Investigation into the circumstances surrounding the death of a man at HMP Isle of Wight in March 2011

Report by the Prisons and Probation Ombudsman for England and Wales

April 2012

This is the report of an investigation into the death from natural causes of a man at the Parkhurst site of HMP Isle of Wight on the morning of 1 March 2011

I extend my sincere condolences to his family and friends and to all those affected by his loss. I apologise for any additional distress caused through the delay in issuing this report.

The investigation was undertaken by one of our investigators. I should like to thank the Governor of HMP Isle of Wight and his staff for their co-operation. A clinical review of the man's care and treatment was carried out by a Clinical Reviewer on behalf of Isle of Wight Primary Care Trust (PCT).

The man died suddenly and unexpectedly from coronary artery atheroma (narrowing of the coronary arteries). The clinical review found that his clinical care was generally equivalent to that expected in the community. Despite this assessment, there were areas where care could have been improved and the review makes seven associated recommendations. For example, the man was a comparatively young man whose only risk factor for heart disease was his 25 year smoking habit. This was not recorded at Parkhurst, so no advice was given to him about the benefits of ceasing smoking. Medical record keeping is also criticised, as it has been in previous death in custody investigations at the prison. However, despite the weaknesses identified, the investigation concludes that there were no substantive reasons to believe the man was at risk of sudden and unexpected death.

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Prisons and Probation Ombudsman **April 2012**

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SUMMARY

1. Following the man's conviction of several serious offences in January 2009, he was sent to HMP Lewes. He was subsequently sentenced to 12 years imprisonment and, in May 2009, transferred to HMP Parkhurst.

2. He was noted to be a quiet and polite prisoner. He worked and attended educational classes.

3. During the initial healthscreen, the man reported no significant medical history, apart from being a long-term smoker. He had little contact with healthcare staff until January 2010 when he reported pain in his left shoulder down to his wrist. At a follow-up consultation a few weeks later a different doctor made a tentative diagnosis of frozen shoulder. The doctor referred him to the physiotherapy department and prescribed tramadol for pain relief.

4. From that time onwards, the man was reviewed regularly for the same condition, as well as later reporting pain in his knee. Doctors continued to prescribe tramadol despite his concern that he was becoming addicted to the drug. Plans were made for him to be referred for physiotherapy and to orthopaedic services, although there were delays in the referrals being made. It seems there was no provision for treatment with therapeutic ultrasound, which might have helped with his frozen shoulder.

5. The man was due to be transferred to HMP Wandsworth on 28 February to complete an offending behaviour course that was not available at Parkhurst. The purpose of such courses is to reduce the risk of re-offending and allow the prisoner to progress through his sentence. However, he said that he would not undertake the course so the transfer was cancelled.

6. On the morning of 1 March, the man's cell was unlocked by an officer on the wing, but he was not checked. A short while later, other prisoners entered the cell and found the man unresponsive. They raised the alarm and an officer responded. On checking the man, the officer found no signs of life and found rigor mortis present in his body. A doctor was asked to attend and he confirmed that the man was dead.

7. The clinical review makes seven recommendations.

THE INVESTIGATION PROCESS

8. The appointed investigator first visited HMP Isle of Wight on 4 March 2011 when he spoke with senior prison managers and was provided with copies of prison documentation relating to the man. Notices were posted informing staff and prisoners about the investigation. No member of staff or prisoner came forward to volunteer information regarding the investigation.

9. A clinical reviewer was appointed by Isle of Wight Primary Care Trust (PCT) to carry out a review of the man's clinical care and treatment. The clinical reviewer's work was subject to consideration and approval by a clinical review panel. The panel comprised: Senior Commissioner Offender Health, Isle of Wight PCT, the clinical reviewer himself, GP Governance Lead, HMP Isle of Wight, Head of Prison Healthcare, Acting Deputy Governor, HMP Isle of Wight, Healthcare Manager, HMP Isle of Wight, Modern Matron, Isle of Wight PCT and Commissioning Administrator, Isle of Wight PCT. The panel met on 18 August 2011 and the investigator attended.

