Investigation into the circumstances surrounding the death of a man, a prisoner at HMP Highpoint, in January 2010

Report by the Prisons and Probation Ombudsman for England and Wales

June 2011

This is the report of an investigation into the death of a man, a prisoner at HMP Highpoint. The man died in January 2010 at outside hospital. He had spent the majority of the previous three months as a hospital inpatient. The cause of his death was pneumococcal pneumonia (an infection of the lungs) and pulmonary fibrosis (scarring of the lungs) with a secondary condition of HIV infection. I offer my sincere sympathy and condolences to the man's family, and to all who have been affected by his loss.

The investigation was carried out by one of my colleagues. A review of the man's medical care in prison was carried out by a clinical reviewer on behalf of the Suffolk Primary Care Trust. I am most grateful to him for his assistance. I apologise for the delay in publishing this report.

I would also like to thank the Governor and staff of Highpoint for their full and ready co-operation during the course of the investigation. My particular thanks go to the head of residence for her work in liaising with the investigator.

The person who is the subject of this report was a man who knew his own mind with regards to his medical treatment. He had a long history of significant medical conditions, including heart disease and the HIV virus, but consistently refused interventions. The clinical reviewer concludes that the man's medical care was equitable to what he could expect to receive in the community. Nevertheless, there are some areas in which more could have been done. My report makes five recommendations, all relating to the man's clinical care, and highlights an example of good practice.

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

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

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SUMMARY

This man had a significant medical history before he arrived at HMP Elmley on 17 April 2009. He had been diagnosed as HIV positive many years earlier whilst living abroad and, after a heart attack in 2000, underwent double bypass surgery. Despite these significant conditions, he regularly missed hospital appointments and did not take medication for either his HIV or heart disease.

These omissions continued following his reception into prison. At Elmley, he was prescribed medication for his heart disease but rarely took it. He did agree to have a chest x-ray but the results were not reviewed for some time afterwards and the prison doctor who carried out the review was mistakenly told that the man had left the prison. The clinical reviewer makes a recommendation regarding improvements to clinical governance procedures at Elmley.

Following his transfer to HMP Highpoint on 20 July 2009, the man continued to refuse his medication. He told healthcare staff that he was "intellectually superior" to other prisoners and indicated that he knew better than anyone else how to look after his health. Two months after his arrival at Highpoint, the man began to report symptoms including chest pain and difficulty breathing. An out of hours doctor was asked to see him but apparently refused as the symptoms were "too vague". The report makes one recommendation about the out of hours service at Highpoint.

The man was admitted to hospital on 28 September, where he was diagnosed with pneumonia. His condition deteriorated rapidly on 1 October and he spent several weeks in the hospital's intensive care unit. His condition improved in November and, by 23 December, he was well enough to be discharged. Rather than returning to Highpoint, he was taken to HMP Chelmsford so he could live in their inpatients unit and therefore be monitored more closely.

After a week at Chelmsford, the man was admitted to hospital again. He suffered a significant deterioration on 7 January 2010 and, the following day, his registration was transferred back to Highpoint. This was to enable consistency in the arrangements in the event of the man's death, as staff at Highpoint had been in regular contact with his family since 1 October 2009. (I consider the extent of their contact to be an example of good practice.) The man's condition did not improve and he died soon after.

Including those noted above, my report makes five recommendations. Three of these refer to the man's time at Elmley and two to Highpoint. Nevertheless, the clinical reviewer concludes that the medical care the man received was "equitable with the wider community".

THE INVESTIGATION PROCESS

1. The investigation was opened on 11 January 2010 when the investigator 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.

2. The investigator visited Highpoint on 19 January 2010. During the visit he met the Governor, Head of Healthcare and the Deputy Chair of the Independent Monitoring Board (IMB, a body of local people who independently monitor and report on the prison). The investigator also visited the unit where the man lived and met a prisoner who knew him well. He was provided with copies of the man's prison records, including the medical record.

