Investigation into the circumstances surrounding the death of a man at hospital while in the custody of HMP Isle of Wight in January 2012

Report by the Prisons and Probation Ombudsman for England and Wales

July 2012

This is the report of an investigation into the circumstances surrounding the death of a man, a prisoner at HMP Isle of Wight. He died of a heart attack in January 2012. I offer my condolences to those affected by his death.

The investigation was carried out by an investigator. The local Primary Care Trust (PCT) commissioned a clinical reviewer to review the standard of healthcare the man received at HMP Isle of Wight. Staff at the prison cooperated fully with our enquiries.

The man suffered from long term heart disease and diabetes. He was seen regularly by a cardiologist and healthcare staff. He did not take his medications as prescribed and his medications were not always kept up to date to match his changing health needs. On 13 December 2011, he suffered a suspected stroke and was admitted to hospital. He was taken to hospital in restraints. When he was discharged on 4 January 2012, he went to the prison's in-patient unit as he required full nursing care. On 13 January, he suffered a heart attack and was taken back to hospital, and died a few days later.

The clinical review found that, while some aspects of his healthcare were managed well, the overall standard of care the man received at HMP Isle of Wight fell below that which he could have expected in the community, particularly in relation to the management of his medication, management of his catheter and oversight of his chronic conditions. He was also not consulted on a decision that he should not be resuscitated if the need arose. While he was not restrained when he was taken hospital for his last illness, on a previous visit handcuffs were used despite not being justified by a fully considered risk assessment.

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.

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Prisons and Probation Ombudsman **July 2012**

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SUMMARY

1. The man arrived at HMP Isle of Wight, Parkhurst site, in early 2009. He was serving a twelve year sentence. He suffered from heart disease and diabetes, for which he took various medications. Shortly after arriving at Parkhurst, he was fitted with a catheter[1] as he had become incontinent (a side effect of one of his medications).

2. He was admitted to hospital for two weeks in January 2010. He was suffering from a build up of fluid on his lungs and was experiencing chest pain. During the hospital admission, he was told by a consultant that he had a life expectancy of approximately two years. There was no mention of the prognosis on his discharge summary, but he told staff about it on his return to the prison, and he was provided with appropriate support.

3. The man was reviewed regularly by a cardiologist and healthcare staff. He suffered several episodes of cardiac failure and hyperglycaemia[2], after which his medications were changed. As his condition began to deteriorate, he was admitted to hospital for three weeks in November 2011. A family liaison officer was appointed to make contact with his next of kin.

4. On 13 December 2011, after his return to the prison, he suffered a suspected stroke. He was taken to hospital, escorted by two officers who used double cuffs to restrain him. He was admitted to a ward and his restraints were then removed. He stayed in hospital until 4 January 2012, when he was discharged back to the prison's in house hospital unit (IHU).

5. The man suffered a heart attack on 13 January and was taken back to hospital. Hospital staff managed his pain, but there was nothing else that could be done for him in terms of medical intervention. His condition continued to deteriorate and he was pronounced dead at 9.28am a few days later.

6. The clinical reviewer writes that the man suffered as a result of changes in his medication. His diabetic control was poor, often because he did not comply with treatment. The clinical reviewer considers that his needs were difficult to meet in the prison environment. Although some aspects of his care were managed well, the clinical reviewer concludes that his overall care, particularly his medicines and chronic disease management, fell below that which would have been expected in the community. The clinical review also notes that he was not informed or consulted about a decision that attempts should not be made to resuscitate him in the event of a cardiopulmonary arrest.

7. The man had complex medical needs and he was reviewed regularly by healthcare staff and secondary services. Oversight of his diabetes and control of his medications were not as good as they should have been. We agree with the findings of the clinical review and make recommendations about medication changes, consultation with prisoners about resuscitation and the use of restraints

[1] A tube inserted into a patient's bladder via the urethra. It allows the patient's urine to drain freely from the bladder and is collected in a bag at the end of the tube.
[2] High blood sugar, which can be potentially serious.

when taking prisoners to hospital.

THE INVESTIGATION PROCESS

8. The investigator began the investigation on 19 January 2012 and issued notices informing staff and prisoners of the investigation and inviting them to contact her with relevant information. No-one responded to the notices.

9. HM Coroner for Isle of Wight was informed of the investigation and will be sent a copy of the investigation report. A copy of the post-mortem report was received on 2 March 2012.

10. The clinical reviewer was appointed by the local Primary Care Trust (PCT) to conduct a clinical review of the care the man received in custody. He received copies of all the relevant medical and prison documentation.

