

**Investigation into the circumstances surrounding the
death of a man in hospital whilst in the custody
of HMP Hewell, in January 2009**

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

January 2010

This is the report of an investigation into the death of a man, aged 76, who died in January 2009 at hospital, whilst in the custody of HMP Hewell. The man had been released from HMP Whatton in 16 December 2008 on a licence supervised by Staffordshire Probation Area, but was recalled to prison just seven days later. He had been transferred to Hewell from HMP Shrewsbury on 8 January 2009 and entered hospital the next day. The man suffered from confusion, heart disease, type two diabetes and illnesses common to older age. He was admitted to a medium acute unit (MAU) in the hospital, where his condition continued to deteriorate.

Her Majesty's Coroner for Worcester did not hold a post mortem into the man's death and noted that death was due to multi-organ failure. I extend my sincere condolences to the man's family and friends.

This investigation was undertaken by one of my colleagues. In addition, a review of the man's healthcare was commissioned from Worcestershire Primary Care Trust. I am particularly grateful to the PCT for ensuring the clinical review encompassed examination of the man's time in different prisons and in the community. Two clinical reviewers conducted a very thorough piece of work that has been of great assistance to the investigation, and I thank them for that. I would also like to thank the Governor of Hewell, the Governor of Shrewsbury, the Governor of HMP Whatton, and their respective groups of staff, for their help and assistance. I am particularly grateful to the liaison officer at Hewell and the liaison officer at Whatton. In addition, I would like to thank the Chief Officer of Staffordshire Probation, with whom I will share this report. The report will also be sent to the Governors of HMP Nottingham, Whatton, Shrewsbury and Hewell.

I have been particularly concerned by the arrangements made for the man's release in December 2008. Despite efforts by his offender manager, when the man was released from prison he had nowhere to live. The arrangements were woefully inadequate for a man with his needs, and there are important lessons to be learned from this investigation.

I make two recommendations to the National Offender Management Service. The recommendations reflect my anxiety over the release plans of elderly prisoners subject to Multi Agency Public Protection Arrangements (MAPPA). One recommendation (for a review of the man's case) is for the joint attention of the National Offender Management Service and the Department of Health.

I make five other recommendations to the Department of Health, three to ensure elderly and confused prisoners are medically supported and two relating to computerised records. Finally, I make two recommendations for the Governor and Head of Healthcare at Whatton. Those recommendations relate to the timely passing of information and the medical management of elderly and frail prisoners.

In this final report seven recommendations have been accepted, two recommendations partially accepted and one recommendation not accepted. That recommendation relates to the risk of computerised record systems. The Department of Health had already taken action on this issue.

The man's family have read the draft report and commented that they would be interested in reading the responses to the recommendations as noted in this final report.

This report has been anonymised, by removing names and titles, for publication on our website.

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Prisons and Probation Ombudsman

January 2010

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SUMMARY

The man was received into HMP Nottingham in June 2008 following a court appearance for domestic sexual offences. He was sentenced to one years imprisonment. On arrival at Nottingham it was noted that he was an elderly and frail man with complex medical problems including heart disease, type two diabetes, asthma and poor hearing. After spending two days in the healthcare unit the man was moved to the vulnerable prisoner wing.

He transferred to HMP Whatton on 16 July. Again, his medical history was noted on reception and he was allocated a shared cell with a prisoner who could support him with his daily prison regime. On 1 August, it was recorded that the man had confusion with some loss of memory. Four days later, he was examined by a doctor after reporting he had rectal bleeding. The doctor referred the man for a specialist appointment at a hospital.

The man was escorted to hospital on 13 August and, following a consultation, was told that an examination under anaesthetic would be arranged. The following day, his offender manager, spoke to Adult Social Services in the man's home town to set out plans for his release in December. Two weeks later, it was noted in his medical record that the man had chronic kidney disease.

On 10 September, the offender manager attended a sentence planning meeting in preparation for the man's release. A week later, the man's cell mate raised concerns to nursing staff that he was abusive to other prisoners, waking in the night to eat his breakfast, and experiencing mood swings.

The man was escorted to the hospital on 1 October for examination of his bowel complaint. However, the procedure did not take place as hospital staff felt his heart problems would preclude him from safely having an anaesthetic. Before the man returned to Whatton he saw doctors in the cardiology department.

The offender manager requested medical information from Whatton on the man's present medical condition on 5 November. Despite several telephone calls, the offender manager did not receive these details until early December.

On 29 October, the offender manager referred the man to Social Services for assistance with his care upon release. Later, the Social Services Department told the offender manager that they were unable to help as the man was presently resident in Nottinghamshire. The offender manager also made contact with Approved Premises (probation hostels) and housing associations in an effort to secure accommodation for the man.

A meeting was held on 5 December between Social Services, the Probation Service and a housing association in an attempt to find a home for the man. However, following the meeting accommodation had still not been identified.

The man was released from Whatton on 16 December and met by his sister who took him to the Probation Service offices in Stoke. No long-term accommodation had been found and eventually the man was accepted for one night by the Salvation

Army hostel. He was taken there by his sister. The following day he reported as homeless to a housing association who then placed the man in a hotel. A social worker saw the man in his hotel room on 19 December to assess his care needs.

On 21 December, the man was admitted to hospital after hotel staff called the police when the man told them he wanted to take his own life. He was discharged from hospital the following day but, because of his recent behaviour at the hotel, was denied further accommodation by the housing association. The man returned to the Probation Service offices in Stoke and it was agreed by a senior probation officer (senior offender manager) that his licence be revoked. The man was taken into police custody.

He was received into HMP Shrewsbury on 23 December. It was noted that he was frail, confused and in poor health. A medication regime was formulated and the man was moved to a wing. Nevertheless, his health deteriorated and he was admitted to hospital on 30 December.

A week later, the man was discharged back to Shrewsbury to be cared for on a wing with support from discipline and nursing staff. On 8 January, he transferred to Hewell in a high dependency ambulance for 24 hour nursing care (Shrewsbury does not have in patient healthcare). The following day, the man was admitted to hospital. His condition had continued to deteriorate, and he was in need of intensive medical treatment. At 4.00am on 18 January, the man died in hospital. The cause of death was recorded as multi-organ failure.

I conclude that the agencies involved in the man's custodial and community care failed to offer support and assistance on his release from Whatton. He was an elderly, frail, confused man who was released from prison with no accommodation or continuity of care.

I have made recommendations for the attention of the National Offender Management Service in relation to the pre-release and discharge plans of elderly and vulnerable prisoners. A joint recommendation is made to the National Offender Management Service and the Department of Health for a review of the man's case.

Further recommendations are made to the Department of Health regarding the care of elderly confused prisoners and the use of electronic records. Finally, recommendations are for the attention of the Governor and Head of Healthcare at Whatton.

