Investigation into the death of a woman at Pinderfields General Hospital on 31 March 2006, whilst in the custody of HMP New Hall

Report by the Prisons and Probation Ombudsman for England and Wales

October 2006

This is the report of an investigation into the circumstances of the death of a woman at Pinderfields Hospital on 31 March 2006. The woman was a prisoner at HMP New Hall and died as a result of multiple organ failure. She was 55 years old.

I extend my condolences to her family and to all those touched by her death.

The investigation was undertaken by two of my investigators. Both they and I would like to thank the Governor of New Hall, and the Safer Custody Group Officers, for their cooperation during this investigation. Particular thanks go to the Senior Officer who acted as Liaison Officer at short notice. Wakefield West Primary Care Trust (PCT) carried out a clinical review of the care the woman received during her time in custody, for which I am also very grateful. In addition, the Medical Director of Wakefield West PCT, requested a review of the woman's healthcare from Pinderfields General Hospital

As a child, the woman had been diagnosed with cerebral palsy, a condition caused by injury to the parts of the brain that control the ability to use our muscles and bodies. She was registered disabled and a wheelchair user and required a high level of nursing care throughout her sentence. In addition to her disability, she had a history of cellulites of the leg, hypothyroidism – a complaint linked to insufficient production of the thyroid gland, arthritis in her back and a severe heart condition.

My investigators found that healthcare staff provided excellent care for the woman, and it is a pleasure to commend the doctors, nurses and uniformed staff for their dedication in making her life as comfortable as possible with the limited resources they had. She was already ill when she was sent to New Hall and caring for her was undoubtedly a stressful and draining experience. Healthcare staff inherited the added problem of MRSA when a chest wound the woman had from a previous operation became infected. Again, I commend the staff for the speed with which they obtained and shared information about the level of nursing required to control the infection. Due to the complexity of her physical needs, at times staff had to improvise to nurse her effectively. I have highlighted examples as evidence of good practice.

This report makes five recommendations. The clinical review makes six recommendations of its own. I have also drawn attention to no fewer than six areas of good practice which I hope the Governor will share with her staff.

Stephen Shaw CBE
Prisons and Probation Ombudsman **October 2006**

SUMMARY

The woman was convicted of a serious offence in July 2005. Sentencing was adjourned pending pre-sentence reports (PSRs) and reports into her medical condition. She appeared at Manchester Crown Court again on 20 January 2006. She was sentenced to three years imprisonment.

The woman was taken to HMP New Hall outside Wakefield to begin her sentence. Although it is not unusual for women prisoners to be allocated to prisons some distance from their homes, she was sent to New Hall because she was registered disabled with extensive medical needs. Her nearest prison, HMP Styal, no longer provided inpatient care and New Hall was considered sufficiently well equipped to care for her as the prison's healthcare inpatient facility had a wheelchair accessible cell.

The Healthcare Manager at New Hall was given advance notice of her arrival. This was communicated through the Prison Service Area Office. However, without a full needs assessment of her condition in a prison environment, healthcare staff could do little other than prepare the inpatient cell for her arrival.

The woman spent a total of 69 days in custody. Her time was split between the healthcare centre and hospitals. The medical staff who cared for her at New Hall made concerted efforts to provide her with as much comfort as possible. However, her condition deteriorated and on 28 March 2006, she was admitted to hospital for the last time.

On the morning of 31 March, she drifted into a coma and died at 11.45am. Her daughter was at her bedside.

INVESTIGATION PROCESS

1. The investigation was opened at New Hall on 11 April 2006. My investigators, began by requesting all relevant prison records relating to the woman. These included her medical records and records drawn up as a result of the number of visits to hospital she had made.

2. Notices to staff and prisoners were supplied and displayed around the prison. These invited anybody with information to talk to my investigators. In this instance, no prisoners came forward. The woman's records were examined and significant events were recorded. One of my investigators interviewed a number of staff from the healthcare centre during a second visit to the prison.

3. Representatives from Wakefield West Primary Care Trust (PCT), undertook the Clinical Review on behalf of West Yorkshire PCT. In addition, the Medical Director of Wakefield West PCT, requested a review of the healthcare the woman received from Pinderfields General Hospital.

4. The Coroner was informed of the Ombudsman's investigation. The post mortem report gave the cause of death as:

   1a. Bronchopneumonia
   2. Cardiac failure, valvular heart disease and hepatic failure.

   The Coroner will receive a copy of this report when it is completed to assist him in his enquiries.

5. The woman's daughter-in-law was named by her as next of kin. She was contacted by one of my Family Liaison Officers and asked whether she or other members of the family had any comments or concerns about her mother-in-law's death. The family raised no issues but expressed an interest in receiving a copy of my report.

HMP NEW HALL

6. In 1987, New Hall was re-roled to become a women's prison. It currently holds female prisoners of all categories, both remand and sentenced prisoners, adults, young offenders and juveniles on Detention and Training Orders. The prison has a certified normal accommodation of 395. A small percentage of women at New Hall are currently serving life sentences. The prison has dormitories holding 21 prisoners, a semi-open unit for approximately 40 adult females and a Mother and Baby Unit.

7. New Hall acts as a local prison and runs education and work programmes as part of the regime. The prison offers accredited Offending Behaviour Programmes, has four workshops and a resettlement unit where prisoners can get careers advice and access voluntary services.