11. The investigator received and reviewed all documentation relating to the man's time in custody. She liaised with the Governor throughout the investigation. She sent a feedback letter informing him of her preliminary findings.

12. The clinical reviewer interviewed two doctors from IHU on 27 March 2012. He and the investigator then interviewed two IHU staff and the Head of Custody on 17 April. On 1 May, they attended a panel review, during which issues and recommendations relating to the man's level of clinical care were discussed with healthcare staff and members of the PCT. The clinical review was received on 5 May 2012.

13. One of the Ombudsman's family liaison officers contacted the man's next of kin, his ex-wife, shortly after his death to explain the investigation process. She had no issues to be considered as part of the investigation. The family received a copy of the draft report as part of the consultation process. In response to the draft report, they commented that they had no further comments or feedback to add to the findings of the investigation.

14. The report was also issued for consultation with the Prison Service. There were no factual inaccuracies and the response to the recommendations has been added to the recommendations page.

HMP ISLE OF WIGHT

15. HMP Isle of Wight was formed in April 2009 from the organisational amalgamation of the former Albany, Camp Hill and Parkhurst prisons. Each site is led by a head of regime under one governor. The Parkhurst site is where the man spent most of his time.

16. Parkhurst holds category B prisoners (category B prisoners do not need the highest conditions of security, but escape must be made very difficult) and a small number of remand prisoners. It has an operational capacity of 536, and is made up of eight residential units, seven of which are Victorian-style galleried units and the eighth a small former health-care unit. Healthcare services are commissioned by NHS Isle of Wight. Each site had its own healthcare centre and there is an in-house hospital unit (IHU) at the Albany site.

17. Healthcare services are available on site between 7.30am and 5.30pm each day. After that time, the nurses from IHU are available for telephone advice, or staff can contact the local general practitioner (GP) out-of-hours service. There is a daily GP clinic at all three sites.

18. The most recent inspection report by HM Chief Inspector of Prisons from October 2010 comments on the standard of healthcare:

    > "A recent health needs assessment 'refresh' had been undertaken but had not identified, or focused on, clinical need. Clinical governance arrangements were variable, with primary care trust policies not adapted appropriately for the prison environment. There were few care plans and some were out of date and not adhered to. Treatment times clashed with regime provision. In Parkhurst and Albany the primary care environments were poor. Nurse-led clinics varied across the sites, as did waiting times for the GP and other health professionals, which were long... There were long delays and cancellations for secondary care appointments. The inpatient unit environment had improved but lacked structured or therapeutic activity for patients."

Previous deaths at Isle of Wight

19. In the last two years, there have been fourteen deaths from natural cause at HMP Isle of Wight, including that of the man. Of these deaths, three were on the Parkhurst site. In a previous investigation, we recommended that the quality of care provided to prisoners with long-term and chronic illnesses should be improved, a recommendation which is repeated in this case.

KEY EVENTS

20. The man was remanded into custody in 2008 and was sentenced to 12 years imprisonment. He transferred to HMP Parkhurst in March 2009. This was his first time in prison.

21. According to his medical record, the man had a history of heart disease that dated back twelve years. He also suffered from diabetes and had a heart bypass in 2003. He was taking many medications for his health conditions, such as warfarin[3], co-amilofruse[4], digoxin[5], ramipril[6], metformin, gliclazide, rosiglitazone[7] and atorvastatin[8].

22. In July, the man was briefly admitted to hospital, and a long term catheter was fitted. It was noted that one of his medications had made him incontinent.

23. The man was reviewed regularly by a cardiologist. He was diagnosed with an impairment of the left ventricular systolic function[9] in August and he also had an impaired function on the right side of his heart. In November 2009, the cardiologist wrote to the prison to increase his medication for high blood pressure. The consultant described him as looking “chronically unwell” and wrote that no further care could be offered at that stage as his medications were appropriate and a lot of thought had already gone into his cardiac care.

24. Throughout 2009, the man’s warfarin dose was amended regularly. His international normalised ratio (INR)[10] fluctuated between being under-treated (increases risk of a blood clot forming) and over-treated (increases the risk of profuse bleeding). For patients on warfarin, their INR should be between 2 and 3. His INR settled at 2.5 during early 2010.

25. On 28 January 2010, the man was taken to hospital. He had a build up of fluid on his lungs and chest pain. He was admitted to the cardiac care unit for two weeks while he received treatment. The Head of Custody visited him in hospital on 4 February. He made an entry on the prisoner national offender management information system (P-Nomis)[11] that the man had been told by his consultant that he only had two years left to live. He noted that close liaison with healthcare would be required to confirm this and, if necessary, arrangements put in place to transfer the man to less secure conditions.