THE INVESTIGATION PROCESS

1. The investigation into the man's death was opened on 19 January 2009, when my investigator visited HMP Hewell. She reviewed his medical notes and prison file and asked for copies to be sent to her.
2. The following day, the Ombudsman's notices of the investigation and terms of reference were sent to Hewell. On 22 January, the liaison officer at Hewell, telephoned my investigator and it was agreed that the notices should be forwarded to the Governor of Shrewsbury as the man had spent more time in that prison than at Hewell. My investigator telephoned the Governor's Secretary at Shrewsbury to inform her that the notices would be sent to the prison for display.
3. However, no members of staff or prisoners from either Hewell or Shrewsbury, have responded to the notices. Nor have the Independent Monitoring Board (IMB) or the Prison Officers' Association (POA) at Hewell or Shrewsbury asked to see my investigator. (Hewell and Shrewsbury both have previous experiences of death in custody investigations.)
4. A review of the man's medical care was commissioned from Worcestershire Primary Care Trust (PCT). That review, conducted by two clinical reviewers, analysed the man's medical care from his first time in custody. The reviewers carried out interviews with hospital medical staff, and with healthcare staff from Nottingham, Whatton, Shrewsbury and Hewell.
5. On 10 February, my investigator telephoned the man's offender manager and asked for copies of his probation notes to be sent to her. Notice of the Ombudsman's investigation and terms of reference were in turn forwarded to the offender manager. On 23 February, my investigator visited Whatton and spoke to the man's former cell mate and with the Resettlement Team.
6. One of my family liaison officers spoke to the man's sister to tell her about the investigation. She requested a visit from my colleagues. On 4 March, my investigator visited the Probation Offices in Stoke on Trent and spoke to the offender manager. Later, my investigator and family liaison officer visited the man's sister. She raised concerns about her brother's resettlement and accommodation plans following his release from Whatton. These are concerns I share, and I will return to them in the issues section of this report.
7. My investigator met with the Head of Healthcare at Whatton on 2 April to review the man's medical notes and interventions prior to his discharge from the prison.

HMP HEWELL

8. Hewell was created on 24 June 2008 by the merger of three formerly separate prisons located on adjacent sites (Blakenhurst, Brockhill and Hewell Grange). The new prison caters for Category B, C, and D prisoners. There are seven houseblocks on the site. One has dormitory accommodation with the remainder having single or double cell occupancy. Hewell primarily serves the West Midlands, Worcestershire, and Warwickshire areas.
9. Healthcare is provided by Worcestershire Primary Care Trust. The unit has 24 hour nursing staff on duty with in-patient care situated on the lower floor of the unit. All in-patients are encouraged to associate out of their cells, including eating in a communal dining area. There is a varied timetable of activities with nursing staff supporting patients to actively socialise together. A weekly multi-disciplinary meeting is held to discuss individual cases (both those who are physically and mentally ill).
10. The most recent report by HM Chief Inspector of Prisons on HMP Blakenhurst, (the part of the site where the man was located) was in 2006. An extract from that report said:

“Health services were good quality and safe, with adequate cover out of hours. The prison and the primary care trust were working well together to develop clinical governance and a whole-prison approach to health.”
11. There has not been an Annual Report by the Independent Monitoring Board since the clustering of the three prisons in June 2008.
12. The death of the man was the third death since the merger of the three former establishments. All the deaths have been from natural causes with no evident similarities between them.

HMP SHREWSBURY

13. Shrewsbury is a category B prison for adult men. It houses unconvicted and convicted prisoners, mainly from the magistrates' courts in the Shrewsbury, mid-Wales, and Stoke-on-Trent areas. It is a local prison and therefore prisoners serving long term sentences are transferred elsewhere. There has been a prison on the site since 1793, but the main prisoner accommodation currently in use dates from the 1870s. The site offers little room for expansion or structural change.
14. The Staffordshire Primary Care Trust (PCT) is responsible for healthcare provision within the prison. There is no in-patient hospital bed accommodation. HM Chief Inspector of Prisons last inspected Shrewsbury in June 2006. She described it as the most overcrowded prison in an overcrowded system. However, staff-prisoner relationships were mainly cheerful and mutually respectful.

HMP WHATTON

15. HMP Whatton is a category C training prison which holds men who have committed sexual offences. In recent years the prison's population has doubled, and its maximum operational capacity is now 841. In general, prisoners at Whatton are much older than the prison population as a whole. They may have been convicted of a sexual offence many years after it took place.
16. With regard to healthcare provision, nursing staff are on duty from Monday to Friday between approximately 7.30am and 7.30pm. Amongst a variety of tasks, they complete the reception of new prisoners, run clinics and triage prisoners. Different nurses have specialist training in areas such as the management of terminal illness. Doctors from local practices also hold surgeries each weekday. During the weekend, nursing staff work from approximately 7.30am until 2.30pm. During out of hours periods, nurses and prison officers can contact the Nottingham Emergency Medical Services (NEMS). (This is an out of hours service which provides medical advice and allows nurses and prison officers to speak with a doctor to decide whether an ambulance should be called. It is the same out of hours service that the general public would call.)
17. Since April 2004, I have investigated 15 deaths at Whatton. Of these, 12 were as a result of natural causes.

HMP NOTTINGHAM

18. HMP Nottingham is a category B local prison, located three miles from the city centre. It first opened in 1891 and has capacity for 550 prisoners. A Vulnerable Prisoner Unit (VPU) is located on E Wing. A modern healthcare unit opened in 2006 and provides 24 hour nursing care.
19. There have been two natural cause deaths at Nottingham since 2004. Both of those deaths were due to cardiac disease.

KEY FINDINGS

Time at HMP Nottingham and HMP Whatton

20. On 24 June 2008, the man was received into HMP Nottingham following a court appearance. The first reception health screen document noted his medical history which included heart disease, high cholesterol, type two diabetes, constipation, and glaucoma (a disease of the optic nerve in the eye). He was also hard of hearing. The man had brought his medication with him, which was logged. He was seen by a doctor, who ordered blood tests, and was admitted to the healthcare unit for observation.
21. The following day, it was noted that the man was demanding of staff time and used his cell bell inappropriately by consistently pressing for attention. Later he was located to a cell in the vulnerable prisoner unit. On 5 July, a nurse noted that he was embarrassed by fluid coming from his bowels. The nurse made an appointment for him to see the doctor. The man saw the doctor on 7 July, and was advised to take alternative medication to help with this problem.
22. The man was transferred to Whatton on 16 July and his medical history was reviewed by a reception nurse. He was allocated a shared cell. The man's cell mate's role was to ensure that the man was supported in his day to day routine and to offer help and assistance. The man's medical notes recorded that he required regular blood tests to assess his Warafin levels (Warafin is a medication used to thin the blood.) The man was seen twice daily by healthcare staff to ensure he took his medication.
23. A nurse saw the man on 1 August and recorded that he had little recall, with no memory of his family until prompted by her. He was also unsure of where he was and why he was in prison. On the same day, a member of probation staff in Stoke on Trent completed a housing questionnaire and sent it to a housing association to start the process of finding accommodation for the man on his release. The application for housing was forwarded to the man at Whatton for him to complete and return to the Probation Service.
24. On 5 August, the man had an appointment with a doctor. The doctor examined the man and noted that a further assessment for his bowel complaint should be treated as urgent. The referral to hospital was completed by the doctor under the two week rule. (The two week rule is a timescale for the patient to be seen by a hospital specialist when a cancer is suspected.) A week later, the man went to an out-patient appointment at the colorectal clinic at hospital. (This is a department which specialises in bowel disease.)
25. The man was seen as an out-patient at hospital on 13 August in the colorectal clinic, and the following day he saw a doctor. The doctor noted that the man had a painful lesion to his ear and referred him to a dermatologist. The doctor further noted that the man was unable to tell her any details of his hospital appointment from the previous day. The man's offender manager, visited the Adult Social Care Offices in Stoke that day to make a referral for the man in preparation for his release. The offender manager was told that adult social

care would not accept the referral until the man was released. The offender manager was advised that he would need to be in agreement with any involvement.