3. A review of the man's medical care in custody was carried out by a clinical reviewer on behalf of the Suffolk Primary Care Trust. The clinical reviewer and the investigator visited Highpoint on 19 May and interviewed a prison doctor. They also visited HMP Swaleside on 27 May to interview a doctor who had previously worked at the neighbouring HMP Elmley, where the man lived before his move to Highpoint.

4. The Ombudsman's senior family liaison officer wrote to the man's mother on 8 February 2010. She explained the purpose of the investigation and provided the opportunity for them to ask questions or raise any concerns they might have. The man's mother did not raise any issues for the investigation to address. I hope this report clarifies any issues that might remain unclear for the man's family and helps them better understand what happened in the time leading to his death.

HMP HIGHPOINT

5. HMP Highpoint is located near Stradishall, around 13 miles from Bury St Edmunds in Suffolk. Originally split into north and south sites, the north site is now a separate prison called HMP Edmunds Hill. Highpoint holds category C sentenced adult male prisoners and has a capacity of 944 men.

6. Healthcare at Highpoint is provided by Suffolk Primary Care Trust. The healthcare centre is open from 8.00am to 8.00pm, seven days a week. The Practice Plc employ prison doctors at Highpoint, who provide cover from the hours of 8.30am to 5.00pm on weekdays and 9.00am to 12.00 noon on Saturday mornings. A telephone triage service during healthcare opening hours when prison doctors are not on site. Outside of healthcare opening hours an out of hours service is provided. At the time that the man was at Highpoint this was provided by Take Care Now (formerly known as Suffolk Doctors On Call), based locally in Haverhill. Since April 2010 out of hours cover has been provided by Harmony.

7. Her Majesty's Chief Inspector of Prisons last inspected Highpoint in 2007. The then Chief Inspector reported that there was a generally negative response from prisoners in her survey about health services. However, care for prisoners with life long conditions was "good and well organised".

8. This is the fifth death my office has investigated at Highpoint, and the first since May 2008. Two of the previous deaths were due to natural causes. The investigation into the most recent of these deaths commended the medical care received by the deceased at Highpoint. The previous report highlighted the need to identify patients with underlying medical conditions who do not wish to engage with routine checks.

HMP ELMLEY

9. HMP Elmley is the largest of three prisons that make up the Sheppey Cluster on the Isle of Sheppey. It opened in 1992 and is a local prison for Kent with a capacity of 985 prisoners over five residential house blocks. Healthcare is commissioned and provided by Eastern and Coastal Kent Primary Care Trust. The healthcare centre includes a 29 bed inpatient unit, treating patients with both physical and mental health needs.

10. Her Majesty's Chief Inspector of Prisons last inspected Elmley in April 2009. She reported that health services were "much improved" since the previous inspection. She added that reception procedures and the health screening of new arrivals was good, although secondary health screens were often carried out without the prisoner's full clinical record.

11. There have been six deaths of prisoners as a result of natural causes since the Ombudsman began investigating deaths in custody in England and Wales in April 2004. The most recent report, involving the death of a man in July 2008, commended staff for the respectful and appropriate way

HMP CHELMSFORD

12. HMP Chelmsford is a local prison and Young Offender Institution (YOI). It has a capacity of 695 adult males and young offenders (aged 18-21) and accepts convicted or remand prisoners from courts in its catchment area. Healthcare at Chelmsford is commissioned by Mid-Essex Primary Care Trust. The healthcare centre contains an inpatient facility consisting of 12 beds. Prison doctors provide cover from 8.30am to 10.00pm on weekdays, and a doctor also attends on Saturday afternoons and Sunday mornings.

13. Her Majesty's Chief Inspector of Prisons last inspected Chelmsford in August 2009. She found that health services as a whole were satisfactory, but the inpatient regime was "poor" and prisoners on inpatients spent too much time locked up. Some cells in the inpatient facility were inappropriately used for prisoners unable to cope on the wings.

14. There have been four deaths due to natural causes of prisoners at Chelmsford since April 2004. The most recent of these reports, following the death of a prisoner in October 2007, praised the exemplary care provided by both clinical and discipline staff.

