breach of the General Medical Council's guidance 'Good Medical Practice'.

Contact with the nursing home

66. Prison Service Order (PSO) 3050 instructs that:

    > "When a prisoner enters reception … efforts should be made to retrieve any information required from the prisoner's GP or other relevant service he/she has recently been in contact with."

67. Prior to his imprisonment, the man lived in a nursing home in the Republic of Ireland for several months. On the evening of 24 June, Nurse B attempted to telephone both the home and the Irish pharmacy that supplied his medication, but was unsuccessful. The following day, Nurse C noted that it was "extremely difficult" to obtain information with regards to him.

68. The investigator was able to obtain the telephone number for the home from the internet and spoke to the Director of Nursing at the home, who provided details of his medical history. A fax number and email contact details can also be found online. (A fax number for the pharmacy is also easily obtainable online.) It is not clear why staff at Leicester were unable to contact the home. Given his age and ill health, it would have been of benefit to obtain more detailed information about his medical history.

    The healthcare manager should ensure that patient records are obtained from all relevant providers for all new receptions into custody who report a chronic disease or other serious condition in their medical history.

Management of diabetes

69. Prior to his imprisonment, the man received insulin injections three times a day to control his blood sugar levels. He continued on this regime for the majority of his time at Leicester. The clinical reviewer notes that his blood

sugar levels were checked on a frequent basis, and were "very erratic". He goes on to comment that a "significant number" of insulin doses were omitted or given late because of low blood sugar levels.

70. A diabetes specialist nurse at the hospital was twice contacted for advice, on 6 August and 1 September. He was formally referred to the diabetic clinic at the hospital on 26 August, and went to an appointment on 29 September. At this appointment, his insulin regime was reduced from three doses per day to two doses.

71. It is not clear why he was not referred to the diabetic clinic at the hospital until he had been at Leicester for two months. The clinical reviewer comments that the management of his diabetes at Leicester "did not conform to current standards". During interview with the healthcare manager, he referred to his thrice daily insulin regime as "quite unusual".

72. The healthcare manager observed at interview that Leicester is receiving "more and more" diabetic prisoners. He identified a need for staff training in the modern management of diabetes. The clinical reviewer recommends in the clinical review that this be addressed as a matter of urgency. I agree with his view.

    The healthcare manager should ensure, as a matter of urgency, that staff are, where necessary, trained in the management of diabetes.

Prescription of flucloxacillin

73. At his reception screen on 24 June, the man told Nurse A that he was allergic to penicillin. She recorded this on his electronic medical record.

74. On 28 August, Prison Doctor E prescribed flucloxacillin (a type of penicillin) to treat an open wound on his ankle. At interview, the doctor said that he was not aware of his allergy when he made the prescription and had not noticed the reference to the allergy in his medical record. That evening, nursing staff noticed the mistake and, after contacting the out of hours doctor, stopped the prescription.

75. The clinical reviewer considers the doctor's error in prescribing flucloxacillin and comments that, as the mistake was detected, "no harm was done". However, he goes on to consider how such an error might be avoided in future. The doctor entered the prescription manually on a standard prescription chart (this is required at Leicester). He did not enter the prescription on the electronic medical record. Had he done so, the system would have automatically alerted him to the problem. The clinical reviewer subsequently makes the following recommendation:

    The healthcare manager should instruct prison doctors to enter prescriptions onto the electronic medical record. Consideration should be given to moving to a computer based prescribing service.

Review of blood results

76. A blood test was taken on 31 August, following a weekend in which the man's blood sugar levels fluctuated and the out of hours doctor had to be contacted on several occasions. It is not clear who requested this test. The results were available on the same day, but were not assessed until Prison Doctor B saw them on 15 September.

77. The results of the blood test showed a high thyroid stimulating hormone, for which the doctor prescribed the medication L-Thyroxine. The results also showed a high creatinine level, which can indicate that the kidneys are not working properly. The doctor did not make an entry regarding these results. At interview, he said that "in an ideal world" he would have repeated the test, but this was delayed by his infections and subsequent hospital admission.

78. Following his death a post mortem examination gave his cause of death as acute renal (kidney) failure due to sepsis. The clinical reviewer comments as follows:

> "It is very likely that he had chronic renal failure but this was not proved while he was in HMP Leicester. Chronic renal failure means that his kidneys were functioning less well than they should have been but the situation was stable. In order to prove that he had chronic renal failure it would have been necessary to repeat the original creatinine test after an interval of a few days to show that there had been no significant deterioration or improvement. A significant deterioration over a matter of a few days would have represented the development of acute renal failure [rapid progressive failure of kidney function]. It is possible for someone with normal kidney function or someone with chronic renal failure to develop acute renal failure if they become ill for other reasons. Acute renal failure can be treated but has a high mortality rate."

79. As well as the blood test of 31 August, there were other occasions in which blood or urine tests were requested but not acted upon. Samples were taken on 29 July, following a request by Prison Doctor B, with no indication of the results being assessed. On 19 August, blood was taken at the request of Prison Doctor C. On this occasion, the results of the test are not included in the electronic medical record. A urine sample was taken on 22 September, with no indication that the results were assessed. It is obviously vital that, when tests are conducted, the results are assessed quickly and accurately to prevent any problems being missed. I therefore endorse the clinical reviewer's recommendation:

    The healthcare manager should design a protocol to ensure that all blood and urine tests requested are tracked, reviewed and acted upon in a timely manner.