10. The investigator contacted HM Coroner for Isle of Wight, to inform him of the nature and scope of the investigation. Upon completion, a copy of the report will be sent to the Coroner to assist his enquiries into the man's death.

11. One of the Ombudsman's family liaison officers contacted the man's family to inform them of the nature and purpose of the investigation. They raised no specific concerns or questions, but did ask to receive a copy of this report.

12. The delay in issuing this report was caused in part by workload pressures in the office, together with the time taken for the clinical review was finalised.

HMP ISLE OF WIGHT

13. HMP Isle of Wight was established on 1 April 2009, and contains approximately 1,700 prisoners on the three sites: Parkhurst, Albany and Camp Hill. Each site is led by a head of regime, who reports to the single governing governor. The man lived on the Parkhurst site.

14. Health services for HMP Isle of Wight are commissioned by the Isle of Wight Primary Care Trust (PCT). There are three nurses on duty at Parkhurst from 7.30am to 6.00pm from Monday to Friday. Doctors from a local community general practice provide six general practice sessions each week. Evening and weekends are covered by on-call doctors from the same general practice.

15. A new inpatient healthcare centre was completed and opened in October 2009 and is situated on the Albany site. During the night, a nurse is based in the healthcare centre on the Albany site. Although unable to leave the healthcare centre to attend to the needs of prisoners in Albany or either of the other sites, the nurse can give medical advice by telephone to staff on any of the three Isle of Wight sites.

16. Her Majesty's Chief Inspector of Prisons carried out an inspection of HMP Isle of Wight in October 2010. The inspection was critical of many aspects of healthcare provision:

> "Clinical records were maintained on SystmOne but its use varied across the sites … Some entries on SystmOne, both by nurses and doctors, were poor … A recent death in custody report from the Prisons and Probation Ombudsman had made reference to the need to improve the accuracy and consistency of clinical record keeping.
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> "… There were inconsistencies between the sites in the clinics offered and in some cases there was no correlation between the prevalence of clinical conditions and the services provided.
>
> "There did not appear to be evidence-based prescribing, and there was no prison formulary in place. The prescribing of tramadol [and other powerful analgesics] appeared to be high, with over 10% of the population being prescribed at least one of these for pain "

17. Each prison in England and Wales is monitored by an Independent Monitoring Board made up of volunteers drawn from the local community to help ensure that standards of decency and care are maintained. Members of the Board have access to every part of the prison and all prisoners held there. The Board's last report for HMP Isle of Wight before the man's death was published in December 2010. The Board made a number of observations about healthcare provision at the Parkhurst site and commented on problems relating to understaffing in the service.

18. The man's death is the ninth natural cause death to have occurred at the Parkhurst site since the Ombudsman took on the responsibility for the investigation of deaths in custody in April 2004. Relevant recommendations from these other investigations include those regarding chronic disease management and on record keeping.

KEY FINDINGS

19. The man joined the Army aged 20, but was discharged four months later after suffering an injury to his knee. He then worked in various other trades and spent the last eleven years prior to his imprisonment employed at a plastic mouldings company. He was twice married and had one child from his first marriage.

20. On 16 January 2009, he was convicted for a number of sexual offences. He had been on bail during the court proceedings but, upon conviction, was remanded to HMP Lewes.

21. Upon arrival into Lewes, the man received the standard reception healthscreen assessments as part of the prison induction process. He reported that he smoked 15 cigarettes per day. (It seems he had smoked for 25 years.) His blood pressure was recorded as 163/96. (The top of the normal range for blood pressure is 120/80. Anything above 140/90 is classed as high.) His pulse was recorded at 96. (This, again, is a high reading.)

22. During the assessments, the man was also asked about personal or family history of various diseases. He said there was no such history of heart disease, but reported a family history of diabetes. The only personal history he relayed was an allergy to nuts. He was asked whether he had undergone Hepatitis B vaccinations. He reported that he had received the first two injections, but not the final booster injection. (Hepatitis B is a viral infection of the liver. A preventative vaccination is available against this infection and is delivered through a course of three injections.) His records from Lewes contain no information about any plan to complete vaccination against Hepatitis B.

23. The man's blood pressure and pulse were retaken on 17 January. Both readings had dropped slightly. His blood pressure was 158/88 and his pulse was 85.