[3] A drug used to help thin the blood. Helps to prevent strokes in patients with heart disease.
[4] A drug used to relieve symptoms of water retention.
[5] A drug used to treat heart failure.
[6] A drug used to control high blood pressure
[7] Metformin, gliclazide and rosiglitazone are medication’s used to treat diabetes
[8] A drug used to help lower cholesterol
[9] A condition where the left ventricle of the heart has difficulty ejecting blood from its chamber.
[10] A test used to monitor how effective the patient’s blood thinning medications are and if the dose needs to be amended. Over-treating increases a risk of haemorrhage and under-treating increases the risk of clots forming.
[11] An electronic case management system used in prisons to record prisoners’ details.

26. The man was discharged to Parkhurst on 11 February. His discharge letter said that he had a diagnosis of "decompensated cardiac failure"[12]. There was no mention of his poor prognosis, but the letter did say that he did not need any follow up appointments with the consultant or a doctor. The Head of Custody said that following his discharge, the man returned to his wing and continued to work. On 19 February, he told an officer that the doctor told him he had two years left to live and explained that it "was like a form of cancer to the heart". She noted that he seemed to have come to terms with the news.

27. The clinical director at Parkhurst referred the man to an occupational therapist on 1 March. He was having difficulty dressing and walking to healthcare to collect his medication, so was reliant on others to collect it for him. She explained that he was sometimes pushed to healthcare in his wheelchair by his "buddy"[13]. He would then receive all his medications for the day in the morning, which meant he did not have to go back and forth to the healthcare centre.

28. The man's catheter was changed on 30 March. It was noted it had been in place for six months and should have been changed after three months. The investigator was told that the prison now has a system to remind staff when a catheter change is due. After this his catheter was changed as required.

29. The clinical team manager explained to a senior nurse in IHU on 3 April that the man had been given a prognosis of two years. As the nurse specialised in end of life care, she went to speak to him on 12 April and noted in his medical record that they discussed his poor prognosis and the support that was available to him. He assured her that he felt very well.

30. The man had problems with his catheter throughout 2010, and had many episodes of urinary retention which required prompt treatment. He was admitted to hospital in September 2010 with chest pain. He was treated for acute coronary syndrome[14] and was given a blood transfusion. His warfarin and metformin were stopped, without explanation. He was discharged back to Parkhurst on 15 September and his metformin was restarted a few days later as his blood sugar levels had become high.

31. The clinical director referred him to a cardiologist in October. His cardiologist concluded that he had severely impaired left ventricular function and this had caused several episodes of heart failure. It was noted that nothing had been missed in relation to his care needs.

32. The man was reviewed by a doctor on 22 December. A blood test had shown that he had a reduced kidney function (kidney function can be affected by diabetes and diabetic medications). His kidney function was tested again a month later and showed a significant improvement.

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[12] A common and potentially fatal cause of respiratory distress often associated with fluid on the lungs and caused by left ventricular dysfunction.

[13] A prisoner that helps with another prisoner's basic care needs, such as collecting meals and medications.

[14] A term used to describe a range of problems affecting the heart. It is caused by sudden narrowing of the arteries taking oxygen to the heart.

33. The man's kidney function deteriorated again in January 2011 and the clinical director referred him to a nephrologist[15]. A letter was received from the nephrologist on 18 February, saying that his renal function was stable, so he did not need to be reviewed. However, the consultant advised that his blood pressure needed to be controlled and nephrotoxic[16] drugs should be avoided, and in particular, metformin should be stopped. Despite the nephrologist's recommendation, his metformin was not stopped and he continued to take it until he was reviewed by the clinical director seven months later. She said that she had listed him for review to discuss stopping his metformin, but accepts she should have put an entry in his notes to prompt whoever saw him to check the consultant's letter.

34. The man was taken to hospital in an ambulance on 18 August. He had presented to staff with blue hands and lips, had a lump on his right arm and was in pain. He had several investigative tests, such as echocardiograms[17] and Doppler scans[18] during his hospital admission, and was restarted on warfarin. It was concluded that he had a blockage of the artery to his kidney. He was discharged back to Isle of Wight on 1 September and was admitted to the IHU on the Albany site for observation and assessment.