26. A letter was received by healthcare on 19 August from the hospital regarding the man's appointment and examination. Whilst no obvious abnormalities were identified it had been decided that an urgent examination of the man's bowel should be undertaken under anaesthetic.
27. A doctor noted in the man's medical notes that he had chronic kidney disease on 28 August. The following day he returned his housing application form to the Probation Service and this was forwarded to two housing associations, Aspire and Staffs Housing.
28. The man attended an out-patient appointment at the dermatology clinic at hospital on 2 September. A week later the man was reviewed once more by a doctor. The doctor noted that, following the man's out-patient appointment at the colorectal clinic, the hospital was arranging further investigations.
29. On 10 September, the offender manager attended Whatton for a sentence planning meeting. The man was unable to participate in any education or work due to his age. It was agreed that a full sentence plan would be revised when he was released in December. The offender manager tried to explain to the man about his housing needs, and an exclusion zone in the Stoke area that he would not be able to enter on his release. The man was unhappy that he might have to live in a hostel, and said he would rather stay in prison.
30. An entry in the man's medical notes on 18 September referred to concerns about his behaviour raised by his cell mate. The cell mate said the man was not sleeping through the night, eating his breakfast in the early hours, and said that wandering around the cell was disturbing him. (Prisoners are provided with breakfast packs the previous evening; they contain milk, cereals and bread.) Furthermore, the man was soiling his underwear and not using the pads supplied by healthcare staff. The cell mate said that the man had mood swings and became abusive to other prisoners. A nurse noted that these concerns would be discussed with the health team and the doctor.
31. The man was admitted to hospital for a pre-operative assessment for his bowel complaint on 29 September. The following day, it was noted that the procedure had been cancelled as it was felt there was a risk given the man's health and heart problems. He was seen in the cardiology out-patient department whilst at hospital and returned to Whatton on 3 October. Four days later, it was noted that the man seemed confused by his recent hospital admission and was unable to relay any information to healthcare staff.
32. The offender manager received a letter on 10 October from the man's cellmate, raising concerns about the man's accommodation on release. (The man had spoken to the cell mate about his worries that he would have nowhere to live when he was released.) The offender manager had also made a referral to a MAPPA panel. (MAPPA panels are drawn from the

Prison Service, Probation Service, police, and other interested parties to plan the supervision of offenders who pose a risk to the public. Level two offenders are supervised by the Probation Service and restrictions may be placed on where they live.)

33. On 28 October, the offender manager was notified that the man had been accepted by the MAPPA panel although there was some discussion on which area he should be placed as his accommodation issues were unclear. It was further noted in the referral that Social Services and Adult Social Care could not be involved until the man was resident in the community following his discharge from Whatton.
34. A letter was received by healthcare from the hospital on 12 October. The letter indicated that the man's heart problems might be more severe than previously thought. However, there was no reference in the medical record as to the outcome of the letter and any actions taken. Six days later it was recorded in the man's medical notes that he attended the healthcare unit for a blood pressure check as he was feeling dizzy.
35. On 29 October, the offender manager visited the offices of the local Social Services to make a referral for the man. She was told there was no standard format for her to refer him, and she therefore took away some information. Offender manager also made contact with Approved Premises to find the man a suitable place. The following day, the offender manager was asked by Social Services for information on his medical needs so a decision could be made to see if they could help. On 3 November, the offender manager was told by Social Services they could not offer assistance as the man was in prison in Nottinghamshire, and that therefore a referral should be made to Nottinghamshire Social Services. Nottinghamshire Social Services were unable to help as the man would be discharged from Whatton to Staffordshire.
36. The offender manager asked for medical information on the man's health needs and current medical condition from healthcare staff at Whatton on 5 November. She was told that he would need to sign a medical disclosure form before that information could be released to her. Despite many telephone calls to the prison, the offender manager was unable to find a staff member who could facilitate a disclosure form for the information.
37. The man had an appointment with the doctor on 6 November. The doctor noted that the man would soon be ready for discharge from Whatton, and that the medical investigations of his bowel had been cancelled due to the high risk if he received an anaesthetic. On 10 November, an officer in the Offender Management Unit was able to deal with the medical disclosure request and the man signed it.
38. On 11 November, the offender manager telephoned healthcare at Whatton and was told the disclosure form had been signed but the nurse she needed to speak to was unavailable. Six days later, the offender manager finally received the medical information relating to the man.

39. The doctor wrote that the man's diabetes was well controlled on 20 November and she would 'chase up' his follow up appointment with the hospital. The doctor further noted that the man was reasonably well and his main cause for concern was anxiety that he might have to live in a hostel on release.
40. The man was examined by the doctor on 2 December. He did not wish to discuss any problems he was having with his eyesight, but said he was feeling unsteady on his feet. He told the doctor he had lots of worry about his impending release.
41. On 5 December, the offender manager held a meeting with the Probation Service housing worker, a homeless worker from a housing association, and a representative of Social Services. Information was shared on the man's impending release and the urgent need to find him appropriate accommodation. Social Services said they could now complete an assessment prior to the man's release, but from the information available it seemed the man was low risk and would not be suitable for residential care. (Low risk indicated that he was able to care for himself.)
42. The housing association said they would not be able to manage his risk in their accommodation. The meeting concluded that Social Services would complete an assessment and develop a care plan. The offender manager said she would look into the possibility of a placement in Approved Premises in Cannock.
43. Later, the offender manager made contact with the Staffordshire Probation Area Manager for Approved Premises. The offender manager noted the man's health problems in an email to the manager and said that, whilst no formal diagnosis of dementia had been made, there was some cognitive impairment. The offender manager asked manager to help her find Approved Premises accommodation for the man.
44. The offender manager spoke to the approved premises manager on 10 December. The manager told the offender manager that she was unable to help identify accommodation for the man, and an out of area referral would not be accepted for the same reasons that local Approved Premises had declined to accept the man.
45. On 11 December, the man went to the out-patients ophthalmology clinic at hospital. There was to be no change in his ongoing treatment, and his next appointment would be in Newcastle in six months time. Later, the man telephoned the probation office in Stoke. He asked about his accommodation and how he was going to get from Whatton to the probation office. As the offender manager was unavailable, the man was told by a colleague of hers that he would be given money on his release to travel to Stoke. On arrival at the probation office, his accommodation issues would be discussed. The man told the offender manager's colleague that he was unhappy about this and would write to his Member of Parliament.