24. On 16 February, he attended court and was sentenced to 12 years imprisonment. He was transferred to HMP Isle of Wight (Parkhurst site) on 12 May. Documentation from Lewes was sent with him and a further reception healthscreen was carried out. His blood pressure on this occasion was 144/82. He was not asked whether he smoked and, if so, whether he wanted help in stopping smoking.

25. Entries in his prison records indicate that the man settled well at Parkhurst. He was noted to be polite and compliant. He obtained work as a wing cleaner. He also attended education and creative writing classes. He was elected onto the wing council.

26. The man appeared to be of reasonable health and had no significant contact with healthcare staff until 14 January 2010. On that day, he attended an appointment with the first prison doctor. He reported that he

had suffered a whiplash injury in 2005 and was presently suffering pain radiating form his neck to his wrist. The pain was worse when lying on his left hand side. On examination, the first doctor found that the man had restricted movement in his neck and shoulder. The first doctor prescribed ibuprofen 600mg (microgram) tablets to be taken three times per day when required. (Ibuprofen is a non-steroidal anti-inflammatory drug used for pain relief and inflammation.)

27. Another of Parkhurst's doctors, the second doctor, examined the man for the same complaint on 3 February. The second doctor noted that the man had the signs and symptoms of early frozen shoulder. The second doctor also noted that the man had not benefited from the ibuprofen and prescribed an alternative analgesic (tramadol). The prescription was for one 200mg tablet to be taken once per day. The second doctor also referred the man to physiotherapy. The second doctor wrote that a cortisone injection was not an option as the man had an "aversion to needles".

28. On 24 February, the first doctor stopped the prescription of 200mg of tramadol and replaced that with a prescription for 100mg of the drug. The first doctor noted that the rewritten prescription was in accordance with prison healthcare protocol.

29. The man's medical records show that it was not until 3 March that a referral letter was sent for him to the local hospital's physiotherapy department. This was almost a month after the second doctor had advised that a referral should be made.

30. Following the referral, the man was seen at a physiotherapy clinic in the local hospital on 7 April. Having examined him, the physiotherapist advised him about exercises he should carry out and also suggested he use a cold damp towel on his shoulder. The physiotherapist noted that therapeutic ultrasound treatment was not available at Parkhurst. (The entry in the man's clinical records immediately preceding the one made by the physiotherapist stated that he had not attended his physiotherapy appointment. This was clearly an erroneous entry.)

31. At a consultation on 15 April with the first doctor, the man asked for his tramadol dose to be increased. The first doctor rewrote the prescription and raised the dose from 100mg tablets back to 200mg tablets (one per day).

32. On 10 June, the man consulted another doctor, the third doctor, about pain in his knees. The third doctor noted that he would review the man a week later. At the follow-up appointment the man said he was still suffering the same pain so the third doctor noted that he should be referred to the orthopaedic service at the local hospital.

33. The man consulted the third doctor again on 14 September. The third doctor noted that he could find no evidence of a referral to the

orthopaedic department as he had instructed in June. He repeated that such a referral be made and noted that he would review the man in six weeks to follow this up. The third doctor also increased the dose of tramadol to 300mg per day, although he did not record why he made this change. (Up to this point, the man had continued to be prescribed 200mg of tramadol following his review in April.)

34. On 9 November, the man was reviewed by an orthopaedic specialist. On examination, the orthopaedic specialist found that the man had tenderness around the knee cap while an x-ray showed non-specific age-related knee problems. The orthopaedic specialist told the man that the best way forward would be an injection of local anaesthesia and steroids. The man said that he was not happy with that plan as he did not want to have an injection. In his letter back to the prison, the orthopaedic specialist wrote that, as the man had refused treatment from him, he would discharge him from his care.

35. At a consultation with a fourth doctor on 13 December, the man said that he was not keen about long term use of tramadol so would prefer an alternative. The fourth doctor noted that his plan was to decrease the tramadol to 200mg per day for a week, to reduce further to 100mg per day for another week, and to then stop that medication. Pregabalin would then be prescribed in place of the tramadol.