KEY EVENTS

15. The man contracted the HIV virus (human immunodeficiency virus, a virus that attacks the body's immune system and therefore affects the body's ability to fight disease and infection) during a period of around 30 years he spent living abroad. Medical records prior to his time in custody show he was not keen on attending hospital clinics to address his HIV and did not wish to take anti-retroviral medication (the main type for treatment for HIV, the medication is used to try to limit the level of HIV in the body and hence prevent weakening of the immune system).

16. In addition, the man had a heart attack in 2000. He subsequently underwent a double coronary artery bypass (to supply the heart with more blood). The man was prescribed various medications to help prevent a further heart attack but, in 2004, told his specialist that he no longer wanted to take any medication. A small cancerous tumour developed on the man's right temple in late 2006. This was removed during surgery in March 2007.

17. On his arrival at Elmley on 17 April 2009, the man saw a nurse for a reception health screen (a routine health screen for all new arrivals into custody). The man told the nurse about his heart attack in 2000 and said he had no concerns with his heart since then. He also mentioned that he had previously been imprisoned in Asia. He did not disclose that he was HIV positive. However, the nurse noted that the prisoner escort record (PER, a form used by the contractors responsible for moving prisoners from court to prison) referred to the man's HIV. As a result of this and the man's history of heart problems, the nurse referred the man to a prison doctor. He was initially allocated a cell on the prison's inpatients unit for observation.

18. The following day the man saw a prison doctor. He told the prison doctor that he had recently been treated for tuberculosis (TB, a bacterial infection usually affecting the lungs) but it had cleared up. The prison doctor examined the man's chest and noted that there were "scattered crackles". He therefore referred the man for a chest x-ray. (This took place on 24 April.) His blood pressure had earlier been taken by a nurse, and was within the normal range. The man also spoke of his HIV and was therefore referred to the prison's genito urinary medicine (GUM) clinic. The man's GP records from the community were not requested.

19. Two days later, a nurse saw the man after he complained of chest pain in the evening. The nurse took the man's blood pressure, which was slightly raised, and an electrocardiogram (ECG, a test to measure the electrical activity of the heart). She noted that the results of the ECG were abnormal but consistent with an old heart attack. The nurse made an appointment for the man to see a prison doctor the following day.

20. The man subsequently saw a prison doctor on 21 April. After discussing his medical history, she prescribed aspirin (to thin the blood and prevent a

21. The following day, the man attended the prison’s GUM clinic. Records of the GUM clinic at Elmley are kept separately from the main medical record and are not therefore available to prison doctors or nurses. This is to ensure that any consultations and treatment are confidential. The man underwent a full assessment at the clinic but was not prescribed medication.

22. On 23 April, the doctor saw the man in follow up to the consultation two days previously. After discussing his symptoms, she concluded that it was likely he was experiencing panic attacks. She decided to continue the medication she had prescribed on 21 April, and advised the man to eat a healthier diet. On the same day, the man moved from the inpatients unit to a single cell on a standard prison wing.

23. The man attended the prison’s GUM clinic for a second time on 29 April. On this occasion he saw a consultant from outside hospital. The results of blood tests indicated that the man would benefit from treatment with anti-retroviral medication. However, a summary of his earlier treatment was required before this medication could be prescribed. A letter requesting this information was sent on 1 June.

24. On the same day, the man saw a nurse for an ‘elderly health assessment’. The nurse noted that the man was fully independent but was “very unhappy” about the prison regime. He said he did not like the food and thought he was losing weight. The man’s weight was not checked at this consultation and there is no record of it being checked during the remainder of his time at Elmley.

25. The man was next seen by healthcare staff on 18 May, when he told a nurse that he had poor hearing due to a build up of wax in his ear. The prison doctor who had seen the man earlier on 21 April examined him and prescribed a course of ear drops. Two days later, the man failed to attend a scheduled appointment at the GUM clinic. It is not clear from the records why he did not attend.