8. The healthcare centre is managed by three Primary Care Trusts. It is a 10 bed facility that offers primary care services. The centre is staffed by both general and mental health trained nurses, holds GP surgeries and runs a number of clinics including substance misuse and Mental Health In-reach services. Adult females and juveniles are cared for alongside each other and, since the closure of the in-patient facility at HMP Styal, the healthcare centre now takes female prisoners from the Greater Manchester area.

9. The most recently published inspection report by Her Majesty's Chief Inspector of Prisons, dated March 2004, described New Hall's healthcare centre as generally of a good standard, but not appropriate for the physically ill. The report highlighted the high number of prisoners admitted to the healthcare centre with mental health needs and noted that, while facilities for prisoners with psychiatric needs must continue, this should not impact on provision for women with physical health needs.

10. The Senior Health Care Officer said that, despite the high number of in-patients with mental health needs, the healthcare centre at New Hall is the only facility in the region with an adapted room for prisoners with physical disabilities.

KEY FINDINGS

Events leading up to the woman's death

11. When the woman arrived at HMP New Hall on the afternoon of 20 January 2006, she was taken straight to the healthcare centre, bypassing the main prison reception. Her medical risk in transit was not recorded on the Prisoner Escort Risk (PER) form. She was seen by an officer from the main prison and a limited reception process was carried out. She was then seen by a qualified mental health nurse (RMN) for her first health screening to identify any immediate health needs. She was referred to see a doctor and her medication and allergies were recorded. According to the first health screening form, she was not referred to the Mental Health In-Reach team or to a psychiatrist.

12. The woman was located in a cell that had been adapted to accommodate a wheelchair. The disabled cell was on the first floor, but there was a lift in use and vehicle access to the cell via a ramp which led up to the door of the in-patients wing. She was seen by a GP the same day and her medical needs were entered into her clinical record. The doctor's entry stated that she was too unwell for a proper examination and that this would be postponed until the following day, 21 January.

13. She had an uncomfortable first night in custody and needed assistance from staff on two occasions. An entry in her clinical record made at 4.00am said that she was unsteady and weak in getting from the chair to the toilet. Another entry at 6.40am recorded the difficulty she had in reaching the cell call bell. The nurse on night duty moved the bed so that she could reach the bell more easily.

14. On the morning of the 21 January, two members of staff helped the woman move from the bed to her wheelchair and then to the toilet. An entry made by a Registered Mental Health Nurse, said that the woman became very tired when she tried to move on her own. She also said that cell facilities were not appropriate for independent living, and a full needs assessment should be completed. The nurse also felt that the woman was at a high risk of falling. A later entry revealed that the woman was then told about the 'no lifting' policy which meant that nurses could assist but not lift her. The nurse said that she was not able to see her other in-patients that morning because she spent all of her time with the woman.

15. She was then examined by a doctor and taken by taxi to hospital at 11.45am, with a referral letter for a vascular disease assessment. At lunchtime, the local disability service in Wakefield delivered mobility equipment to help staff move her safely.

16. The woman was discharged and retuned to New Hall at 4.35pm. An entry in her medical record said there was no indication that she would receive treatment from the hospital.

17. At 4.55pm, a nurse called the hospital and spoke to a Sister in Accident and Emergency who allegedly said, “It’s pointless sending referral letters, doctors never read them.” The nurse explained the purpose of referral letters and told the investigator she got a “very abrupt and curt” reply. No PER form was found to record the hospital visit.

18. On 22 January, the woman attended a second health screening. She told a Health Care Assistant (HCA), that she was registered disabled and gave a full medical history. Later that morning, she was found short of breath and very weak when the HCA assisted her with toileting. She was also seen having difficulty holding a cup, fork and spoon and explained that she drank through a straw at home. The HCA obtained a straw from a member of staff and the Governor gave permission for the straw to be used as a temporary measure.

19. During her second night in custody, the woman fell to the floor on two separate occasions. No injuries were sustained in the first fall, but the second incident report form, completed by another Registered Mental Nurse, stated that she sustained an injury to her toes. The fall was not witnessed by the nurse and the woman was reminded to use the cell call button for assistance instead of trying to move on her own.

20. On the morning of 23 January, a member of staff from reception came to the healthcare centre to complete the induction process. The woman was issued with a smoker’s pack. The Healthcare Manager, later explained that her reception was broken up into two parts because she arrived late on a Friday and the regime is minimal at the weekend.

21. Another nurse was appointed as the woman’s ‘named nurse’. The nurse explained that this was a practice, equivalent to the Personal Officer scheme in the main prison.

22. As the woman’s ‘named nurse’, she devised a thorough care plan for healthcare staff to follow. It was entered in full into the woman’s medical record. The nurse also discussed the possibility of adopting an open door policy with the Security and Senior Health Care Officer (SHCO). The policy was incorporated into the management plan. An assessment form for cups and cutlery was faxed to Disability Services, before the full needs assessment had been completed. The nurse said that she felt it was a priority because the woman was not eating and drinking properly.

23. The woman saw one of the prison doctors at lunchtime on 23 January and was referred to the Vascular Clinic at Pinderfields Hospital. An entry in her clinical record stated that there had been some confusion

over exactly what medication she had been allergic to. The doctor confirmed that the woman could take Paracetamol for pain relief but not Aspirin.

24. Appointments were made for her to see an Occupational Therapist (OT) on 25 January and a pressure care nurse on 26 January. An entry in her medical record said that the physiotherapy assessment would be arranged separately. She spent the afternoon in education on the healthcare centre and mixed well with other prisoners.