36. The next day a fifth doctor noted that pregablin was not on the formulary list (which means that it was not a drug normally stocked by the prison). The fifth doctor noted that a different plan would be needed for dealing with the tramadol prescription. In the meantime, the tramadol prescription continued.

37. Up to the end of December, the continued to work as a wing cleaner. He then obtained a packing job with DHL. (DHL is a private company with a Government contract to supply employment and training opportunities in prisons.) An entry in the man's records by one of the wing staff said that the early feedback from DHL was that he was a good and polite worker.

38. The man had another medication review on 7 January 2011, this time with the sixth doctor. The man again said that he did not want to continue with the tramadol and explained that pregabalin had previously been suggested as an alternative. The sixth doctor noted that, on examination, the man had reasonable movement in his shoulder. The sixth doctor wrote that in his view the man did not need to be on either of the two drugs and suggested reducing the tramadol to 200mg per day. He also prescribed sleeping tablets.

39. On 26 January, the man submitted a letter to a doctor in healthcare. He wrote that he had experienced pain in his shoulder and arm since the reduction in his tramadol dose. He added that he had not slept well. He asked for the tramadol prescription to be increased again to 300mg per

day or to be prescribed a different medication that was less addictive, but with the same pain relieving qualities.

40. The man was due to see a doctor on 8 February for a review of his medication but his appointment was cancelled as the clinic overran.

41. As part of his sentence planning, the man's categorisation status was reconsidered in February 2011. (Prisoners fall into any one of four categories running from Category A, the highest status, to category D, the lowest. Factors such as length of sentence and nature of offence will initially determine a prisoner's categorisation and the type of prison to which they will be assigned. Other factors considered during the ongoing categoristion proicess include the likelihood that a prisoner might attempt to escape and the risk they would pose to the public should they succeed in escaping.) Following his conviction, the man was assigned category B status. The recategorisation review in February 2011 was to determine whether his status should be lowered to category C. It was noted that his behaviour was good, that he worked and that he attended education classes. However, note was also made of the fact that he had not undertaken a particular offence related course (the Sexual Offending Treatment Programme – SOTP). Having considered the recommendations made by a senior officer, one of the governors noted:

> "I agree with the assessment to remain [category] B as there is no reduction in risk. I do not agree [location in Parkhurst]. [The man] needs to complete [an SOTP course] and [this is not delivered] here. [Management of prisoners] is about reducing risk … He needs a transfer out."

42. The man consulted a staff nurse on 14 February to discuss his medication. The staff nurse noted that:

> "Seen this morning due to confusion in relation to tramadol prescription and wanting to come off [this drug] … [The man] has gone through history of shoulder pain … Wanted to come off tramadol and swap to another analgesic because he felt he was addicted to the tramadol. He realises now that pregabalin is not in our formulary and certainly explaining side-effects [of that drug] he is not interested … Have made an appointment to see [a doctor] on Wednesday to discuss it further …"

43. The second doctor conducted a follow up medication review on 16 February. He made an entry in the medical record that the man protested against the stopping of tramadol. The second doctor prescribed 200mg tramadol tablets to cover the following seven days.

44. The man had had a further medication review on 21 February with the third doctor. The third doctor re-prescribed 200mg tramadol tablets for the next 28 days, but also added gabapentin (another medicine used to

treat nerve pain). The third doctor wrote that the gabapentin should be tried for three weeks and, at the end of the trial, it might be possible to reduce or stop the tramadol. The third doctor also noted that the man should be referred for a nerve conduction study (to test nerve damage following an injury), to be possibly followed by a referral to an orthopaedic unit.

45. The man telephoned his mother three days later. Among other things, he mentioned that he was going to be prescribed a different drug for his shoulder pain. He told his mother that gabapentin was less addictive than tramadol, although it had more side effects.

46. Following his sentence planning review earlier in the month, plans were made to transfer the man to HMP Wandsworth where SOTP courses are delivered (unlike Parkhurst). He was told on the morning of 28 February that he was to be transferred to Wandsworth that day. His response was to say that he was not guilty of the offences for which he had been convicted so he was not prepared to do the course. Parkhurst telephoned Wandsworth for clarification. Wandsworth confirmed that if the man would not do the course they would immediately transfer him back to Parkhurst. Staff told the man that he would not be transferred to Wandsworth after all.