46. The Probation Service housing officer had contacted a local Salvation Army hostel to see if they had any rooms. He was told that the hostel already had six MAPPA offenders living there and they might not be able to help. The housing officer faxed the man's Offender Assessment System (OASys) document to the Salvation Army. (This document records a full risk assessment, in addition to details about the offender and their offending behaviour history.)

Time in the community

47. On 16 December 2008, the man was released from Whatton on licence to Staffordshire Probation. He was met by his sister and taken to the probation offices in Stoke to see the offender manager. At the time of his release he was unaware if any accommodation had been found for him or where he would be sleeping that night.
48. On arrival at the probation offices, it became apparent that accommodation for the man had not been found. The offender manager had been actively seeking suitable accommodation for the man with housing associations, the local authority and social services since July 2008. One Approved Premises was unable to accept the man due to his complex medical condition and frailty. Another Approved Premises was unable to offer him accommodation due to the denial of his offences which precluded him for participating in offending behaviour courses.
49. The offender manager spent time telephoning pension services to get the man's pension reinstated, along with an attendance allowance. She also made a telephone call to the man's community doctor. He was still registered with his previous doctor and an appointment was made for him. Lastly, the offender manager checked to find at which police station the man should report to for him to sign the Sex Offender Register.
50. Accommodation for the man had proved impossible to find. Housing options for him outside an exclusion zone had narrowed the area for where he could live. (As part of his release on licence, the man was excluded from entering a specific area of Stoke.) Accommodation away from Stoke had been considered, but information from the approved premises manager indicated that Approved Premises would not accept the man due to his complex needs and the unwillingness of local Approved Premises to accept him.
51. Social Services were contacted and said they could not assist with any housing. However, they could arrange for a social worker to visit the man and assess his needs once accommodation had been found. A housing association was unable to help at that stage but suggested that the man report to their offices the following day as homeless.
52. The Probation Service housing officer made numerous enquiries with emergency housing providers that afternoon. Eventually, an overnight stay was found in the Salvation Army hostel. Whilst these enquiries were being made, the man spent some time at his sister's home. (The man was unable

to reside at his sister's home as there was no appropriate accommodation for him.) On return to the probation offices he was told that he could stay overnight at the Salvation Army hostel. The man was reminded of his licence conditions, in that he could not contact his former wife or enter the exclusion zone.

53. The following day the man reported to the housing association offices to declare himself homeless. The housing association could only offer somewhere to stay in hotel type accommodation and he was taken to this address by his sister.
54. The offender manager telephoned the man's sister on 18 December. On speaking to the man's brother in law, the offender manager was told that the family could no longer help the man with a search for private accommodation as they had been told by Social Services that prospective landlords would need to be told of the man's licence conditions. The offender manager passed this information to the Probation Service housing officer, who then clarified the next steps with a housing association.
55. On 19 December, the man was visited by a social worker at the hotel. Following an assessment, she reported back to the offender manager. The social worker told the offender manager that the man did not fit their criteria as he was seemingly able to care for himself. However, because of his circumstances, Social Services could provide meals on wheels and a carer who would visit daily to see that he was coping. The social worker also told the offender manager that the man had been aggressive and asked her to leave shortly after the assessment had been completed. She had told him that he would need to pay for his own meals on wheels. The social worker added that staff at the hotel had told her they were concerned as the man had been up at 1.30am that morning telling the receptionist about his offences.
56. Two days later, the offender manager contacted the hotel to speak to the man. Staff told the offender manager that the man had threatened to take his life the previous day. The staff had contacted an out of hours housing team, who in turn advised the hotel to contact the police. On arrival at the hotel the police took the man to a mental health unit at a hospital as an overnight crisis admission. The following morning, the hospital discharged the man and he made his way back to the hotel. However, the hotel refused to have him back and the housing association said they had completed their duty in finding him temporary accommodation, to which he had now been refused re-entry.
57. He arrived at the probation offices and was now homeless. Following discussion with a senior probation officer, it was decided that the man should be re-called to prison with what was deemed as poor and erratic behaviour. Alternative accommodation had not been identified, the man's safety was being comprised, as was that of his victim. He was taken into police custody from the probation offices.

Time spent in Shrewsbury

58. On 23 December, the man was received into HMP Shrewsbury. A first reception health screen document noted his medical history and his medication regime was recorded. Later, he was examined by the doctor who wrote that the man had swelling in his lower legs. The doctor ordered blood tests and the man was located on a ground floor wing. The next day, he was seen by a nurse and a daily care plan was opened. The nurse recorded that the man was mobile although slow on his feet. His blood sugar levels were monitored and showed a reading of 2.2 (7-9 is an ideal reading taken before food). The man was advised to eat a good lunch; afterwards his blood sugar level had risen to 4.8 when tested.
59. The man's blood sugar levels had dropped to 3.8 at 5.15pm. He told the nurse that he had not eaten any tea and that he had been feeling unwell for several days. He also said that he had been surviving on biscuits and that he should be in hospital as he needed looking after. The man was encouraged to eat his tea and it was written up that his blood sugar levels must be checked twice a day.
60. On 24 December, the man's blood sugar levels were recorded at 3.1. He was advised to eat his breakfast and was given some biscuits. The next day, the man was verbally abusive to staff during the morning medication round. He refused his medication and demanded to be given a hot drink and to have his breakfast brought to his cell.
61. An Assessment, Care in Custody and Teamwork (ACCT) document was opened on 25 December at 6.30pm. (An ACCT document is a plan for the care of prisoners who are thought to be at risk of self harm.) The man told officers he was low in mood and unhappy to be back in custody. Furthermore, he was concerned over family issues. The man was visited by a Listener. (A Listener is a prisoner trained by the Samaritans to offer support and assistance to other prisoners.) Observations were set hourly, and it was noted that the man had a peaceful night but was up at 5.00am. At 10.00am on 26 December, the ACCT document was closed. The man was more settled, denied any thoughts of self harm, and had moved to C wing where he could associate with other prisoners.
62. At 11.30pm a nurse visited the man in his cell. He told the nurse that for half an hour he had experienced some chest pain. His blood pressure was 123/100 (a normal blood pressure is around 120/80), his pulse was regular at 95 beats per minute (a normal pulse rate is 85-110 beats per minute), and his temperature was 35.5 degrees (a normal temperature is 36.5 degrees). The man looked unwell and an electrocardiograph (ECG), a procedure to monitor the heart rate, was carried out. The ECG indicated an abnormal heart rate. An ambulance was called so that paramedics could assess the man.
63. The paramedics arrived at 12.10am the following day. They concluded that the abnormal ECG reading was related to the man's heart disease rather than any recent problems. The paramedics smelt ketones on the man's breathe.

(Ketone is an acid which is left when the body burns its own fat, and is a symptom of diabetes). A blood sugar test showed the man's level at 6.2. He was advised to eat more regularly. The paramedics advised healthcare staff to re-call the ambulance service if his condition deteriorated.