Use of restraints in hospital

80. The Prison Service has a duty to protect the public and hence restraints and escort staff are routinely used when prisoners are taken out of the prison for any reason. An individual risk assessment is completed on each occasion and regular management checks are made. The assessment will consider the offences and the risk of further offending, as well as the prisoner's health and mobility.

81. The man was taken to hospital on three occasions during his time at Leicester. The first two were scheduled appointments and the third was an emergency admission. On 10 September, he went to a clinic and was accompanied by two officers and restrained using double cuffs. On 29 September he was also accompanied by two officers but on this occasion an escort chain only was used. Finally, on 30 September, he was again accompanied by two officers and initially cuffed to one by an escort chain.

82. He was an 85 year old man who mainly used a wheelchair to get about. His mobility was very limited. He was able to walk just a few yards with the help of a frame and was unable to get out of bed without assistance. There is no evidence to suggest he was an escape risk. I appreciate that his offence was very serious and he had not completed any offending behaviour work to reduce his potential risk. However, my view is that his lack of mobility meant that the presence of two officers would have been an adequate security arrangement and it would have been reasonable to escort him without the use of restraints. This is particularly the case during the final admission when he briefly lost consciousness in the ambulance on the way to hospital. In my view, it is not dignified for a prisoner – even one convicted of serious offences – to be restrained in these circumstances. I am pleased to note, however, the actions of the bedwatch staff who contacted the duty governor to ask for permission to remove the escort chain after they were told that he might not live through the night.

    The Governor should review the use of risk assessments and encourage senior managers to give greater weight to a prisoner's mobility when they assess risk and consider the use of restraints on an escort or bedwatch.

CONCLUSION

83. When he arrived at HMP Leicester, the man had lived in a nursing home for several months and had a number of care needs. Looking after him therefore took up a lot of time and resources for healthcare staff at the prison. The clinical reviewer comments in the clinical review that, on account of his age and medical history, his prognosis was “very poor”. He goes on to say that it is “not surprising” that he developed infections, which caused complications leading to his death.

84. However, the investigation has identified several areas in which practice could be improved. Among these, better systems to monitor the results of blood tests might have helped to identify his renal failure at an earlier stage.

RECOMMENDATIONS

1. The healthcare manager should seek to transfer inpatients for whom the facilities at Leicester are not suitable.

   Accepted - In order to assist with this recommendation a detailed list of the various healthcare facilities in prisons around the country would be useful in order to establish which establishments could offer suitable facilities.

   Prisoners with chronic illnesses are to have a transfer element built in to their care-plan.

2. The local Primary Care Trust should review its contract with Serco Health to ensure that staffing levels on the Enhanced Care Facility are adequate.

   No response was received to this recommendation.

3. The healthcare manager should develop a comprehensive induction pack for doctors newly employed at HMP Leicester.

   Accepted – An orientation and induction pack for new doctors is already in place, however its structure and content is limited. A new induction package is to be written and developed using multi-disciplinary input.

4. The healthcare manager should ensure that a formal handover is available to doctors working on the Enhanced Care Facility at the start of each shift.

   Accepted – The healthcare worker who is assigned duties on the Enhanced Care Facility is to formally handover (and record the handover) patients, activities and interventions.

5. Every member of healthcare staff who needs access to the computer should be given a personal log in identity so that the author of every entry can be quickly and accurately identified. Doctors should always record interactions with patients and should be reminded that failure to do so is a breach of the General Medical Council's guidance 'Good Medical Practice'.

   Accepted - Work is already in progress to ensure that all staff members have a personal log-in identity to the SystmOne computerised medical records system.

   A list of all staff members has been submitted to Leicestershire Health Informatics Service (HIS) who are managing and facilitating this changeover.

   The re-developed induction pack for doctors (see recommendation 3 above) is to include reminders to doctors of their obligations under GMC guidance.

6. The healthcare manager should ensure that patient records are obtained from all relevant providers for all new receptions into custody who report a chronic disease or other serious condition in their medical history.

   Accepted – Every effort is made to contact relevant providers currently. However a more formal system and approach will be developed in order to ensure that all avenues of information provision are exhausted.

7. The healthcare manager should ensure, as a matter of urgency, that staff are, where necessary, trained in the management of diabetes.

   Accepted - It is accepted that more up-to-date training in the management of diabetes is sourced and delivered. This has been arranged for 2 key members of staff in August 2011; this will then kick-start clinical provision on a more formal basis for the management of diabetes.

8. The healthcare manager should instruct prison doctors to enter prescriptions onto the electronic medical record. Consideration should be given to moving to a computer based prescribing service.

   Accepted - It is acknowledged and accepted that the use of the SystmOne computerised medical records system should be used to enter prescriptions on to a medical record.

   However, there remain issues with reliability of the system before the routine use of SystmOne for prescribing can be considered. Currently a good deal of “down time” is experienced with SystmOne.

   Leicestershire HIS are investigating the reasons for this and seeking a solution.

9. The healthcare manager should design a protocol to ensure that all blood and urine tests requested are tracked, reviewed and acted upon in a timely manner.

   Accepted – A protocol is to be designed in order to facilitate the tracking of tests are tracked and acted upon.

10. The Governor should review the use of risk assessments and encourage senior managers to give greater weight to a prisoner’s mobility when they assess risk and consider the use of restraints on an escort or bedwatch.

    Accepted - The risk assessment form will be amended to include more information on a prisoner’s mobility. Risk assessments are always completed by the Head of Security or the person in charge of the prison. These managers will be made aware of the issues in this report to ensure that mobility issues are taken fully into account when deciding the level of restraints.