47. In the early afternoon, the man was told that his Incentives and Earned Privileges (IEP) level would be reduced from 'enhanced' to 'standard'. Prison IEP schemes aim to encourage and reward responsible behaviour through the award of greater privileges where a prisoner has been compliant with the prison regime and has engaged in work, education or other constructive activity. Enhanced status is the highest level within the scheme. Standard status is the middle ranking level and basic status the lowest ranking with the least level of privileges. The man was told that the reason for the change was that, having refused to undertake the course, he had failed to comply with his sentence plan. This, he was told, was not the behaviour expected of an enhanced prisoner. The man was noted to have responded: "That's fine. I'm not going to admit to something I haven't done".

48. The man had telephoned his family in the morning to inform them that he might be transferred to Wandsworth. In the late afternoon, he telephoned again and spoke with his father. He told his father that his transfer had been cancelled, so he would remain in Parkhurst. He also asked his father to pass a message to his mother about sending him some money as he wished to purchase a duvet. Having listened to a recording of the conversation, the investigator was of the view that the man sounded content.

49. At 6.30am on 1 March, an Operational Support Grade[1] member of staff carried out the early morning role check of prisoners on D wing (where the man was located). The purpose of the early morning role check is to ensure that all prisoners are present in their cells. Provided all appears well, it is not mandatory for the member of staff making the check to rouse or obtain a response from prisoners. At around 7.50am, a Senior Officer unlocked the cells on D wing. Before unlocking each cell, he first looked through the observation hatch. On checking the man, he saw him lying in bed and seemingly asleep. The Senior Officer unlocked the door and moved to the next cell.

50. Not long after the cells were unlocked, one of the man's friends went to his cell to wake him, but found that he was unresponsive. The prisoner called out to an officer who went into the cell. At first, the officer thought that the man was still asleep but, when he tried to rouse him, he realised something was wrong. The officer issued an urgent message for healthcare support as well as a response from senior officers. Staff did not attempt resuscitation as there were clear signs that the man was dead. This was confirmed a few minutes later when a doctor attended and found that rigor mortis had set in. (Rigor mortis is the stiffening of the muscles which occurs some time after death.)

51. The prison's death in custody contingency plans were implemented and a prison's family liaison officer (FLO) was appointed at 8.55am. A hot debrief was held at 11.00am. Hot debriefs give staff involved in the incident an opportunity to talk about their involvement and to state whether they have any concerns or issues. They are also offered the support of the staff care team, should they feel they need it.

52. The prison FLO, accompanied by a colleague, visited the home of the man's parents at 2.30pm that afternoon to inform them of their son's death. The staff explained that they were unable to confirm cause of death at that time, but said that a post mortem examination would be carried out. The prison FLO noted that the family were shocked as their son had seemed cheerful when speaking on the telephone the previous night.

53. The prison FLO told the man's parents that their son was in the local chapel of rest and that they could visit him if they wished. She expressed her condolences and gave them her contact details so that they could contact her at any time.

54. The prison FLO spoke with man's parents and sister-in-law over the following days. She answered their questions and arranged for them to visit the chapel of rest. She also spoke with the funeral directors and arranged for the prison to meet reasonable costs for the funeral.

[1] Operational Support Grade staff do not receive the same level of training as prison officers and have limited direct contact with prisoners.

55. At the post mortem examination, the consultant pathologist found the man's cause of death was coronary artery atheroma. (Patches of atheroma are small fatty lumps that develop within the inside lining of arteries (blood vessels) causing narrowing. This can lead to restricted and reduced blood flow.) The pathologist found narrowing of up to 80 per cent of the man's coronary arteries. She explained that the severity of the atheroma in this case was sufficient to cause sudden death. She also explained that those with coronary artery disease may, or may not, experience symptoms. Symptoms that may be experienced include sweating, shortness of breath and chest pain (which may radiate down the left arm). The pathologist added that it was possible that the man's chronic pain (from previous motoring and other accidents) and paraesthesia (feeling of 'pins and needles') in the left shoulder and arm may have masked cardiac symptoms.