64. At 9.00am, it was recorded that the man seemed confused but was not complaining of any pain. An appointment was made for him to see the doctor in the afternoon. Later, the doctor noted the man's low blood sugar, prescribed some oral medication, and advised him to eat regularly. The doctor wrote that if the man complained of chest pain an ECG should be carried out. The man was monitored by staff at 11.00pm and at 6.30am the following day. All his observations were within normal range.
65. On 28 December at 9.00am, a nurse visited the man in his cell. The nurse encouraged the man to be more mobile and to take fluids. His blood sugar level was recorded as 4.5, but he did not complain of any chest pain. The next day, the man was seen by a nurse in his cell for his medication. The nurse noted that his blood sugar levels were down to 3.6. He was given some medication and biscuits, and his sugar level then rose to 4.2. The nurse further noted that she was unable to administer his medication and he had become abusive towards her.
66. The man's blood sugar level was noted as 3.3 on 30 December. The nurse was unable to access a vein to take blood for testing and the man was reluctant to get out of bed. The nurse recorded in the man's medical notes that he should be assessed three times a day for blood sugar levels, and a new nursing assessment plan was added to his medical record. He was referred to the doctor. At midday, the man was noted to be sitting out of bed taking some fluids and yoghurt.
67. Later that day, the man was transferred to hospital, with confusion, shortness of breath, irregular heart beats, retention of fluid in his legs and refusing to take his medication. He was escorted by two officers and restrained on an escort chain. (An escort chain is a 1.8metre length of chain with a cuff attached to the prisoner at one end and a prison officer at the other.)
68. The man was admitted to a ward for further tests and assessments. The following day at 6.10am he assaulted a senior officer (SO) on the ward. The man became abusive towards the SO and a second officer. The man got out of bed but was told by one of the SOs to return to his bed. He refused and struck out at the SO. The two officers restrained the man and applied ratchet cuffs. (Ratchet cuffs are a double handcuffs attached to the prisoner's wrists.) SO Freeman was assessed in the hospital's Accident and Emergency Department as a routine (I am pleased to say he was not injured). The man was seen by hospital staff and was also found not to be injured. Later the ratchet cuffs were removed and an escort chain re-applied.
69. At 8.00am, the man was seen by a hospital doctor who noted that he was aware of his medical condition and that, if he continued to refuse treatment, he would be sent back to Shrewsbury. At 2.00pm, a consultant from the

hospital requested that the man be returned to Shrewsbury. However, he would require intra vein medication for the next seven to ten days. As Shrewsbury does not have 24 hour healthcare, the healthcare units at HMP Birmingham and Hewell were contacted to see if they had room for the man with his complex medication. Both prisons were unable to accommodate him and he stayed as an in-patient in the hospital.

70. Over the next seven days, the man remained in hospital. There was little change to his physical health although he was responding to medication and the fluid in his legs was receding. However, he was still confused. On 7 January 2009, the man was discharged back to Shrewsbury. It was written in his medical notes that a catheter had been inserted to drain his urine and he was incontinent of faeces. (A catheter is a tube that is inserted externally into the bladder.) The deputy governor was concerned that whilst the man was in hospital he had been fed by nursing staff. On his return he was seen by the doctor. The doctor noted the man's observations and a care plan was written for the attention of nursing staff. He was placed in a cell on a wing as there is no in-patient healthcare.
71. A nurse visited the man in his cell to dispense his medication at 9.50pm. The nurse recorded that he was looking frail, confused and unsure of where he was. He took his medication, but at 10.45pm a wing officer asked the nurse to visit the man again. He was demanding sleeping tablets and becoming agitated. The nurse re-assured him and made him comfortable. An hour later, the nurse returned to see him. She helped him to take some fluid and assisted him to sit up in his bed.
72. At 2.50am the following day, the man was seen by the nurse. He was agitated, shouting and banging his table. The nurse made him a hot drink and made sure he was comfortable. At 7.15am, he was given breakfast which he managed to eat by himself. A full nursing care plan was now in operation and he was assisted with his personal hygiene.
73. The man was next seen by a nurse at 11.30am. The nurse assisted him to take his medication and noted that he had sat out of bed to eat some lunch. The man's blood pressure was recorded as low at 97/77 with a pulse rate of 79. His blood sugar level was high at 10.1. The nurse wrote that the man would be seen by a doctor in the afternoon. Later, the man was examined by a doctor who made contact with Hewell to find out if they had any spare beds in their healthcare unit as the man was now in need of 24 hour nursing care.

Time at Hewell

74. The man was transferred to the healthcare unit at Hewell at 6.30pm. He was escorted from Shrewsbury in a high dependency ambulance with two officers and a nurse and not restrained. (This journey would take around an hour and a half.) On arrival at Hewell, a nurse attended to the man and assisted him to settle in his cell. The nurse noted that he looked pale and had some swelling in his legs. His urine collection bag was changed and it was also noted he was incontinent of faeces. The nurse gave the man some toast and a hot

drink, which he vomited back ten minutes later. The nurse wrote that he would need a full care plan formulated, and arrangements were made for access to his cell overnight so night staff could tend to his needs.

75. On 9 January at 6.00am, the man's medical notes recorded that he had been trying to climb out of bed and was very unsettled, banging his cup and shouting for the door to be left open. A nurse noted he was confused and disorientated and would need to be examined by a doctor. Later, a doctor wrote in the man's medical notes that he had fluid retention, nausea and abdominal pain. The doctor requested blood samples with regular monitoring of his observations.
76. A nurse attended to the man at 2.00pm and wrote that he had been incontinent of faeces several times and that his urine output was poor. The nurse asked that the man be seen again by a doctor and at 4.00pm he was examined. The doctor recorded that the man was too ill to be in prison and he was transferred to hospital at 5.00pm. Two officers acted as an escort, and the man was restrained by an escort chain. The man's risk assessment completed prior to his admission to hospital noted his conviction and the previous assault of an officer in Shrewsbury.
77. The man was admitted to the hospital and placed in the resuscitation unit. Later he was transferred to medium acute ward. On 11 January, the healthcare staff made contact with the hospital for an update on the man's condition. They were told that he was eating and drinking with encouragement, but was still disorientated. Three days later, the hospital told the healthcare unit that the man was now in multi-organ failure. The man's next of kin details (the contact details for his sister) were passed to hospital staff so they could be contacted. The duty governor reviewed the use of restraints and authorised their removal.
78. On 16 January, the man was noted to be very poorly and still confused. On 18 January at 3.55am, the man passed away. The cause of death was noted to be multi-organ failure.
79. Hewell's family liaison officer spoke to the man's sister and offered support following her brother's death. The liaison officer gave the man's sister information on funeral arrangements and the prison's obligation to provide financial assistance towards expenses. However, the man's sister said that he had made financial arrangements for his funeral prior to his death.
80. The man's sister subsequently made contact with my family liaison officer. The man's sister said she would in fact appreciate some financial assistance towards her brother's funeral expenses, and that she had not fully understood that the prison could offer help towards the cost. On 6 March, my investigator spoke to Hewell's liaison officer about funeral expenses. The liaison officer made contact with the man's sister and discussed how Hewell could help.
81. As the man had been in Hewell for a short period, the liaison officer then spoke to the Governor of Shrewsbury who agreed to assist the family with

funeral expenses. I should say at this point that I appreciate the manner in which this sensitive matter was handled both by Hewell and Shrewsbury.