35. He had symptoms of urine retention on 7 September. Staff tried to treat him at the prison, but following the doctor's advice, he was admitted to the urology department at the local hospital. He was re-catheterised and a litre and a half of urine was drained. He returned to the prison the next day. The clinical director assessed him later that afternoon. She noted that his metformin and medication for fluid retention needed to be stopped. On 9 September, she decided that he needed to be admitted to hospital due to his complex medical issues and a rapid decline in kidney function. He stayed in hospital until 30 September, when he returned to his cell on the wing.

36. The clinical director made an entry in the man's medical record on 9 September that, after he had been admitted to hospital, he had started on insulin[19] and his gliclazide and ramipril were stopped. She said there was a delay in receiving his discharge summary, but the changes to his medication were made as soon as he returned and he received insulin. His discharge letter was eventually received and filed in his medical record. According to the letter, he had been diagnosed with diabetic neuropathy[20] and chronic renal failure[21].

37. On 18 November, the man presented to the clinical director with pain in his kidney area. He said the pain was similar to when he had a blockage in the

[15] A consultant who specialises in the diagnosis and management of kidney disease.
[16] The toxic effect of some medications on the kidney's. It is more profound in patients that already have renal impairment.
[17] A scan of the heart which uses sound waves to build up a picture.
[18] An ultrasound test which uses sound waves to evaluate the blood as it flows through a blood vessel.
[19] A hormone that lowers the level of glucose (a type of sugar) in the blood.
[20] Damage to nerves in the body, which occurs due to high blood sugar levels from diabetes.
[21] A slow loss of kidney function over time.

artery to his kidney, but worse. He was admitted to hospital but the following day, 19 November, he refused surgical intervention.

38. Due to the deterioration in the man's condition, a family liaison officer (FLO) was appointed on 20 November. Attempts to contact his next of kin, his ex-wife, were made and a message was left on her answering machine asking her to contact the prison. His ex-wife contacted the prison and asked for a telephone call if he died. She said that if she was not in, she would be grateful if a message could be left.

39. While he was in hospital, a "do not attempt resuscitation" (DNAR) form was completed by a hospital doctor. As it was decided that resuscitation would not be successful, because of his medical conditions. The decision was not discussed with him. The DNAR form was not mentioned in his discharge summary, but a copy was filed in his medical record.

40. The man returned to the prison on 9 December. He had been treated with intravenous (IV) antibiotics and it was noted that a change of his catheter might have relieved an obstruction. His warfarin control was difficult during his hospital admission and so had been stopped. His discharge summary suggested that a doctor review his INR and start him on warfarin "when suitable". He was admitted to IHU for observation and was said to have been cheerful in mood and did not report any pain. He was frail, but was keen to look after himself as much as he could. He used a wheelchair the majority of the time, but was able to stand.

41. On 13 December, the man suffered a suspected stroke. He was taken to hospital by ambulance. A nurse explained to the investigator that he had been in the dining room and had been found slumped in his wheelchair. He was taken back to his cell, where he was cared for until the ambulance arrived. He was drooling, his face had dropped on one side and his nose was also running quite profusely. The corresponding entry in his medical record did not describe his condition or the treatment he received.

42. The man was escorted to hospital by two escort officers and was restrained using double cuffs[22] and an escort chain[23]. The escort risk assessment[24] is a 'points assessment' completed by security staff. Because of his offence (rape and indecent assault), his security category, and time left to serve, he received 58 points, which meant that 'normal escort arrangements' applied, according to the prison's policy. There was no medical contribution to the risk assessment,

[22] Double cuffs refers to two sets of handcuffs being used. One set is applied to the prisoner's wrists and one cuff of the second set is attached to the prisoner and the other to one of the escorting officers.
[23] An escort chain is used when a prisoner is confined to bed or if they require the use of a toilet while on escort. One end is attached to the prisoner and a length of chain connects an officer. The escort chain allows more freedom of movement for the prisoner and makes it easier for nursing staff to administer treatment.
[24] A risk assessment completed by prison and healthcare staff when a prisoner is admitted to hospital or a hospice, to determine the level of restraint required. The level of restraint is based on the prisoners assessed risk to the public and staff, taking into consideration their medical condition and past behaviour.

which suggested the restraints could be removed with authorisation from the duty governor in medical emergencies and if medical intervention was needed, and there was no consideration of his physical condition.