26. The following day, the prison doctor who had earlier referred the man for a chest X-ray examined the report of the man’s chest x-ray taken on 24 April. The x-ray report had been received on 5 May and, at interview with the investigator, the prison doctor did not know why it had taken over two weeks to be made available to him. The x-ray report showed a fine shadowing in the man’s lungs. (This could result in various diagnoses and would normally require further investigation.) The prison doctor added that he was mistakenly told by a clerk that the man was no longer at the prison. He therefore asked that the x-ray report be forwarded to the man’s doctor in the community. A copy was retained in his prison medical record.

27. On 26 May, the man saw a nurse regarding his ear wax. The nurse asked the prison doctor who had earlier referred the man for a chest X-ray to examine the wax, who recommended that the ear be syringed. The prison doctor told the investigator that he did not recognise the man as he had only met him once before, on 18 April. He did not therefore realise that the man was the prisoner who he had been told, incorrectly, was no longer at Elmley.

28. The following week, the man saw a nurse to discuss his diet and other issues. However, the consultation had to be terminated as the man reportedly became "rude and offensive". On 3 June, the man went to the GUM clinic, where he was described as "looking better". A blood test was taken and it was noted that he would be reviewed when the result was available. This review did not take place. The requested summary of the man's treatment in the community arrived on 11 June, although the man was not seen in the GUM clinic following its arrival.

29. The man had no further contact with healthcare services at Elmley prior to his transfer to Highpoint on 20 July. On his arrival at Highpoint, the man saw a nurse for a reception health screen. His medical history, including his HIV and previous heart attack, was noted. The nurse made the man an appointment with a prison doctor to review his cardiac (heart) history and medication. It was noted that the man said he was "intellectually superior to the majority you have in here" and "does not suffer fools gladly".

30. Four days later, the man saw a doctor for his scheduled appointment. The consultation was delayed for around an hour and a half as the doctor had to attend an emergency response in another part of the prison. The man was reportedly angry at having to wait. The doctor told the investigator he was concerned that the man was not taking his medication regularly, and encouraged him to do so. He suggested to the man that they arrange another appointment to discuss his HIV. The man declined and said that "as an aircraft pilot [he] knew how to look after his health". The doctor told the investigator that it would be standard practice to refer a patient with HIV to the GUM clinics at a local hospital and in the prison. However, he could not do this as he did not have the man's consent. The man did agree to have a blood test, but this did not go ahead for reasons which are unclear.

31. The following day, the man was the subject of a discussion at a healthcare handover meeting. The nursing staff said they found him to be defensive and non-communicative. It was agreed that they would continue to do all they could to encourage him to comply with his treatment. On 23 August, it was noted that the man was continuing to decline his medication and said he "doesn't take it and has taken none since his [heart attack] ten years ago".

32. On 22 September, a nurse was asked by wing staff to see the man in his cell. The man said he was having a "malaria attack" and was found

33. That evening, a nurse visited the man in his cell. She took his temperature, which was raised at 37.8°C and noted that the man said he felt “awful”. The nurse noted that the man should be reviewed the following day. There is no record of this review taking place.

34. The man next saw a member of healthcare staff on 26 September, when he was visited in his cell by the nurse who saw the man for a reception health screen on his arrival at Highpoint, at the request of wing staff. The man said he had chest pain, swine flu and was having difficulty breathing. The nurse noted that there was “no obvious sign” of any of these problems. The man was recorded as being “extremely angry” and “demanded” to be taken to Accident and Emergency at the local hospital. The nurse returned to healthcare at 5.15pm and telephoned the on-call doctor. He noted that the on-call doctor was already coming in to see another patient and thought the man could be seen at the same time. However, the on-call doctor was reportedly “not concerned as he felt the symptoms were too vague”.

35. The following morning, a nurse saw the man on his wing. He noted that the man showed no sign of breathlessness and was “ranting” about his treatment. After a request from the man, the nurse gave him some ibuprofen (a painkiller).