56. Toxicological investigations confirmed the presence of the man's prescribed medication. The concentration of this medication was consistent with normal therapeutic (prescribed) use.

ISSUES

Clinical care

57. A review of his clinical care was carried out by the Clinical Reviewer on behalf of Isle of Wight Primary Care Trust. A review panel then met to discuss the clinical reviewer's findings and to consider relevant recommendations.

58. The man's death was caused by coronary artery atheroma. The atheroma in his case was significant and was sufficient to result in sudden death. In his review, the clinical reviewer points out that there was no family history of ischaemic heart disease and the man's only risk factor for such disease was his 25 year smoking habit. Although his blood pressure was elevated on the two occasions it was tested at HMP Lewes, it had settled on the one occasion it was checked at Parkhurst.

59. The man's clinical records contain no instances of reports to staff about chest pain. The pathologist had pointed out, however, the possibility that his chronic symptoms of shoulder pain and sensation of 'pins and needles' in the arm might have masked cardiac symptoms.

60. While the overall finding on the man's care was that he received care equivalent to that which he would have expected to receive in the community, the review has nevertheless identified areas for improvement and made linked recommendations.

Preventative medicine

61. One of the areas discussed by the clinical reviewer was preventative medicine. He pointed out that the man was not formally risk assessed for cardiovascular disease. For instance, he did not have a lipid screen (a check of cholesterol and other blood fats that can contribute to heart disease). Nor did he have a diabetic screen (he had reported diabetes in his family). The clinical reviewer acknowledges, though, that the man had an aversion to needles, so might have declined those tests even if they had been offered.

62. The clinical points out that the man's smoking status was not recorded at Parkhurst (although it had been at HMP Lewes). He explained that it was an omission in the 2009 version of the healthcare reception screening form that no question was asked about smoking status and, if a smoker, whether help was wanted in stopping smoking. He adds that this information is now recorded routinely.

63. Another aspect of preventative medicine the clinical reviewer notes is Hepatitis B vaccination. The man's records from HMP Lewes suggested that he had undergone two of the three injections needed for vaccination but had not had the third (booster) injection. His records from Parkhurst contain no information about this. The clinical reviewer points out that

his' aversion to needles might, again, have made this difficult for him. However, it should have been made clear in the records if he declined the treatment. Without such clarification, the implication would be that the matter was not pursued. With the aim of providing prisoners with health promotion and chronic disease management equivalent to that they would receive in the community, the review panel makes the following recommendation:

The head of healthcare should ensure that at risk/vulnerable groups are identified for appropriate testing via Wellman clinics

Medicines management

64. The man had a long standing shoulder injury for which he was prescribed a high dose of tramadol. The clinical reviewer is critical about the length of time the tramadol was prescribed as well as the lack of regular monitoring. The clinical reviewer mentions that the man was seen by several different doctors resulting in a variety of treatment plans being started and a lack in continuity of care. The clinical reviewer recognises the security issues relating to codeine (an opioid analgesic), but considers it undesirable that the man was not offered co-dydramol or co-codamol (codeine based medicines) in place of tramadol. The review panel makes a recommendation regarding analgesic use at HMP Isle of Wight.

The head of healthcare and the Primary Care Trust should devise a plan for improved prescribing of analgesic medication. The findings should be shared across HMP Isle of Wight

Provision of other health services

65. The man was referred on separate occasions to both physiotherapy and to the local hospital's orthopaedic department. In the case of the physiotherapy referral, a month elapsed between the referral being planned and the referral letter being sent.

66. In the case of the orthopaedic referral, this was first noted during a consultation in June 2010. But at another consultation three months later, no evidence could be found of an earlier referral so a further referral had to be made.