43. The man was assessed at hospital. His bedwatch log[25] shows that the restraints were removed shortly after arrival at hospital and were not re-applied. He had a CT scan later that afternoon, which showed that he had suffered from a large cerebral infarction[26]. He was receiving fluids through an IV drip and had a feeding tube inserted through his nose. He pulled out the feeding tube three days later and refused to have another inserted. He remained in hospital for care and assessment until 4 January 2012, when he was discharged back to the IHU. It was noted that he would require help with his care needs. He was able to swallow, but needed assistance with eating, drinking and taking his medications. A doctor assessed him on 5 January. He noted that he was not to be resuscitated, but advised that he was to be taken to hospital if he suffered another stroke.

44. On 6 January, the man was examined by a doctor as part of an application for release on compassionate grounds. He noted that the man was unlikely to live longer than a few months and was bed-bound. His disability was permanent and the doctor believed he was "absolutely incapable of committing further criminal acts". His most recent discharge summary was attached to the report. The doctor also prescribed his insulin on this day. He continued the prescription from his time in hospital, the same dose as when he had been eating properly.

45. During the early hours of 7 January, a nurse contacted Beacon Healthcare (the out of hours service) for advice, as the man's condition had deteriorated. He was having short bursts of rapid breaths, followed by a long spell of not breathing. A further entry by the clinical director says that although a DNAR was in place, the prison had been advised to admit him to hospital if he deteriorated. She noted that he was probably suffering from more symptoms related to his recent stroke and he was sent to hospital by ambulance. He was not restrained, although he was accompanied by two escort officers.

46. Bedwatch staff contacted the IHU at 5.20am. They said that the man's blood sugar had been high, but it had stabilised and he was eating and drinking. He was to have further tests later that day. In the afternoon, he began to fall in and out of consciousness. He had a CT scan, the results of which showed that he did not have any bleeding on his brain.

47. The Matron spoke to the Sister on the man's ward on 10 January. The Sister said that he was very unwell and nothing more could be done for him. He was to be reviewed by a doctor that afternoon and if no further medical intervention could be given, he was to be discharged to the IHU.

48. The man was discharged later that day and returned to the IHU. His discharge letter shows that he was diagnosed with hyperglycemia. He was not to have any

[25] A history, recorded by escort officers, of time and events which take place while a prisoner is out of the prison as an inpatient at hospital.
[26] Stroke caused by a blockage in a vessel to the brain.

insulin unless he ate or his blood sugars improved. He was provided with an airflow mattress[27] and was turned every two hours to minimise the risk of him developing pressure sores. He was said to be very drowsy, but was able to make himself understood. He was able to swallow and was not in any pain.

49. The doctor recorded on 11 January that the man had paralysis down his left side, including his arm, leg and trunk. He was difficult to understand, but was able to take his medication. He did not complain of being in pain.

50. At 8.50am on 12 January, the man was found in an unresponsive state. His breathing was very rapid and his blood sugars were very high. He was given insulin, which lowered his blood sugar levels, after which he became responsive to voice and touch.

51. That same day, a probation officer completed the probation officer section of a compassionate release application. She noted that his level of risk of further offending was low, but there were no prospects for suitable accommodation arrangements if he was to be released. The Governor's section was completed, which noted that he did not fit the criteria for release on compassionate grounds, as there was no suitable accommodation for him to be released to.

52. On 13 January, a doctor noted that the man's condition was not yet at a stage where he needed to be started on the Liverpool Care Pathway (LCP)[28], but he should be reviewed as his condition changed.

53. At 12.00pm, the doctor was asked to examine the man. He had a sudden onset of severe, central chest pain. His appearance was pale and clammy. An electrocardiogram (ECG)[29] showed he was having a heart attack. He was given morphine for the pain, but became unresponsive soon after. Although it had been decided he should not be resuscitated, and there was no requirement for active treatment, he was sent to hospital. This was due to him needing regular injections of morphine into his vein (a potentially risky procedure), and there was not a doctor on duty in the IHU to do this over the weekend. Restraints were not used for the journey.

54. The man's condition remained critical in hospital. Two escort officers were present, but he was not restrained. Hospital staff managed his pain, but there was nothing else that could be done for him. His condition continued to decline and he was pronounced dead several days later.

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[27] A special mattress used for patients' who are unable to turn themselves independently. They minimise the risk of pressure sores developing.

[28] A pathway with clear guidelines for care of patients' in the end stages of their lives.

[29] A test that records the rhythm and electrical activity of the heart. It is commonly used to detect and assess problems of the heart. This could include heart attack, measure your heart rhythm and detect other abnormalities such as and enlarged heart.

Post-mortem report

55. A post-mortem examination was carried out on 19 January. The man's death was found to be due to a heart attack caused by a clot in one of his coronary arteries.