36. On 28 September, a nurse saw the man shortly before 9.30am. She noted that he had a painful cough and right sided abdominal swelling. His blood pressure was low, at 90/50. The nurse sought advice from the doctor who had earlier seen the man on 24 July, who examined the man. The doctor told the investigator that the man did not look too ill, his breathing was “not bad” and he was walking around the room. Nevertheless, he felt it best to send the man to hospital for tests. He was admitted to outside hospital later that morning.

37. During his time in hospital, the man was accompanied by two members of prison staff. It is standard practice that prisoners are handcuffed to a member of prison staff when outside of the establishment. The man was therefore initially handcuffed to one of the escorting staff. However, the handcuff was removed on 1 October when the man was admitted to the intensive care unit following a sudden deterioration in his health. The man’s mother and step-father were contacted on 1 October and told of his admission to hospital. The following day, the man’s family were telephoned by a governor at the prison who offered to arrange transport if they wished to visit. Due to their poor health and the distance involved,

38. Having been diagnosed with pneumonia, the man remained in a serious condition over the following days. He had a tracheotomy (to open up the windpipe and create an airway to help the patient breathe) on 13 October. The man began to improve towards the end of October. By 1 December he was described as "independently mobile". Hospital nurses expressed concern about his behaviour and said he was "manipulating staff". Following a risk assessment, it was decided to re-apply restraints with the use of an escort chain (a long chain with a handcuff at each end which is applied between the prisoner and one of the escorting officers). Over the following weeks, the man began to attend physiotherapy and use the hospital gymnasium as part of his rehabilitation. He was also described as "becoming challenging to hospital staff over his treatment". He was prescribed the anti-retroviral medications tenofovir and efavirenz during this period, which he began to take.

39. By 23 December, the man was well enough to be discharged from hospital. It was agreed that he should be discharged to a prison with inpatients facilities so that he could be subject to closer observation. He was subsequently discharged to HMP Chelmsford, where he was given a cell on their inpatients unit.

40. Following his arrival at Chelmsford, the man was reviewed by a prison doctor. The prison doctor noted the man's medication as prescribed by the hospital, which now also included temazepam (a sedative used to treat insomnia). The man was noted to have "no new problems".

41. The man suffered a deterioration in his health on 30 December. He was examined by a prison doctor who noted crackles on his left lung. The man was admitted to outside hospital for further investigation. On the same day, the duty governor at Highpoint was told of the man's admission. She telephoned his family and passed the news on to them.

42. Staff from Highpoint provided the escort during the man's time at outside hospital. This followed an agreement reached when the man was discharged to Chelmsford, that if he were to return to hospital Highpoint would provide the staffing cover. Following a risk assessment, completed by staff at Chelmsford, the man was accompanied by two officers and cuffed to one by means of an escort chain.

43. Following his admission, the man was diagnosed with pneumonia. It was initially thought that he would remain in hospital for a few days before returning to prison. However, he suffered a significant deterioration on 7 January and the escorting staff were told he was "very poorly and might not survive". On hearing this news, they contacted the duty governor at Chelmsford who gave permission for the escort chain to be removed.

44. The following morning, the man's registration was transferred from Chelmsford back to Highpoint. This was so that staff at Highpoint could be responsible for the necessary arrangements were the man to die, to ensure consistency in their contact with his family. The duty governor at Highpoint telephoned the man's family that morning to update them on his condition.

45. The man's condition did not improve and he died at 1.15pm on a day in January. The duty governor telephoned the man's family that afternoon to break the news of his death (they had previously indicated that they were happy to be told over the telephone rather than be visited) and to arrange to visit them to return his property. The investigation found that the prison's contribution to the funeral costs was in accordance with PSO 2710 (the Prison Service Order that sets out the actions to be taken following a death in custody).

ISSUES

Compliance with medication

46. The man contracted the HIV virus whilst living abroad, a number of years before he was sent to prison in the United Kingdom. Records show that before his imprisonment he attended few hospital appointments relating to his HIV and refused treatment with anti-retroviral medication. Following his heart attack in 2000 and subsequent double coronary bypass, the man took his prescribed medication for some years. However, in 2004, he told his consultant that he no longer wished to take the medication prescribed to treat his heart condition.