ISSUES

82. A clinical review was commissioned from Worcestershire PCT. I am particularly grateful to the PCT for agreeing to review the man's healthcare across the four prisons in which he had served his sentence. As noted earlier, two clinical reviewers carried out an in depth and comprehensive analysis of the man's medical care.
83. The man's sister had a number of concerns about the way her brother was treated, in particular by the Probation Service in regard to his accommodation needs on release from Whatton. She wanted to know why the arrangements broke down, and why the man was left homeless and unsupported before Christmas. It seemed to the man's sister that he appeared to fall between Social Services and the Probation Service, with neither offering any real help to a sick and confused elderly man. I have great sympathy with this view.

Clinical care whilst in custody at Nottingham and Whatton

84. The clinical reviewers visited both healthcare units. They noted that the man gave a poor history when providing healthcare staff with details of his present medical condition. Nevertheless, both prisons identified his main health problems and seemingly managed them appropriately and to an expected standard. I summarise their other findings below.
85. On the man's reception into Nottingham, his medical history was noted, confirmed with his community doctor, and he appeared to be frail. He was admitted to the healthcare unit for observation and assessment, then transferred to the vulnerable prisoner unit.
86. The man was received into Whatton on 16 July 2008 and seen by reception healthcare staff. His medication was recorded and the man was located on a wing to share a cell with a prisoner who could support him. In August, he was referred to hospital for further medical investigations into rectal bleeding.
87. A referral to a dermatologist in September for a lesion to his ear did not reveal a malignancy (a tumour associated with cancerous cells). In October, a surgical procedure to examine his bowel was cancelled due to his other health problems.
88. Blood and urine tests carried out at Whatton indicated that the man had chronic urine failure and anaemia. However, the clinical reviewers note that these conditions were managed and monitored regularly. They comment:
- “We are satisfied that the day-to-day management of the man's illnesses in all four prisons and the hospitals was appropriate and of a high standard. Given the policy aim to ensure that as far as practicable prisoners receive the same level of healthcare as would people in the community, it appears to us that the man received more regular input from GPs and specialist nurses than many people outside prison might expect. The one criticism that we have is that HMP Whatton did not produce a

detailed care plan bringing together the management of all of the man's health problems. Instead, nursing staff appeared to rely on their protocols for the management of various chronic diseases."

I endorse the recommendation made by the clinical reviewers

All prisoners with chronic disease should have a care plan which considers how their conditions will be managed whilst in custody, wherever they are located in the prison.

The management of the man's confusion

89. It was recorded in the man's medical notes that he seemed to be confused on numerous occasions. In November 2007, the man underwent a detailed psychological assessment and it was noted that he might have been suffering from a dementing process but diagnosis was uncertain. The psychologist recommended that a further assessment in six to nine months time might be able to determine whether this was the case. The clinical reviewers comment:

"However, a further assessment did not take place. It is unclear whether this report was made available to prison healthcare staff but some of them appeared to be aware of it."

90. On 1 August 2008, the man was noted to have an episode of acute confusion. He said he felt peculiar and was unable to recall anything about his family. Whilst this episode passed, there were other incidents when he was observed by healthcare staff, prisoners, and others, to be confused. There was no plan to explore this and to see if there was a clinical reason for the confusion.

91. The clinical reviewers write that there were 'significant differences' in the ability of the prisons to cope with the needs of older prisoners. Nottingham appeared to have addressed some of the issues and had set up separate older adult clinics and chronic disease clinics. Whatton was similarly well organised with dementia awareness training for staff, and a buddying scheme for prisoners to speak to each other about any concerns they had. Age Concern regularly visited Whatton, along with visits from an outreach psychiatrist.

92. The clinical reviewers say:

"Whether or not the man had dementia, he appears to have manifested some behavioural and personality problems that were not fully addressed. He was variously described as belligerent, abusive, aggressive, difficult, controlling and manipulative, although not all the time. The risks presented by the man's confusion and behaviour could have been better addressed when decisions were made about his needs at the time of release."

93. I endorse the following recommendations made by the clinical reviewers, the first of which is consistent with the British Geriatrics Society guidance. I would urge the Department of Health to consider them all:

All prisoners over the age of 65 should undergo cognitive testing using an appropriate screening test (Abbreviated Mental Test or Mini Mental State Examination) when they are first received into prison.

Healthcare units in prisons which receive elderly prisoners should have protocols for the investigation and management of delirium and dementia in older people.

All prisoners who are identified as being confused or delirious should be properly investigated to identify and treat, if possible, the underlying cause of the confusion.

Discharge Arrangements

94. The man's sister told my colleagues, my colleagues, that she had made eleven telephone calls to the offender manager prior to his release regarding her concerns for his accommodation. The man's Probation Service record noted the calls his sister made in relation to his accommodation needs. On each occasion she was given an update on the situation.
95. The man also made telephone calls from Whatton to the Probation Service and was similarly updated. However, it caused him great concern that nowhere had been found for him to go on his release. This could not have helped his mental health and he understandably became anxious and distressed.
96. On 5 November 2008, the offender manager made a request to healthcare staff at Whatton for news on the man's current medical condition and health needs. It took nearly two weeks before the offender manager received this information. Trying to track the correct staff member who could deal with the disclosure form and get it signed took five days. It then took 11 days before the offender manager received the necessary medical information from Whatton.
97. This was a significant delay in accessing the man's current medical condition. Plans for his impending release were already proving to be extremely difficult, and the man's medical history was an important part of identifying suitable accommodation and support services for his release. The following recommendation is directed to Whatton:

All requests for medical information should be dealt with in a timely manner. Medical information, deemed to be an important part of release plans, should be prioritised.

98. Previous enquiries and approaches to Approved Premises had been made by Offender manager. Those approached had said their premises were not able

to provide suitable accommodation for the man's complex needs. No accommodation could be found for the man that was not in the exclusion zone or was too far from his probation officer. It was crucial that the man be located near to the offender manager, so she could continue to monitor his progress and supervision, taking into account his age, mobility and poor state of mind.