56. According to the post-mortem report:

> "The death of [the man] was clearly the result of natural disease. One of the major coronary arteries providing the heart with its blood supply had become blocked by blood clot (thrombosis) in an area of degenerative narrowing. This had brought about the sudden death of a substantial patch of muscle fibres in the wall of the heart (a damaged area described as a myocardial infarct). This is a common form of "heart attack", which was in this case fatal; an unsurprising outcome in view of other autopsy findings."

Support for prisoners

57. The Governor issued a notice to all prisoners that the man had died. The notice indicated the support that was available. Listeners were made available to all prisoners who needed additional support. Prisoners who were subject to ACCT monitoring procedures were reviewed.

Support for staff

58. When a prisoner dies in custody, a hot debrief is held with staff involved in his care, to ensure staff have an opportunity to discuss any issues arising, and for support to be made available. A hot debrief was held on the afternoon of 15 January, chaired by the Head of Reducing Reoffending. The care team attended, along with the FLO and both bedwatch officers. Wing staff were invited to attend, but declined. It was noted that IHU staff were not informed as they should have been. The Head of Reducing Reoffending acknowledged that this was "not ideal" and took responsibility for the error. She apologised to the IHU staff and made a note to add them to the contingency plan so they would always be contacted following a death in the future. The staff were offered the support of the care team, should they have felt they needed it. She confirmed to the investigator that IHU staff have since been added to the contingency plan.

Support for next of kin

59. As requested by the man's ex-wife, a message was left on her answering machine to tell her that her ex-husband had died. She later contacted the prison to confirm she had received the message. The FLO said that she could contact her at any time, should she need any further assistance.

Funeral

60. The man’s funeral service was held in the prison chapel on 1 February. The prison chaplain led the service, which staff and prisoners attended.

ISSUES

Chronic disease management

Diabetes

61. The man suffered from diabetes for many years. It is a chronic disease that requires close monitoring and treatment and is strongly linked with cardiac conditions. According to the clinical review, his diabetic control was poor, despite taking three medications to manage it. In the clinical reviewer's view, this was a likely result of him not always taking his medications as prescribed and not sticking to a controlled diet. His medication was also not managed as proactively as would have been expected for a chronic disease and an earlier referral for switching to insulin and withdrawing from metformin might have reduced his kidney problems.

62. Complications with diabetes, and diabetic medications, can cause kidney damage, which in turn affects the function of the kidney. The clinical director referred him to a nephrologist in January 2011, due to a decline in his kidney function. A letter from the nephrologist in February said that his metformin needed to be stopped as this could have a further effect on his kidney function. Unfortunately this did not happen until September, when he was reviewed by the clinical director again. He was admitted to hospital shortly after his review with the clinical director, as his kidney function had significantly deteriorated. During the admission, he was started on insulin. The clinical director explained that she regretted not stopping his metformin as advised. She said she had put him down for review to discuss stopping his metformin, but acknowledged that he was not actually reviewed until seven months later. She accepts she should have put an entry in his notes, to prompt medical staff who assessed him, to refer to the letter.

    The Head of Healthcare should develop a robust system for clearly recording required medication changes in a patient's medical record and ensure they are actioned immediately.

63. The man was discharged to the IHU on 4 January 2012, following an admission to hospital, as he had suffered a stroke. A doctor prescribed his insulin on 6 January, at the dose he had been on when discharged. Subsequently, on 7 January, he was admitted to hospital as his condition had deteriorated. He was diagnosed with hyperglycemia. His blood sugar was stabilised and he was discharged on 10 January. The doctor said that, on reflection, he should have reduced his insulin dose to compensate for him not eating.

64. It is concerning that the man was not reviewed appropriately following his discharge. His needs had changed since his admission to hospital and he was no longer eating as well as he had been, this consequently had an effect on the dose of insulin he needed. The doctor prescribed him the same dose of insulin as he had been receiving while he was eating properly and, as a result, he was hospitalised with hyperglycemia, a potentially dangerous condition. The clinical reviewer concludes that:

"This episode of low blood sugar could have been avoided by reducing his insulin dosage but it is unlikely that this was connected with his subsequent deterioration."

Heart disease

65. The man was prescribed warfarin to prevent a stroke, as he had an irregular heart beat and was suffering from heart failure. His warfarin dose was amended regularly, as his INR fluctuated between being under-treated and over-treated. After some time, his INR settled at a therapeutic level during early 2010.