67. The clinical reviewer has identified similar problems in other cases at HMP Isle of Wight and the review panel makes the following recommendation:

The head of healthcare should develop a system to ensure that referrals planned during healthcare consultations are actually made

The head of healthcare should monitor the number of cancelled and missed hospital appointments and put in place a system to reduce these should any pattern be identified

68. A physiotherapist who examined the man in April 2010, and who advised him on exercises and other self-care options, noted that therapeutic ultrasound treatment was not available at Parkhurst:

The Governor and Head of Healthcare should ensure access to all clinically appropriate treatments, whether available on or off site. This should apply to all prisoners at HMP Isle of Wight

Record keeping

69. The clinical reviewer notes a number of areas where he deemed the operation of the electronic record system to have been "less than optimal". Examples included duplicate entries in the records, incorrect data being entered or no entry being made at all. There were two occasions when the man was recorded as not attending a clinic, when on one occasion he clearly was seen by a clinician and on the other occasion he was sent away as the session overran. Other omissions included missing referral letters, no record of smoking status or referral to stop smoking services.

70. The clinical reviewer also notes that the man's NHS number was not used in the referral letters to the hospital. When the clinical reviewer checked the man's status on the NHS database three months after his death he was still recorded as a "live" patient. This risks letters being sent, inadvertently, to bereaved families as well as allowing opportunities for fraud and identity theft. The panel makes the following recommendation:

The head of healthcare should ensure that healthcare staff document in full their contact with patients so that they accord with the record keeping standards required by their professional bodies

Risk assessment

71. When the man was first remanded into prison custody he received a standard risk assessment to determine if he was at risk of self-harm or suicide. Such assessments were repeated at other stages, such as when sentenced at court and on transfer to Parkhurst. The clinical reviewer questions why no risk assessment was carried out when his transfer to Wandsworth was cancelled and his IEP level reduced on the same day. The answer to this is that a risk assessment would not be made as a matter of routine in such circumstances. Instead, it would depend on the prisoner's reaction to the events. From the tone of his conversation with his father following the cancelled transfer, and his documented response when told of the change in his IEP status, neither incident seems to have disturbed the man.

CONCLUSION

72. The man's cause of death was coronary artery atheroma. At post mortem, the consultant pathologist found up to 80 per cent narrowing of the coronary arteries. She explained that the severity of the disease in his case was sufficient to have caused sudden death. The man reported no symptoms of chest pain during his time in custody and no family history of heart disease. His only risk factor for heart disease was his long-term smoking habit. Although the lack of apparent signs mean that his death may not have been predicted, the pathologist pointed out that his chronic shoulder pain and associated pain in his arm might have masked cardiac symptoms.

RECOMMENDATIONS

The following recommendations were made in the draft report. The Service responses are included in italics following each recommendation:

1. The head of healthcare should ensure that at risk/vulnerable groups are identified for appropriate testing via Wellman clinics.

   Recommendation accepted:
   The knowledge gained from the development of Quality and Outcomes Framework (QOF) registers is used to inform the development of appropriate clinics and ensure the standardisation of clinic types across all three prison sites. Clinical coding has improved and has enabled more accurate data upon which to plan services.

   Actions for above in place. Reviews conducted monthly within Operational and Modernisation Group.

   SystmOne templates are in use for those patients on Chronic Disease Registers and algorithms have been agreed with GPs for nurse led activity.
   First 6 week Prison Expert Patient programme commenced as planned on 9th November 2011. Completed December 2011. Formal review feedback awaited – but informal feedback from participants was very positive.

2. The head of healthcare and the Primary Care Trust should devise a plan for improved prescribing of analgesic medication. The findings should be shared across HMP Isle of Wight.

   Recommendation accepted:
   This has been the focus of attention for over 2 years with the development of an opiate prescribing policy and pain management formulary which has resulted in a significant drop in opioid prescribing.

   Action for above in place and is the subject of ongoing improvement and monitoring via monthly audit.

   More recently a regular monthly audit has been instigated to monitor the prescribing of 'prized' drugs (those drugs most likely to be misused).

   The above is reported as part of monthly Operational and Modernisation Group and overseen within Partnership Board.

   A policy regarding the prescribing of pregabalin was implemented 12 months ago which has resulted in the prescribing of pregablin has remained static, despite ongoing pressure from patients for it to be prescribed.