99. MAPPA had been alerted to the man's release, but his accommodation had proved difficult to arrange, and their role at this stage was limited until it had been addressed. Nevertheless, MAPPA have overarching supervision of offenders in the community. A proactive approach by the panel might have offered some assistance in finding suitable and appropriate accommodation for the man.
100. The Area Manager for Approved Premises, was contacted for assistance in finding a place for the man. Despite the offender manager writing detailed information outlining the man's circumstances and the urgent need to find accommodation, the manager was unable to assist the offender manager in identifying a suitable place.
101. In several of my death in custody reports of residents of Approved Premises, recommendations have been made with reference to elderly prisoners being released to inappropriate accommodation. Staff working in hostels and Approved Premises are not trained or resourced to cope with residents whose physical and mental health needs preclude them from participating in hostel life. The man's medical condition and state of confusion would not have made him suitable for hostel accommodation. However, because no other accommodation had been identified for him, senior managers in the Probation Service should have made efforts to ensure that a probation supervised facility was found.
102. The man displayed signs of confusion, aggression and anxiety throughout his prison sentence and subsequent release. During his time in Whatton a full mental health assessment was not undertaken, despite healthcare staff being alerted to his confusion and erratic behaviour by his cell mate. Nursing staff also noted his behaviour. A mental health assessment might have offered evidence of the social care the man would need on release. It could then have been used to support applications for appropriate accommodation.
103. I make the following recommendation to the National Offender Management Service, which is endorsed by the clinical reviewers, to be implemented with immediate action.

Elderly prisoners approaching release from custody, especially those displaying signs of mental health problems, should have a full assessment prior to release so their individual situation can be reviewed when pre-release accommodation is being sought.

104. On 16 December, the man was released from Whatton with no known address where he was going to live. This caused him great distress and

could not have helped his mental state. He was met at Whatton by his sister, who then drove the man to see his probation officer in Stoke.

105. On arrival at the probation offices, it became known that the man's accommodation for that night had still not been identified. Despite the work completed prior to his release and on the day of release, the only accommodation that could be found for the man was one night in a Salvation Army hostel. This overnight accommodation did not include a bed and the man spent the night in a chair. The Salvation Army was unable to offer any more assistance as they had already provided accommodation for six other high risk offenders.
106. The following morning, the man reported as homeless to a housing association and was placed in hotel type accommodation with no meals provided or facilities to cook food. It should be remembered that the man was 76 years old, frail and confused. This accommodation was totally inappropriate for his needs.
107. An assessment by a social worker who visited the man on 19 December indicated that meals on wheels could be provided on a daily basis, and a carer would visit him each day to ensure he was taking care of his personal hygiene and medication. The man refused the social worker's help when he was told that he would have to pay for those services.
108. It is not surprising that the man was unable to settle in this environment. Hotel staff became concerned when he spent one night telling the receptionist about his offences. On 20 November, he told hotel staff he would take his own life. They made contact with the housing association who told the staff to contact the police.
109. On arrival of the police, the man was taken to a local mental health unit in a hospital as a crisis admission. During the night he tried to discharge himself from the hospital. The following morning he was discharged by doctors as his mental health needs were deemed as low risk for that unit.
110. The man returned to the hotel and was told that he could no longer stay there. The housing association refused him further help by saying he had made himself intentionally homeless. When the offender manager became aware of the situation, and following discussion with her line manager, a decision was made to re-call the man to prison. In the circumstances there seemed be no other option at that time, taking into account the man's safety and that of the public. Nevertheless, the revocation of the man's licence was due to the breakdown on the part of the agencies supposed to provide support for the man following his discharge from Whatton. A recall on these grounds demonstrates the degree to which the Prison Service has become a default social service and a backstop to the welfare state.
111. The clinical reviewers analysed the man's inadequate discharge arrangements from Whatton. The reviewers refer to a joint Nacro and

Department of Health document published in 2008. An extract from that document says:

“Prior to discharge, arrangements for a single multi-disciplinary assessment should be made to identify each older prisoner’s needs. Inter-agency co-operation is essential to ensure that details of this assessment are shared with any organisations who will be involved with a prisoner following release. Probation, social services and relevant statutory and voluntary community agencies that support older prisoners in custody should also be made aware of the assessment to ensure they have the information they need to put in place appropriate support networks in the community for older prisoners, especially during their first few weeks on the outside.”

112. The reviewers further comment:

“We have noted elsewhere our concerns about the man’s behaviour and state of mind. It is clear that at the time of his release he was not considered to have dementia (although there had been no recent assessment), and the staff at hospital did not appear to think that he had mental health problems that warranted treatment. However, it is possible that inadequate consideration was given to behavioural factors in assessing where he was to be housed and how he would cope. When, through his unacceptable behaviour, he lost the temporary accommodation the housing agency had belatedly arranged, it appears that they considered that they had no more responsibility to house him. We heard different perceptions about the man’s attitude to his release. He had not been happy in prison, but the hope of release was offset by the terms of his licence, which prevented him from returning to his wife. He seemed to find it hard to acknowledge or come to terms with this. The lack of certainty about his new home, such that he became homeless as he left the prison, and the subsequent inadequate provision, would not have been helpful to a man of his age and ill health.”

113. I judge that there was an almost total failure to provide for the needs of a man who fell between the gaps in the provision of social care.

114. The following recommendations are for the National Offender Management Service and Department of Health and are similarly endorsed by the clinical reviewers in the clinical review.

The National Offender Management Service and Department of Health should urgently review plans for elderly sex offenders who require support, accommodation and care when they are released from custody.

The National Offender Management Service and Department of Health should hold a review of the man’s case and any learning points that arise from that review should be implemented immediately.

The Role of the Offender Manager

115. The offender manager commenced work on the man's release plan as soon as he was sentenced. Housing applications were made, and Social Services and Adult Social Care Services were contacted. Managers of Approved Premises were approached for accommodation. All avenues to provide suitable accommodation were exhausted up to the day of his release.
116. Staffordshire Social Services informed the offender manager that an assessment of the man's needs could not be made whilst he was in Whatton, which was out of their area. Likewise, an assessment by Nottinghamshire Social Services was not undertaken as the man was not going to live in their area on release. Whilst the actions and inactions of a local authority are beyond my terms of reference, I note that the result was that no social care assessment was carried out.
117. The offender manager had looked at all the avenues open to her to find suitable accommodation for the man. I commend her for doing so. Offender manager spent time on the day of the man's release sorting his pension, attendance allowance and doctor. She referred his case to the Probation Service housing worker, who used his contacts to try to find the man accommodation. The only housing that could be found was a temporary overnight stay at a Salvation Army hostel.
118. The man's Probation Service notes record in great detail the interventions the offender manager made in her search for accommodation. Approved Premises failed to offer the man a place to stay and no alternative premises were found. The man's supervision by the offender manager was an essential part of his rehabilitation and to ensure he did not enter the exclusion zone or make contact with his former wife. Nevertheless, accommodation out of the Staffordshire area had not been sought, and the man's supervision passed to a 'caretaker' probation officer.
119. I fully understand why the man's family feel the Probation Service and the offender manager failed to support the man when he was released. However, it is evident that the offender manager tried all avenues to identify a place for the man to live within the confines of his licence conditions. Far from criticising her, I am impressed by her actions and would ask the Chief Officer of the Probation Area to pass on my comments. However, there was a systemic failure that I have found both disappointing and alarming.