25. On 24 January, her named nurse noticed a letter from the woman's solicitor. The letter asked for her to be put on 'suicide watch' and explained that she had attempted to take her own life in the past and had suffered from depression for many years. The nurse phoned the solicitor to discuss the issue, but could not speak to anyone and left a message for the solicitor to ring back. The solicitor failed to return her call.

26. The nurse spoke to the woman's own GP on 25 January to discuss her medical history. Her GP confirmed that her medical needs were multiple and that she was a poor complier with treatment regimes. The prison doctor wrote an initial care plan for the woman and instructed staff to request a pressure relief mattress and independent living aids urgently. At her Disability Assessment meeting later that day, ten issues were raised for healthcare staff to follow up. A nurse said she began to carry out requests for equipment, cell facilities, including a toilet seat and to obtain a copy of the woman's community care plan from her local social services department.

27. The woman was also assessed by the OT on 25 January. Along with the equipment already identified by the care plan, it was felt she needed help managing her own personal hygiene. This was because the sink in her cell was too high and not very accessible.

28. On the morning of 26 January, she was sent to hospital by ambulance. An entry in her medical record stated that "[The woman] has turned blue". This was her second visit to hospital and records show that she remained there for ten days until discharged by the hospital at 3.25pm on the 6 February. No PER form was found in her prison records for this transfer.

29. While she was in hospital, the prison's healthcare staff contacted the ward daily for progress reports. Changes to her care were recorded. These showed that she was moved to a Respiratory Unit and saw a consultant on 3 February, a week after her admission. Another Registered Mental Nurse at New Hall, contacted the hospital. She was told that the woman had 'right-sided heart failure' and was receiving treatment for the condition, but her mobility had worsened during her stay in hospital. The nurse was also told that the woman had fallen

again, could not move unaided and would be seen by the hospital's physiotherapist and medical team on Monday 6 February.

30. On the morning of 6 February, the pressure care nurse assessed her environmental needs by visiting her cell in healthcare. The assessment set out how much equipment would be needed to give her some independence. The pressure care nurse told healthcare staff that, once the woman was discharged, an air mattress would be delivered to help relieve the pressure sores she was experiencing.

31. At around 3.25pm on 6 February, the woman was discharged and returned to the healthcare centre at New Hall. On arrival, a nurse attended to her and described her as 'a little demanding in attitude and tearful on a couple of occasions'. She was considered well enough to go out onto the hospital wing for association later that afternoon.

32. On 7 February, the woman's named nurse contacted the OT and the pressure care nurse for a reassessment. Later that day an air bed and mattress arrived in healthcare. The pressure nurse came to see the woman on 8 February and devised a new wound care plan to dress the ulcers on her legs three times per week.

33. On 9 February, the physiotherapist visited the woman and a thorough assessment took place. Staff were instructed to order adjustable footwear for her to reduce ulceration to her feet and to prevent any further damage to them when being transferred. She also needed to perform daily stretch exercises to help her stand up and the healthcare unit was told to re-administer Baclofen, a spasm control drug. The assessment was critical of the lack of appropriate bathing facilities in the cell and requested arrangements be made so that she could shower sitting down.

34. At 9.15am on 12 February, a nurse contacted Local Care Direct, an advisory service for medication, and left a message explaining that the woman had been given the wrong medication by accident. Her medical record listed the medication as Trazaline 100mg, an antidepressant and Quetapine 150mg, which is an antipsychotic. The nurse also contacted the local Accident and Emergency Department and was reassured that the quantities did not amount to an overdose. At 9.43am, Local Care Direct returned the call and said that the woman might become drowsy, but that any side effect would wear off by lunchtime.

35. On 13 February, an Incident Report Form was completed by the nurse who made the error. The form revealed that the woman had been wrongly identified as someone else and that the unlock policy to her cell led to a change in routine and was a contributory factor. The woman was told about the medication error and a new memo drawing attention to the importance of following procedures was issued to staff.

36. On the afternoon of 13 February, a public protection meeting was held to discuss the woman's sentence plan. A nurse attended the meeting on behalf of the healthcare centre and informed those present that she presented no behavioural problems and was 'too ill' to attend any regime or intervention programmes. The nurse also said that the woman presented no risk to staff or prisoners while in custody.

37. On 14 February, a nurse took her to education and then returned her to her cell. In that time, she had two nose bleeds. The nurse made a note of these in her medical record.

38. On the morning of 20 February, a prison doctor saw the woman as part of her daily rounds and noticed a deterioration in her chest wound. An entry in her medical record stated that the chest wall infection had worsened and was 'sloughy'. The nurse redressed her wound later that day and noted no change to its condition. The doctor referred her to a dermatologist.

39. On 21 February, she attended a hospital appointment to see the dermatologist. She returned in the afternoon with a recommendation that she should see a cardiothoracic specialist at Leeds General Hospital. The PER form indicated that the woman was searched, but that escort chains were not used in the transfer.

40. On 22 February, she was again seen by two pressure care nurses and it was agreed that the original wound care plan should continue. A referral to the cardiothoracic team at Leeds was made by the doctor on duty.