66. The clinical reviewer comments in his review that the man's warfarin management was more problematic than it should have been. He said that a general practitioner (GP) in the community would have been more proactive when monitoring warfarin, particularly when administering antibiotics. Potential interaction with warfarin and antibiotics should have been checked with blood tests. He says that:

> "As well as poor control of his warfarin, there was confusion as to whether he had an adverse reaction to it and it was twice stopped, only for him to suffer problems as a result. The first time he suffered damage to a kidney, and had blockages to his limbs, which resolved. The second time, he suffered a massive stroke within days, from which he did not make a full recovery."

67. The man's warfarin medication was not managed effectively by healthcare staff. His warfarin was stopped and restarted on various occasions, however there was no ongoing review of his treatment and no blood tests were taken to monitor the effects. It is concerning that after he had his warfarin stopped on two occasions, he suffered serious medical issues, one of which, he did not fully recover from. We have commented on the management of chronic conditions at HMP Isle of Wight in a previous investigation, and recommended that care for those with long-term conditions be improved. Therefore, we once again recommend:

The Head of Healthcare should ensure that prisoners with chronic diseases are effectively managed and monitored.

Catheter management

68. The clinical reviewer says that the man's issues with his catheter were more problematic than they should have been. He had many episodes of blockages and consequently his urine output was poor. He was left in urinary retention for three days before being admitted to hospital. Once the obstruction was relieved, his kidney function improved, but he would have suffered considerable pain and was very unwell during the three days. We agree with his conclusion that the man's catheter management fell below the expected standard.

The Head of Healthcare should ensure that prisoners using catheters are regularly checked to avoid blockages and the risk of infection.

“Do not attempt resuscitation” (DNAR) procedures

69. DNAR procedures are used when it is not in the best interests of the patient to be resuscitated, such as if it would not be successful due to their health. This enables the person to die with dignity. A DNAR form was completed while the man was in hospital in November 2011. NHS Isle of Wight’s policy advises that medical professionals responsible for making the decision must make every effort to involve the individual in the decision. The policy advises that:

> “When there is only a very small chance of success (of resuscitation) and there are questions as to whether the burdens outweigh the benefits of attempting CPR, the involvement of the individual in making the decision is crucial.”

70. It was not recorded in the man’s discharge letter that a DNAR was in place and there is no information about who had been informed of this decision. Neither is there any record that it was discussed with him. Although the DNAR form was filed in his medical record, there is no reference to it in his clinical on-going record.

71. It is apparent from interviews with the IHU staff that doctors do not feel comfortable initiating such conversations with prisoners and many DNAR forms are completed without involvement of the prisoners. The clinical reviewer comments in his review that “this is outside best practice, where the expectation is that the majority of patients should be included in this discussion”. We agree with his conclusion, that the man should have been informed and involved in the DNAR decision.

72. Given his condition at the time of his discharge, the DNAR process should have been explained to the man. A note should also have been made in his medical record. Clear and thorough documentation of decisions would have enabled all staff to be fully informed of a person’s condition, care needs and any action to be taken in the event of an emergency. We endorse the recommendation made by the clinical reviewer:

    The Head of Healthcare should ensure that, where appropriate, decisions not to attempt resuscitation are discussed and explained with prisoners in advance, take account of their wishes and are fully recorded.

Compassionate release process

73. All prisoners who have not reached their automatic release date, conditional release date or parole eligibility date may apply for early release on compassionate grounds for medical reasons or due to tragic family circumstances. Prison Service Order (PSO) 6000, Parole, Release and Recall sets out the guidelines for early release on compassionate grounds. Early release can be considered when death is likely to occur soon. There are no set time limits, but in practice three months is often the timescale used. There also

need to be adequate arrangements for the prisoner's care and treatment outside prison.

74. A doctor completed a medical assessment for the man's application for release on compassionate grounds on 6 January. He noted that he was bed ridden and was irreversibly disabled. The doctor did not think that he was capable of further offending, based on his condition, and estimated he would not live longer than a few months.

75. A probation officer completed the probation officer's section on 12 January. She noted that his level of risk of re-offending was low, but there were no prospects for accommodation if he was released. If alternative accommodation, such as a hospice, was looked into, exclusion zones and licence conditions would need to be considered.

76. A governor completed the governor's section of the application later on 12 January. He recorded that the man did not meet the criteria for release on compassionate grounds. This was because he had no suitable accommodation for release and he did not have any support networks in the community. We are satisfied that this was appropriate.