The man's time in custody following his recall to prison

120. On the man's reception into Shrewsbury, the clinical reviewers find that he had fluid retention in his lower legs which indicated cardiac failure. He was placed on a wing in a single cell and received support from discipline officers along with nursing care from healthcare staff. He was uncooperative, failing to take regular fluids, food, and medication, and he was admitted to hospital for one week, returning to Shrewsbury on 7 January 2009. The reviewers comment:

“During his [The man’s] short stay in Shrewsbury he had an episode of chest pain. He was appropriately treated, prison healthcare staff carried out detailed observations including pulse, blood pressure, oxygen saturation and ECG before calling for a paramedic assessment.”

121. Following the man’s admittance to hospital and subsequent discharge back to Shrewsbury, it became apparent that the prison did not have the appropriate medical facilities to care for him. Following his transfer to Hewell, he was admitted to their in-patient healthcare unit on 8 January 2009. However the man’s condition continued to deteriorate and he was admitted to hospital on 9 January.

Clinical record keeping

122. The clinical reviewers received copies of records from the healthcare units of the four prisons where the man had been located, in addition to Probation Service records. Both Nottingham and Whatton used SystmOne computerised records, whilst Shrewsbury’s and Hewell’s records were, for the most part, hand written documents.
123. This was the reviewers’ first experience of SystmOne records. But even after familiarisation, the clinical reviewers found some difficulties in establishing a full chronology of the man’s medical interventions. The reviewers found there was a multitude of codes, some duplication, and omission of some medical information.
124. The clinical reviewers have referred to the inconsistency of statements and recordings across SystmOne and the ongoing issues relating to prisoners moving from prisons where there is a change in the format of recording on medical notes. They note an example of a version of medical information held in the man’s medical notes on SystmOne from Whatton:
- “Reminder: Take Care – Risk to Females High Priority Expires: Never”
This did not appear in all versions, and we did not receive an adequate explanation as to its status or why it was there as a statement with potentially significant consequences. Female healthcare staff told us that they did not feel at risk with the man, but this statement had implications for the way his release was handled.”
125. As a result of the clinical reviewers comments in the clinical review, I endorse the following recommendations

The Prison Health IT Implementation Board (PHIT), should note the problems that we have identified with the use of filters and the scanning and retention of both incoming and outgoing documents, and consider whether revised operational guidance should be issued to address these.

Consideration should also be given to the risk that the development of a computerised record system might lead to a failure to ensure that prime documents are completed properly; there should be a clear evidence trail that documents such as consent forms have been understood, signed and dated.

Following the man's death

126. The man's sister told my colleagues that following her brother's death the staff at Hewell had been very helpful and supportive. She was particularly grateful to deputy governor.
127. Following my colleagues' visit to the man's sister, she made contact with my family liaison officer enquiring about financial assistance towards her brother's funeral. My investigator made contact with the family liaison officer at Hewell. The liaison officer told my investigator that she had discussed funeral arrangements with the man's sister following his death, but understood from her that the man had taken care of his funeral arrangements before he died.
128. The liaison officer contacted the man's sister and reiterated an offer towards funeral expenses. As Shrewsbury was the prison where the man had spent more time than in Hewell, it would be Shrewsbury who would assist with the financial contribution. I understand these expenses have been forward to the man's sister. As I have said earlier, I think these matters were well-managed. In particular, I note the good practice of HMP Shrewsbury in taking on the responsibility of providing financial support

CONCLUSION

129. The clinical reviewers have concluded their clinical review with the following statement. Their conclusion accurately sums up how I feel at the end of this investigation:

“The man was a sick man when he first went into prison. The healthcare that he received in prison was generally very good despite the failure to properly investigate his confusion and the lack of proper care planning at HMP Whatton. It is unclear whether these shortcomings contributed to the speed or manner of his death. What is clear is that the arrangements for his release were inadequate. There was a lack of effective coordination between the various agencies resulting in a failure to provide the man with appropriate accommodation on his release. Whilst we cannot point the finger of blame at any one individual or organisation, we can safely say that the man was poorly served by the system. The resulting revocation of his licence and his return to prison were, in our opinion, wholly preventable and may well have been important factors in his subsequent rapid demise. We sincerely hope that all agencies will learn lessons from this tragic episode and ensure that it is never repeated.”

130. It is apparent that the man was unprepared for his release and the agencies that should have supported his transition from custody into the community failed him. As previously noted no individual or agency was wholly and individually responsible for this failure. It was a systems failure. The National Offender Management Service should address the recommendations in this report with urgency.
131. After the man was recalled to prison it is evident that he received a good standard of healthcare, at least the equivalent of that he would have received in the community.

RECOMMENDATIONS

National Offender Management Service

1. The National Offender Management Service and Department of Health should urgently review plans for elderly sex offenders who require support, accommodation and care when they are released from custody.

Accepted – “NOMS will convene a meeting with DH to discuss this.”

2. Elderly prisoners approaching release from custody, especially those displaying signs of mental health problems, should have a full assessment prior to release, so their individual situation can be reviewed when pre-release accommodation is being sought.

Accepted – “These are issues that are being considered by NOMs as part of the Isle of Wight project.”

National Offender Management Service and the Department of Health

1. The National Offender Management Service and Department of Health should hold a review the man's case and any learning points that arise from that review should be implemented immediately.

Partially Accepted – “The issues identified will be picked up by work in hand:-

- Review of initial screening
- Implementation of older prisoners care pathway.

Information flows available from completion of PHIT.

Department of Health

1. All prisoners over the age of 65 should undergo cognitive testing using an appropriate screening test (Abbreviated Mental Test or Mini Mental State Examination) when they are first received into prison.

Partially Accepted – “The care pathway for older prisoners includes provision for cognitive testing. Offender Health aim to implement the care pathway nationally in due course.”

2. Healthcare units in prisons which receive elderly prisoners should have protocols for the investigation and management of delirium and dementia in older people.

Accepted – “Good practice requires such protocols to be in place. Offender Health will review and establish best practice.”

3. All prisoners who are identified as being confused or delirious should be properly investigated to identify and treat, if possible, the underlying cause of the confusion.

Accepted – “Good practice requires the condition to be investigated. This issue will be covered in any best practice guidance.”

4. The Prison Health IT Implementation Board (PHIT), should note the problems that we have identified with the use of filters and the scanning and retention of both incoming and outgoing documents, and consider whether revised operational guidance should be issued to address these.

Accepted

5. Consideration should also be given to the risk that the development of a computerised record system might lead to a failure to ensure that prime documents are completed properly; there should be a clear evidence trail that documents such as consent forms have been understood, signed and dated.

Not Accepted – “This issue has been addressed in the wider NHS as systems are implemented. Professional responsibility for record keeping should be emphasised during training for new implementations.”

Governor and Head of Healthcare at Whatton

1. All requests for medical information should be dealt with in a timely manner. Medical information, deemed to be an important part of release plans, should be prioritised.

Accepted – “Systems are in place to ensure all requests for medical information are dealt with in a timely manner.”

2. All prisoners with chronic disease should have a care plan which considers how their conditions will be managed whilst in custody, wherever they are located in the prison.

Accepted – “Systems are in place to ensure that care plans are raised for all prisoners who are assessed as needing one.”