41. At approximately 1.25pm on 24 February, the healthcare centre received swab results that revealed the woman had contracted Methicillin-Resistant Staphylococcus Aureus, known as MRSA. An entry in her medical record said that staff were not told which of her wounds was infected. A nurse immediately called infection control to obtain information on what type of nursing to introduce. At 3.50 pm, another nurse spoke to infection control and was told that 'universal precautions' applied. The nurse entered full instructions into the woman's medical record and these clearly stated that she could continue to mix with the ward community as long as other prisoners did not have open wounds. She was told of the infection, but did not seem to be familiar with the term MRSA.

42. Infection Control contacted healthcare again and further advised staff to treat her infected wound like any other, but to pay particular attention to hand hygiene to prevent cross-infection. Infection control guidance was placed in her medical records and all materials needed to manage the MRSA were obtained.

43. At 8.20am on 1 March, the woman was escorted to the dermatology clinic at Pinderfields General Hospital by taxi. Later that afternoon, a

nurse spoke to the clinic and was told that the woman had undergone a cyst-removal procedure on her chest. She returned to healthcare the same day with new wound dressing instructions. These were implemented alongside her care plan and the infection control procedures already in place. A PER form relating to this visit was found to be wrongly dated 3 March.

44. On 3 March, she attended education, but later complained of chest pains. She was told that the doctor would see her in the morning. The doctor prescribed Paracetamol for her chest pains.

45. The woman was seen by the doctor again on 6 March. Swabs were taken of her right leg and chest and sent by taxi to the Pathology Department.

46. On 7 March, at approximately 2.15pm, she again fell in her cell and sustained a head injury while reaching to flush the toilet. An entry in her medical record stated that she had some bruising and swelling to a small area of her forehead and was still experiencing discomfort from her chest wound. For the rest of the day, she refused association with other patients and complained of feeling 'unwell'. No incident report form (F213) was found in her file.

47. For the next few days, her wounds were cleaned and dressed according to infection control and care plan instructions. On 10 March, a nurse followed up results of the swabs taken four days earlier and was told by the Pathology Department at Pinderfields Hospital that the sample was never received. The nurse arranged for another sample to be sent by taxi immediately.

48. At the woman's next regime review on 12 March, the board agreed to start the process of upgrading her to enhanced status. Healthcare staff later explained that this meant she would receive additional benefits, including an increase to her weekly cash allowance, extra visits, in cell television and an increase to time allowed out of her cell.

49. At 2.45pm on 14 March, the Clinical Governance Lead GP at New Hall, visited the woman in her cell. On closer inspection of her wounds, the doctor decided that they needed "more extensive exploration" and agreed for an ambulance to be called. At 6.45pm, she was sent to Pinderfields Hospital again and returned at 11.15pm with a new prescription for antibiotics. An entry in her medical record stated that the hospital had agreed to take on the referral made for the woman to see a cardiothoracic specialist at Leeds.

50. On the morning of 16 March, the woman was seen by the prison doctor. The doctor made an entry in her medical record which said that, after two urgent referral letters on 20 and 26 February and an additional referral made by Pinderfields Hospital, the woman had still not been seen by the cardiothoracic surgeon. The doctor contacted

Leeds and noted that the hospital tried to persuade her to refer her back to Pinderfields Hospital. She refused and explained to Leeds that consultants at Pinderfields had agreed she needed to obtain a cardiothoracic surgeon's opinion. The on-call doctor at Leeds said that the doctor at New Hall could send her to Accident and Emergency in the first instance, before any decision over admission to hospital could be taken. The doctor explained that the woman was infected with MRSA.

51. Later that morning, a nurse ordered an ambulance and asked control staff for a wheelchair accessible vehicle for the woman. An extensive entry in her medical record described a series of errors with the transfer. The nurse was given a taxi instead of a suitable ambulance and questioned control staff about the mix up. The entry stated that control staff then questioned the nurse's authority in first asking for an ambulance that took wheelchairs and then enquiring why a taxi was not suitable for the journey. The nurse complained about the attitude of the control staff and described them as "uncooperative". The Orderly Officer on duty that day telephoned the nurse and made a formal apology on behalf of the control staff involved.

52. The nurse was questioned again by gate staff as to why a taxi was not suitable to take the woman to hospital. The complaint was dealt with a second time by a Principal Officer, and the two officers who questioned the original request apologised to the nurse. The Healthcare Manager was told of the incidents and agreed she would raise the questioning of medical staff, and arrangements for ordering transport at the next senior managers meeting.

53. At 2.10pm, an ambulance arrived at the healthcare centre. The nurse noticed that it was not equipped to carry wheelchairs and checked what was ordered with gate staff. A further entry in the woman's medical record said that gate staff told the nurse that a wheelchair accessible ambulance had been specified. The woman was transferred to Leeds Accident and Emergency Department in the ambulance but without her wheelchair. The nurse then told discipline staff who escorted the woman to hospital that she was not to be discharged back to New Hall in a taxi because nursing staff could not lift her from the car to her wheelchair and back to her cell.

54. At 3.00pm, the Accident and Emergency Department phoned healthcare and complained that they had no prior knowledge of the woman's arrival. The nurse explained that the prison doctor had spoken to the on-call doctor earlier and made the arrangement. An entry in her medical record said that the hospital then complained that the prison doctor had not followed the correct procedure and should have been made aware that a specialist's name was always needed for referral purposes.

55. At 5.45pm, escort staff telephoned the healthcare centre at New Hall to inform the nurse that the woman was being discharged. She returned to the healthcare centre at 7.45pm and was helped into her wheelchair by ambulance staff. She slept for long periods in her chair that evening.