Restraints

77. A risk assessment is completed by security staff when a prisoner goes out of the prison, such as to court or hospital. The risk assessment should consider factors such as the prisoner's sentence length, how long he has left to serve, the offence he has committed, the risk of escape and the risk he presents to the public and staff. It should be based on an assessment of the prisoner's actual risk at the time, taking into account his health and physical condition. The duty governor should review the prisoner's level of risk and amend the risk assessment accordingly. The local security strategy for HMP Isle of Wight says that:

> "The medical condition of the prisoner must be taken into account by the Duty Governor when deciding on the use of restraints, and this must be reflected on the risk assessment."

78. The man was taken to hospital following a stroke on 13 December 2011, and two escort officers accompanied him, using double cuffs and an escort chain. No medical assessment took place and no account was taken of his actual risk at the time. The points system used at the prison means it is unlikely that appropriate consideration is given to current risk as it is heavily weighted on historical and static risk factors. As he was reliant on a wheelchair and his physical condition was seriously affected by a stroke, it is difficult to see how any restraints could have been justified by a proper consideration of his condition, still less the use of "double cuffs". This means that his wrists were cuffed together in front of him by one set of handcuffs and he also handcuffed to a prison officer by another set of cuffs. We consider it was not appropriate for him to have been restrained when he was taken to hospital. His risk of escape and of further offending was minimal because of his poor physical condition and paralysis. Although restraints were removed once he arrived at hospital, his medical

condition was not appropriately taken into account when assessing his level of risk. We are pleased to see that when he was admitted to hospital in January 2012 with a heart attack, restraints were not used.

The Governor should ensure that a prisoner's medical condition is fully considered in a risk assessment for the level of escort and use of restraints needed, and that the level of restraint used corresponds with the assessed risk.

CONCLUSION

79. The man had complex medical needs. He was reviewed regularly, but did not always take his medications appropriately, specifically those used to treat his diabetes. He had many hospital admissions for issues relating to his catheter, heart disease, kidney function and medications.

80. The clinical reviewer considers that the man’s complex care needs were difficult to meet in the prison environment. Some elements of his care were equivalent to what he might have expected outside prison, but his overall care fell below that which would have been expected in the community.

81. Restraints were used to take the man to hospital without a fully considered risk assessment.

RECOMMENDATIONS

1. The Head of Healthcare should develop a robust system for clearly recording required medication changes in a patient's medical record and ensure they are actioned immediately.

   Accepted - The issue of the timely actioning of specialist advice/guidance has been has been reviewed within the GP team and is a regular feature of team meetings. Changes in medication are sent via a "task" on the electronic healthcare record (SystmOne) to pharmacy from GPs. This may also be followed up by telephone where an immediate response is required. The need to align response with need has been reiterated to all staff in the chain of supply.

2. The Head of Healthcare should ensure that prisoners with chronic diseases are effectively managed and monitored.

   Accepted - The monitoring and management of prisoners with chronic disease is now more robust and is undertaken within the Quality and Outcomes Framework (QOF), audits of SystmOne electronic healthcare record and overseen within the reporting process with Commissioners on performance on the Prison Health Performance and Quality Indicators.

3. The Head of Healthcare should ensure that prisoners using catheters are regularly checked to avoid blockages and the risk of infection.

   Accepted - All staff involved in the management of indwelling urinary catheters are expected to adhere to the procedures described in The Royal Marsden manual of Clinical Nursing Procedures (which is the standard work adopted by the Isle of Wight NHS Trust). Individual patient care plans reflect this and take account of any particular issues and action required to address them. Compliance is monitored by Team Leaders/Matron by audit of care plans.

4. The Head of Healthcare should ensure that, where appropriate, decisions not to attempt resuscitation are discussed and explained with prisoners in advance, take account of their wishes and are fully recorded.

   Accepted - Where decisions not to attempt resuscitation are in place, where appropriate, these are usually discussed with patients. The South Central Strategic Health Authority (SCSHA) Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) policy was adopted by NHS Isle of Wight (of which the Prison Healthcare Services at HMP Isle of Wight are a part) in June 2010. The Liverpool Care Pathway for the Dying Patient (LCP) was also adopted in November 2010. There is a clear expectation in both documents that a record is made in the clinical information system of any decision not to resuscitate and where it is not felt appropriate to discuss this with the patient. Prison Healthcare staff work to both these policies in line with the principle of equivalence of care.

5. The Governor should ensure that a prisoner’s medical condition is fully considered in a risk assessment for the level of escort and use of restraints needed, and that the level of restraint used corresponds with the assessed risk.

   Accepted - The Head of Security to review the current escort risk assessment with the view to enhancing the medical contribution section to better inform the decision making process in relation to the appropriateness of restraints.