47. This pattern continued during the man's time in prison. At Highpoint he declined an appointment to discuss his HIV having told the doctor who saw him on 24 July that "as an aircraft pilot [he] knew how to look after his health". The man also regularly refused his heart medication in prison. He told a nurse on 23 August 2009 that he "doesn't take it and has taken none since [his heart attack] ten years ago".

48. The doctor who saw the man on 24 July recalled that the man considered himself "intellectually superior" to other prisoners and that he thought he "looks after himself well". In hindsight, however, the doctor thought that the man perhaps did not understand the seriousness of his condition.

49. The clinical reviewer comments that the man's "personality and attitude to his own health meant that he refused treatment for the HIV infection [and] for his heart disease". He goes on to say that it was not possible for either Elmley or Highpoint to initiate treatment without the man's consent. However, it does not appear that he was referred to the mental health team at either prison to confirm he had the capacity to refuse treatment.

Medical care at HMP Elmley

50. On account of his history of heart disease, the man was referred for a chest x-ray following his arrival at Elmley. This went ahead on 24 April 2009, with the results available at the prison on 5 May. These results were not seen by the prison doctor who had referred the man for a chest X-ray until 21 May. At interview, the doctor could not explain why it had taken over two weeks for the results to be made available to him. The clinical reviewer describes this delay as "unacceptable". In addition, the results of the x-ray were not actioned as the doctor was mistakenly told that the man had been discharged from the prison, even though he was seen by healthcare staff on a number of occasions following receipt of the results. It is concerning that such inaccurate information was relayed to the doctor. It is not clear which member of staff passed on this incorrect information.

51. The man was referred to the GUM clinic at Elmley following his arrival at the prison. He first attended a GUM clinic on 22 April 2009, and was seen

52. The clinical reviewer comments on the GUM procedures at Elmley as follows:

> "His care would have been more seamless if the GUM notes at Elmley were included in his general medical record so that all healthcare staff would be able to access his blood test results and management plan decisions. It would also mean that the discharge health summary could include this information."

He goes on to make the following recommendation, with which I agree:

The Head of Healthcare should ensure that GUM clinic records at Elmley are included in a prisoner's general medical record. There should be an explicit entry in the general medical notes stating whether a prisoner declines treatment.

53. The clinical reviewer also notes that there was a delay of one month (from 29 April to 1 June) for GUM staff to request a summary of the man's care prior to imprisonment. His comment links to Prison Service Order (PSO) 3050, which provides instructions on maintaining continuity of healthcare for prisoners. PSO 3050 provides the following instruction:

> "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. The prisoner's explicit consent should be obtained before doing this, although in exceptional circumstances information may be requested and disclosed without consent."

54. Despite his significant medical history, no attempt was made to obtain the man's community doctor's records or hospital records until 1 June, some weeks after he was sent to prison. At interview, the prison doctor who had referred the man for an X-ray explained that GP records are only requested from the community if it is suspected that a prisoner may not be providing an accurate picture of their medical history. However, it is good practice to request all prisoners' community GP records and is particularly surprising that it is not common practice for prisoners with serious medical conditions such as this man's.

55. In light of the above the clinical reviewer makes the following recommendation, with which I concur:

The Head of Healthcare should ensure that clinical governance procedures at Elmley are improved so that x-ray results are actioned

swiftly and further information from outside healthcare professionals is sought without delay.

56. In addition, I make the following recommendation:

    The Head of Healthcare at Elmley should remind staff to request community GP and hospital records for all new arrivals in prison where there is evidence of chronic disease or other serious condition in their medical history.

Events of 22 September 2009

57. The man reported feeling unwell on 22 September 2009. A nurse saw him in his cell and noted that he was "shivering and wrapped in blankets". The nurse said he was having what he described as a "malaria attack". The nurse took his observations which, other than a raised pulse, were within normal ranges. He gave the man advice and reassured him that someone would return to check on him.