56. Following the events of 16 March, another nurse spoke to a doctor in healthcare who then called Pinderfields Hospital to discuss how to proceed with the outstanding referral. Both parties agreed that healthcare should contact Leeds once again and make an urgent appointment for the woman to see the cardio team at the hospital. The nurse telephoned Leeds and left a message for the hospital to call the healthcare centre back.

57. On 18 March, the woman was reviewed again by the prison doctor. Her appearance was recorded as “breathless, yellow skinned, blue lips/tongue with bruised limbs”. The doctor contacted Pinderfields Hospital immediately and explained to a consultant on the Medical Admissions Unit that she was, ”extremely concerned regarding this lady and her presentation and risks…” The entry also recorded that the doctor had discussed the cardio team referral problem, and had been told that Leeds had declined attempts by Pinderfields to admit the woman under their referral process.

58. She spent the next few days in hospital. On 20 March, the dermatology consultant at Pinderfields phoned New Hall to convey the results of her chest x-ray. A nurse logged the results and recorded the telephone conversation at the request of the prison doctor.

59. On 23 March, the woman was taken from Pinderfields Hospital to see a cardiothoracic surgeon at Leeds. Following the appointment, the surgeon informed Pinderfields that he was unwilling to perform any surgical procedures due to her heart condition. The nurse on duty was told by telephone and logged the outcome of the referral. The woman remained in hospital overnight and was prescribed oral antibiotics.

60. She returned to the healthcare centre on 24 March and was not seen by a doctor again until 27 March. During this time she remained in a poor condition and complained of being in pain all over. She took a liquid diet and her medication, and was advised to stay in bed. A nurse said that she noticed small red spots on the woman’s chest. This was entered into her medical record for the doctor to see on her next round.

61. On 27 March, the prison doctor made an extensive entry into her medical record which stated she was ‘clearly unwell’. The doctor questioned the appropriateness of caring for her in prison and suggested that a Palliative Care Plan might be more appropriate to co-ordinate services to meet the woman’s medical needs. The doctor confirmed that it was prison policy to resuscitate a prisoner unless the Home Office decided otherwise and made a request for her cell to be

left unlocked all night to ease access for healthcare staff to attend to her.

62. At lunchtime, two governors approved the unlock request. Following this decision, the doctor saw the woman again and discussed resuscitation arrangements with her. The woman said that she felt "50-50" but was not well enough to discuss the arrangements in any detail, other than that she would like to be resuscitated if her heart were to stop. She did not recall having a similar conversation while in hospital. An entry was made in her medical records to instruct staff to perform active resuscitation in the event that she had a cardiac arrest.

63. At 2.30pm, a governor was told that the woman would be resuscitated if necessary and was asked to pass the information onto the governing governor. She had a blood sample taken and this was sent to the Pathology Department by taxi.

64. At 5.00pm, the doctor made an entry in the woman's medical record that revealed that the Pathology Department had no knowledge of her blood sample. The doctor confirmed that the contracted taxi firm New Hall used had collected the sample at approximately 2.00pm, and explained that it was too late to take another sample and get the results written up that evening.

65. The woman had a very poor night. In the early hours of the morning of 28 March, she was described as disorientated with cyanosed lips and fingers, short of breath on exertion and had difficulty mobilising. At 4.15am, she was helped to the toilet by a night duty nurse who noticed that her hands were very cold. Her pulse was taken and recorded.

66. At 10.15am, the Healthcare Manager asked her whether there was anyone she wanted the prison to contact. She said that she had an aunt, but could not give contact details. The Healthcare Manager said that she would make enquiries to see if the woman could be released on compassionate grounds.

67. Her condition deteriorated further and she lapsed in and out of consciousness. A nurse attended to her and found she was unable to support her own weight, eat or drink anything and was very short of breath. The nurse had difficulty obtaining a blood sample from her and noted that she remained very cold and was sleeping for long periods.

68. At 11.00am, another prison doctor reviewed her condition and noticed a severe deterioration in her health. He explained to her that if she was not admitted to hospital she would die, and asked staff to arrange for a 999 (blue light) ambulance to take her to hospital immediately. The doctor wrote a referral letter which stipulated that she was not to be discharged back to New Hall without a full discussion with him first.

69. The woman was escorted by two prison officers to hospital as an emergency. The escort risk assessment accompanying her made it clear that, because she was very frail and had experienced multiple organ failure, she was not to be handcuffed or restrained.

70. The bedwatch log revealed that a governor contacted one of the officers on bedwatch duty with next of kin details. The officer gave the details to a nurse who managed to contact the woman's son at around 4.35pm. Her daughter was also contacted by the hospital and a nurse from New Hall spoke to the charge nurse and logged the progress in the woman's medical record.

71. At around 5.00pm, a member of the chaplaincy visited her bedside. While she was at the hospital, the Chaplain telephoned the prison and instructed an officer to contact HMP Manchester in order to inform the woman's partner that she was in hospital.

72. At 6.00pm, a Roman Catholic priest arrived at her bedside and she was given the last rites. The charge nurse explained to her what was happening to her before her daughter and daughter-in-law arrived shortly after. The woman's family told the officers on bedwatch duty that they would like to remain at her bedside until she passed away and the prison was kept informed of developments.

73. According to the bedwatch log, she had an uncomfortable but stable night. She was placed on a syringe driver that administered morphine to manage her pain and was kept as comfortable as possible.