   A new process for the prescribing of opioid analgesia is currently being implemented which involves functional assessment of patients on the wings and in the In-patient Healthcare Unit (IHU) prior to any new prescription of strong analgesia. In addition, patients on existing prescriptions are being admitted to the IHU to monitor their need for

analgesia and prescriptions are adjusted as appropriate, based on the outcome of this assessment. The prescriptions are being monitored as part of the monthly 'prized' drug audit outlined above.

3. The head of healthcare should develop a system to ensure that referrals planned during healthcare consultations are actually made.

   Recommendation accepted:
   Referral letters planned during the consultation are the responsibility of the GP making the referral. The process has recently changed so that the GP creates a referral letter with merged information from the Systmone electronic healthcare record. This ensures the consistency of the information provided to the hospital doctor. This will be reviewed in May 2012.

   A 'task' is then sent to the Prison Healthcare admin team via Systmone to record and send the referral and follow up that an appointment is made. 'Tasks' in Systmone are fully auditable and remain attached to the patient record. In this way referrals can be tracked through the system to ensure they are not lost.

   'Fast track' and urgent referrals can be red flagged on the task system to ensure they are urgently followed up. The Prison Healthcare admin team monitor the progress of the referral against the hospital's Patient Targeting list (PTL) which is refreshed several times a week. Once the patient is on the list, contact is made to make the necessary arrangements for attendance. Also see below (4).

4. The head of healthcare should monitor the number of cancelled and missed hospital appointments and put in place a system to reduce these should any pattern be identified.

   Recommendation accepted:
   Actions already in place and robust systems in place that ensure effective liaison between:
   - *Prison Healthcare*
   - *Prison Detail office*
   - *External hospitals (particularly St Mary's Hospital)*

   Cancellations and reasons for cancellations are monitored and reported monthly to inform further remedial action.

   February 2012 figures show a 70% achievement against the maximum number of appointments it would be possible to escort within normal escort officer allocation. 50% of the 30 lost appointments were cancellations by the prisoner rather than by prison system issues.

   Ongoing process in place for checking effectiveness of these systems.

5. The Governor and Head of Healthcare should ensure access to all clinically appropriate treatments, whether available on or off site. This should apply to all prisoners at HMP Isle of Wight.

Recommendation accepted:
Actions already in place to improve access to full range of treatments available to wider Island community under principle of "equivalence". Examples include:

- *External clinicians providing "in reach" specialist interventions within HMP*
- *Agreements in place with local NHS Commissioners for prisoners to be transferred under escort by helicopter to near mainland hospitals for specialist cardiac interventions*

The above are in place and will be developed further.

- *Telemedicine is in process of being installed within HMP Isle of Wight following award of contract to Airedale NHS Foundation Trust. This will enable faster and more efficient access to a range of secondary care consultant specialists without the need for the prisoners to leave the prison site.*

This is being installed in March 2012. The first patients should be seen during April 2012.

Equitable access to care and treatment is overseen by the Prison Services Partnership Board.

It is also likely to be an integral part of any tendering process that may take place during 2012/13 in respect of healthcare services to prisoners.

6. The head of healthcare should ensure that healthcare staff document in full their contact with patients so that they accord with the record keeping standards required by their professional bodies.

Recommendation accepted:
Decisions relating to care, treatment and support options for prisoners are recorded within the SystmOne electronic healthcare record used within Prison Healthcare. Use of SystmOne has improved since the early days following its introduction as staff have become more familiar with its functions and potential. This is subject to audit.

As part of the wider Acute Clinical Directorate of the Isle of Wight NHS Trust, all Prison Healthcare staff attend mandatory training sessions annually including information governance. Mandatory training attendance is monitored and reviewed at annual appraisals and recorded on the e-rostering system as well as within appraisal.

All clinical records systems have 'tracking' capabilities, using a range of electronic admin and records systems including SystmOne and PAS

Standards are part of the Trust's ongoing quality control/performance monitoring assurance programmes. Records Management NHS code of Practise Part 1 & 2 (6 b&c) Caldicott principles are adopted across the Trust. Staff are trained and given access to systems on a role-based professional basis and access to IT systems is auditable.

Contemporaneous record keeping practice is followed to best clinical practice guidelines by all staff who have record keeping requirements. (NMC Code of conduct)

SystmOne is used to track patients records and patients have their own unique identity number and password.