58. Later that evening a further nurse saw the man in his cell. She took his temperature, which was raised. In addition, the man told her that he felt "awful". She noted that the man should be reviewed the following day.

59. This review seemingly did not happen and the man did not see a member of healthcare staff for a further four days. The doctor who saw the man on 24 July told the investigator that it was "unusual" for the man not to be seen as "such requests are not normally missed". He speculated that the man might have been seen and the review not recorded. There is no evidence that this was the case and, even so, it is poor practice to review a patient and not record the findings.

60. The clinical reviewer notes this "failure to follow up [the man]" and makes the following recommendation, with which I concur:

    The Head of Healthcare should ensure that clinical governance procedures at Highpoint are improved so that patients are followed up in a timely manner.

Out of hours service at Highpoint

61. A nurse saw the man in his cell on the afternoon of 26 September 2009. The man said he had chest pain, swine flu and had difficulty breathing. He was reportedly "extremely angry" and "demanded" to be taken to Accident and Emergency. The nurse noted there was "no obvious sign" of the conditions the man was describing. Nevertheless, on his return to healthcare at around 5.15pm he telephoned the on-call doctor and asked him to see the man, as he was already due to visit to see another prisoner. (As 26 September was a Saturday there were no prison doctors on site after 12.00 noon.) However, the on-call doctor reportedly said he

62. There appears to be some confusion at Highpoint as to the correct process for contacting a doctor at this time. The doctor who saw the man on 24 July told the investigator that the out of hours service provided by Take Care Now is in operation throughout the period outside that covered by prison doctors (that is 8.30am to 5.00pm on weekdays and 9.00am to 12.00 noon on Saturdays). The nurse presumably also thought this was the case as he telephoned Take Care Now at around 5.15pm on Saturday 26 September.

63. However, the Deputy Director of Public Health at NHS Suffolk told the investigator and clinical reviewer that the detail of the contract is that a telephone triage service operates during healthcare opening hours (8.00am to 8.00pm, seven days a week) when prison doctors are not on site. Outside of these hours, Take Care Now provided an out of hours service. This means that the contracted hours during which Take Care Now could have been contacted are 8.00pm to 8.00am. (This contract is now held by Harmony but operates on the same basis.)

64. Although the nurse seemingly contacted the on call doctor outside of the contracted hours, the doctor had apparently already planned to come into the prison to see another patient. It is not clear if he intended this visit to take place before or after 8.00pm, the start of contracted hours. The clinical reviewer describes the on-call doctor's refusal to see the man as "not acceptable medical practice". I agree with his conclusion.

The Head of Healthcare at Highpoint should remind staff of the correct process for contacting a doctor outside of prison doctors' normal working hours.

Use of restraints in hospital

65. Following his admission to hospital on 28 September 2009, the man was accompanied by two officers and, following a risk assessment, was initially handcuffed to one of them. This handcuff was removed on 1 October when the man was admitted to the hospital's intensive care unit following a sudden deterioration in his condition. These arrangements remained in place until 1 December, when a further risk assessment determined that an escort chain should now be applied. Given that the man was now mobile and attending the hospital gymnasium, and hospital staff had expressed concern about his behaviour, I consider this decision to be reasonable.

66. After his discharge from hospital on 23 December, the man was admitted for a second time on 30 December. On this occasion the risk assessment was completed by staff at Chelmsford. The man was again accompanied by two officers and cuffed to one by an escort chain. At the time the man's mobility was not affected and, given the previous concerns

Potential release from custody

67. The man suffered a significant deterioration in his health on 7 January 2010. The escorting staff were told he was “very poorly and might not survive”. They communicated this information to the duty governor. The man’s condition did not improve and, on a morning in January, advice was received that he might only have hours to live. He died later that day.