74. On the morning of the 29 March, she managed to speak to her daughter who was at her bedside. For the next two days, she slept for long periods. Her breathing and level of discomfort was monitored by nursing staff. The chaplaincy team took turns to be present from early in the morning until late afternoon. Both Chaplains left their contact details with the hospital and with the woman's family, and asked to be contacted at night if it was felt that she needed them.

75. At around 9.00am on 30 March, the Healthcare Manager received authorisation to start the paperwork for Early Release on Compassionate Grounds. One of the prison doctors completed the relevant section of the application and stated that the woman would need 24 hour palliative care on release. The application ran into difficulties and the doctor made two attempts to resolve the problem of consent to release her medical records. She was too ill to give consent and her consultant was not available to support the application.

76. On 31 March, the woman's daughter was still at her bedside and at around 9.05am, she was joined by a prison chaplain. The bedwatch log recorded a further deterioration in her condition, but said that she was made very comfortable. Again, escort staff contacted the prison and provided a full update of the early morning events.

77. Between 9.40 and 11.30am on 31 March, healthcare staff made two more phone calls to the hospital in an attempt to resolve the problem of consent to release medical records. A consultant rang the prison and told a member of nursing staff that she had fallen into a coma and would probably pass away that day. Both the consultant and healthcare staff agreed that if she remained in hospital over the weekend, the consultant would take legal advice about releasing her medical records on the grounds of best interest.

78. At 11.45am, the woman died with her daughter at her bedside. The hospital doctor formally pronounced the death and the officers on bedwatch duty, informed New Hall immediately.

79. As her daughter was already at the hospital, she contacted the woman's daughter-in-law who arrived within an hour. Her family stayed at the hospital until shortly after 3.00pm and left with the chaplain. Escort staff stayed on at the hospital until approximately 4.30pm at which point they returned to the prison.

Events following the woman's death

80. Shortly after her death, the prison's Family Liaison Officer, and Head of Safer Custody made arrangements to visit the woman's partner at HMP Manchester. During their visit, they provided full details of the funeral to enable him to make arrangements to attend if he wished.

81. The woman's funeral went ahead with her immediate family present. The Family Liaison Officer and a prison chaplain attended on behalf of New Hall. The prison met the funeral costs.

ISSUES CONSIDERED DURING THE INVESTIGATION

82. The woman was a prisoner with significant physical needs. It is comparatively rare for prison staff to encounter this level of disability or be asked to offer this level of care. She was already very ill when she arrived at New Hall. When she contracted MRSA, it was the first time some nursing staff had experienced an infection control situation at the prison.

83. I have no doubt that healthcare staff and officers who came into contact with her did everything they could, within their means, to make her life more comfortable and dignified until her death. That said, although there would have been no effect on the ultimate outcome for her, the investigation also highlighted a number of areas where practice could still be improved.

84. Prison Service Order 1025 (PSO) provides guidance on when and how to complete a PER form. Chapter 1 (1.8) states that 'A PER form is to be completed for every external movement of a prisoner, whether responsibility transfers to another agency or not and to whatever destination.' In her case, not all transfers to outside hospitals were accompanied by PER forms. In other cases, where a PER form was completed for a transfer it was not always filled in accurately. I have not been able to establish why these inaccuracies occurred, and must assume either that the relevant paperwork was not completed or that the prison had subsequently mislaid the forms.

The Governor should remind both dispatching and escort staff of the purpose and importance of completing a PER form for every prisoner transfer and refer staff to PSO 1025 for further guidance.

85. On two separate occasions, the woman's blood samples were not received by the Pathology Department at Pinderfields General Hospital. The arrangement for sending samples for analysis is by taxi from the gate every afternoon. Both the doctor and a nurse said the current transport arrangement usually worked well, and I could not establish whether the problem related to a failure to deliver them to the right hospital department or whether the department mislaid her samples. On both occasions, samples were sent to Pathology again.

The Healthcare Manager should consider implementing a system whereby samples are signed for on collection from the prison and on delivery to outside medical departments.

86. About two weeks before she died, a nurse telephoned control room staff and ordered a wheelchair accessible ambulance to take her to Leeds General Hospital. A taxi was ordered in error. After a lengthy delay, an ambulance finally arrived at New Hall but it was not equipped to take a wheelchair. The nurse felt her authority as a nurse had been

questioned, although she did received apologies for the mix up from all the staff involved. The Healthcare Manager, said she would raise the issue of the relationship between healthcare and the control room at the next senior management meeting but, when interviewed, apologised for not having raised it to date. She did give a firm assurance that the issue would be on the agenda at the next meeting. The woman made her appointment, but she experienced an unnecessary delay and had to travel without her wheelchair. Clearly this was not an acceptable outcome for transporting a registered disabled prisoner to and from a hospital appointment.

The Healthcare Manager should consider implementing a memorandum of understanding between healthcare staff and control room staff to ensure all requests for specific transportation are accurately recorded and acted upon according to medical need.

87. When the woman arrived at New Hall, she was taken straight to the healthcare centre and underwent an initial healthcare screening. This formed part of the reception process into the prison and was designed to highlight immediate areas of concern for referral purposes. She was convicted of a crime against a minor and, as such, should have been automatically referred to the Mental Health In-Reach Team for psychiatric assessment. The nurse who carried out the reception screening was not aware that the form clearly stated that prisoners charged with offences against children must be referred for assessment. As a result, the woman never received a mental health assessment and while, understandably, the focus was on her complex physical health needs, her mental health should not have been overlooked.

The Healthcare Manager should ensure that nursing staff fully understand all referral processes attached to first reception health screening of prisoners.

88. The day before the woman died, New Hall's governing governor gave authorisation for an application for Early Release on Compassionate Grounds to be completed. The prison and hospital ran into difficulties shortly after the paperwork began and, whilst the doctor on duty did all she could to resolve the problem of consent, the application came too late for the woman who died. Doctors interviewed said they were not familiar with the process of early release and this application was the first time they had been asked to contribute. The Healthcare Manager did have previous experience of processing applications, but said that she found the policy difficult to implement.

The Governor and Primary Care Trust should ensure that local policies and procedures for early release are understood by all managers.

89. I also question whether the woman's disability was always considered appropriately when reviewing her conduct and contribution to her sentence under the Incentives and Earned Privileges Scheme (I&EP Scheme). Her disability and medical problems meant that she could only participate in a very limited regime, but she participated well according to her records. She was reviewed on 10 occasions, but was not considered suitable for an upgrade to enhanced until 12 March. She was eventually awarded enhanced status the day before she died, but the decision came too late for her to feel the benefits. The issue of diversity was raised with my investigator but, in speaking to the Health Care Manager, she has been assured that full responsibility for incorporating disability issues into local policies will be taken from August 2006. For that reason, I make no recommendation on this matter but draw it to the attention of the governing governor.

CLINICAL REVIEW

90. The Clinical Review conducted by West Wakefield Primary Care Trust commented on the lack of adequate nursing assessment when she was first admitted to the inpatients unit. It said that an adequate clinical assessment and care plan was not initiated until she was seen by her named nurse, who was also the primary care lead nurse, some days later. However, I have established that she came into prison on a Friday and the regime was in 'Patrol State' for the weekend in between. This meant that the prison operated with a minimum level of staff until the normal regime resumed on Monday 23 January. Therefore, it may have been reasonable for her to have had to wait until that Monday morning for a full assessment by the primary care lead nurse.

The primary care team should introduce a protocol which addresses the immediate need to initiate an effective clinical assessment and care plan within a specified time limit, e,g. within 24 hours, and that this is initiated by a first level registered general nurse. The use and quality of the core care plans should be developed so they are clinically specific to the individual patient with greater emphasis on identifying clinical problems and establishing effective nursing interventions at an early stage of the patient's care pathway through prison.

91. The Clinical Review also suggested a lack of understanding of the correct care pathways when referring a prisoner to outside hospitals. It said that care pathways into secondary care by the prison do not appear to be fully understood by prison healthcare staff or local NHS staff. The Review recorded that the woman's first referral to the A&E Department at Pinderfields Hospital on 21 January was not appropriate and illustrated a lack of awareness as to the role of and function of the A&E. Similarly, medical staff from Pinderfields and Leeds hospitals appeared to have a perception that the prison was a more suitable clinical environment than, in reality, it is. The inpatients unit is not a suitable environment for clinical management of very poorly and severely disabled patients. I fully endorse the recommendations that follow:

The PCT/Prison partnership should improve its communications between local NHS providers and the prison to raise awareness about prison healthcare.

The PCT/Prison partnership should review the function of inpatients so as to establish its parameters to the clinical care it can safely and effectively provide within existing resources.

92. The Clinical Review also commented negatively on the deployment of a healthcare assistant to perform her second healthscreen. It said that this grade of staff does not have the professional accountability or professional clinical skills to undertake a comprehensive healthscreen

and assessment. However, the second health screen is predominantly about health promotion and, having interviewed the healthcare assistant, my investigator was satisfied that she is a highly experienced member of staff who is permitted to undertake all nursing tasks with the exception of administering medication and being present when doctors are reviewing prisoners in healthcare. The Healthcare Manager may wish to consider the following recommendation:

All healthscreens/clinical assessments should be undertaken by a first level registered nurse, which includes the secondary health screen at the prison.

93. The Clinical Review also highlighted the lack of availability of a Registered General Nurse to carry out a clinical assessment of the woman and devise a care plan within an acceptable time. It said that the initial care plan was not adequate, given her high level needs. However, my investigator ascertained from interviewing Registered Mental Nurses (RMNs) that she was the most complex physical needs patient they had cared for on the centre. I should also point out that HM Chief Inspector of Prisons said in her most recent report on HMP New Hall, that the overwhelming majority of inpatients at the prison had mental health needs. The Healthcare Manager may wish to consider the recommendation:

Nursing skill mix and the deployment of nurses and allocation of clinical work needs to be reviewed as a matter of urgency by the primary care provider so as to ensure that, wherever possible, a registered general nurse is either on duty, or is accessible, to expedite an immediate primary care physical health clinical assessment and care plan.

94. The Clinical Review also stressed the difficulty staff had in accessing moving and handling training in order to assist the woman with her mobility. I fully endorse the recommendation that follows:

The PCT, as commissioner of training for their staff, should review the service level agreement it holds with its provider of training to ensure that the agreement includes training provision for prison healthcare staff as a matter of urgency.

95. The Clinical Review found that care pathways and referrals from prison healthcare staff to the PCT for specialist advice and assessment were effective and working.