68. Prisoners who are suffering from a terminal illness and for whom death is thought likely to occur soon can be released from prison by a process known as early release on compassionate grounds. In order to be released by this means, an application form must be completed and sent to the Public Protection Unit in National Offender Management Services (NOMS). The form includes sections to be completed by the Governor, a prison doctor and an offender manager. A full prognosis must also be provided. Once the form is submitted, caseworkers in the Public Protection Unit determine whether the application meets the criteria set out in PSO 6000 (the instruction that deals with the release and recall of prisoners). In making this decision, they consult with the Parole Board and specialist medical advisors in the Department of Health.

69. The deterioration in the man’s health was both sudden and significant. It would have been very difficult to complete and submit an application for early release on compassionate grounds in the time available. PSO 6000 provides details of the timescales required for making a decision:

    “A decision will usually be made within two weeks, but more quickly if the circumstances require it. If there is a medical application involving a very short life expectancy, the [Public Protection Unit] must be alerted by telephone at an early stage.”

70. In light of the above instruction, the Governor will wish to contact the Public Protection Unit in any future circumstances in which advice is received that a prisoner in outside hospital is likely to die very soon. She might also consider release on temporary licence whilst the outcome of such an application is awaited.

Liaison with the man’s family

71. The man’s mother and step-father were contacted on 1 October 2009 and told of his admission to hospital. A governor at the prison offered to arrange transport for them to visit the man in hospital but, on account of their ill health and the distance involved, they were unable to visit. Logs kept by staff at Highpoint show that they contacted the man’s family regularly throughout his time in hospital to update them on his condition. This sometimes involved telephoning them every day, and continued

CONCLUSION

72. This was a man who had clear views about what he thought was best for himself. Despite having several significant medical conditions, including heart disease and the HIV virus, he did not think he needed to take medication or listen to the advice of specialists. The man was consistent with his view both before and after he was sent to prison.

73. Although the man's views meant that he was a difficult patient to manage, the clinical reviewer concludes that the man received medical care in prison that was "equitable with the wider community". Nevertheless there are some lessons that could be learnt and the report makes a total of six recommendations. Of particular concern at Elmley is the delay reviewing the results of the man's chest x-ray. At Highpoint, the apparent failure to carry out follow up checks on the man for four days is similarly concerning, as is the use of the out of hours doctor service.

RECOMMENDATIONS

1. The Head of Healthcare at Elmley should ensure that GUM clinic records at Elmley are included in a prisoner's general medical record. There should be an explicit entry in the general medical notes stating whether a prisoner declines treatment.

   Partially accepted – The Eastern and Coastal PCT do not feel as a GUM service it is in patients' best interests for all our GUM notes to be logged into SystmOne.

   (a) All consultations with HIV patients whether they are seen by a doctor or a nurse, with their consent, will have a letter sent to the medical officer, or details of the consultation added to SystmOne.

   (b) We can arrange for medical summaries regarding HIV care to be sent to other prisons where an individual may be transferred.

2. The Head of Healthcare should ensure that clinical governance procedures at Elmley are improved so that x-ray results are actioned swiftly.

   Accepted – Improve so that x-ray results are actioned quickly. Primary Care Managers to discuss and action with all GPs.

3. The Head of Healthcare at Elmley should remind staff to request community GP and hospital records for all new arrivals in prison where there is evidence of chronic disease or other serious condition in their medical history.

   Accepted – Relevant primary care managers to ensure that this is actioned with reception and first night centre staff.

4. The Head of Healthcare should ensure that clinical governance procedures at Highpoint are improved so that patients are followed up in a timely manner.

   Accepted – NHS Suffolk and the Head of Healthcare will take forward this recommendation as an action through the Prison Health Service Improvement Delivery Group at HMP

5. The Head of Healthcare at Highpoint should remind staff of the correct process for contacting a doctor outside of prison doctors' normal working hours.

   Accepted – NHS Suffolk and the Head of Healthcare will take forward this recommendation as an action through the Prison Health Service Improvement Delivery Group at HMP Highpoint which is chaired by the co-ordinating commissioner and members include service providers as well as the co-ordinating provider.

GOOD PRACTICE

1. The man’s family were contacted by staff at Highpoint on a regular basis throughout his time in hospital.