96. The prison's primary care team provided a good quality of care for the woman within the limited resources available.

RECOMMENDATIONS

OPERATIONAL

1. **The Governor should remind both dispatching and escort staff of the purpose and importance of completing a PER form for every prisoner transfer and refer staff to PSO 1025 for further guidance.**

   Accepted: Local Notice to staff to be issued reminding staff of the importance of completing PER forms for every prisoner transfer.

2. **The Healthcare Manager should consider implementing a system whereby medical samples are signed for on collection from the prison and on delivery to outside medical departments.**

   Accepted: The Head of Healthcare will carry out a review of the current procedures in respect of medical samples. The outcome of the review will be discussed at the Operational Improvement Forum (PCT).

3. **The Healthcare Manager should consider implementing a memorandum of understanding between healthcare staff and control room staff to ensure all requests for specific transportation are accurately recorded and acted upon according to medical need.**

   Accepted: This issue has already been discussed at Senior Management Team Level. Updated instructions on contacting the ambulance service will be sent out as an Operational Order.

4. **The Healthcare Manager should ensure that nursing staff fully understand all referral processes attached to first reception health screening of prisoners.**

   Accepted: The Healthcare Manager will undertake to brief all healthcare staff on the local policy and procedures, and ensure that this procedure is discussed at SPDR Interim Reviews and all staff understand and adhere to local procedures.

5. **The Governor and Primary Care Trust should ensure that local policies and procedures for early release are understood by all managers.**

   Not Accepted: There is a nationally recognised and agreed system in place at HMP/YOI New Hall in respect of releasing prisoners on compassionate grounds due to terminal illness. This procedure was followed in respect of the woman.

   I have no doubt that was the case but those staff interviewed were either not familiar with the procedures or found them difficult to

implement. Consequently, I suggest the Prison Service considers whether there is a training issue to be addressed.

CLINICAL

6. **The primary care team should introduce a protocol which addresses the immediate need to initiate an effective clinical assessment and care plan within a specified time limit, e,g. within 24 hours, and that this is initiated by a first level registered general nurse. The use and quality of the core care plans should be developed so they are clinically specific to the individual patient with greater emphasis on identifying clinical problems and establishing effective nursing interventions at an early stage of the patient's care pathway through prison.**

   Accepted: The new service agreement/service specification with Wakefield West PCT for primary care delivers primary care nursing provision and ensures that a clinical assessment and care plan is initiated within 24 hours by a first level registered general nurse utilising quality core care planning that is clinically specific to the individual patient and has greater emphasis on identifying clinical problems and establishing effective nursing interventions at an early stage of the patient's care pathway through prison.

7. **The PCT/Prison partnership should improve its communications between local NHS providers and the prison to raise awareness about prison healthcare.**

   Accepted: The PCT will work with Mid Yorkshire Hospitals NHS Trust to effectively disseminate information pertaining to Prison Health to clinical teams across the local health economy.

8. **The PCT/Prison partnership should review the function of inpatients so as to establish its parameters to the clinical care it can safely and effectively provide within existing resources.**

   Accepted: The role of the inpatients unit has been reviewed and from that analysis the mental health specification, which includes the function of inpatients developed; the mental health specification for implementation commencing 1 October 2006.

9. **All healthscreens/clinical assessments should be undertaken by a first level registered nurse, which includes the secondary health screen at the prison.**

   Accepted: Responsibility for reception has been transferred to the Substance Misuse Unit (SMU) and is incorporated within their new service specification. Reception procedure has been redesigned following a multidisciplinary process mapping event. An automated and dispensing system (Methasoft) used on the substance misuse unit

is to be extended into the reception area and connected via a local area network. Primary healthcare screening by qualified staff has been implemented and is being undertaken by the SMU.
Secondary healthcare screening will be undertaken by qualified staff in the new service specification wherever possible. Health care assistants would be deployed to this task only in the event of unforeseen staffing shortages on the unit. A reception "stock take" event will review the procedure and ensure it is benefiting and meeting the needs of the women prisoners and the policies and guidelines of safer custody in the prison. This event will determine whether or not sufficient resources are in the specification to enable us to meet the target regarding screening at all times.

10. Nursing skill mix and the deployment of nurses and allocation of clinical work needs to be reviewed as a matter of urgency by the primary care provider so as to ensure that, wherever possible, a registered general nurse is either on duty, or is accessible, to expedite an immediate primary care physical health clinical assessment and care plan.

Accepted: This is incorporated within the new service specification for primary care nursing services provided by Wakefield West PCT.

11. The PCT, as commissioner of training for their staff, should review the service level agreement it holds with its provider of training to ensure that the agreement includes training provision for prison healthcare staff as a matter of urgency.

Accepted: The training provision has been reviewed and new service level agreements are in place in relation to staff training.

GOOD PRACTICE

12. The effort made by the Health Care Assistant, to obtain a straw for the woman in the early stages of her sentence, ensured that she could take a fluid diet without difficulty whilst waiting for a more conventional drinking aid.

13. The request from healthcare staff to secure an unlock policy for her during both the daytime and, later in her sentence, during the night shift, demonstrated a high level of care. The permission granted ensured that she could be attended to quickly by nursing staff.

14. The escort risk assessment decisions to refrain from restraining her for any hospital visits ensured that she was treated with dignity at all times.

15. Bedwatch staff were highly conscientious in updating the prison of her progress on a regular basis.

16. The care pathways and referrals from prison healthcare staff to the PCT for specialist advice and assessment were very effective.

17. The prison's primary care team provided a good quality of care for the woman within the resources they had available.