

**INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING THE
DEATH OF A MAN IN HOSPITAL IN MARCH 2005 WHILST IN THE
CUSTODY OF HMP PENTONVILLE**

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

May 2007

This is the report of an investigation into the circumstances of the death of a man in March 2005. He died in hospital whilst serving a sentence of imprisonment at HMP Pentonville. He was 37 years of age.

The post mortem report concluded that the man died of a cerebral infarction (a stroke). My colleagues and I would like to extend our sincere condolences to his family and friends for their loss.

The investigation was conducted by one of my investigating officers assisted by another officer. A panel led carried out a clinical review on behalf of the Islington Primary Care Trust (PCT). Following receipt of their report, our investigation was supported by a registered clinician.

Following a pre-inquest hearing, the Coroner directed I undertake further investigation into the circumstances of the man's death. This further work has been undertaken by my Deputy Ombudsman and by a registered clinician. They have endorsed the view expressed in my initial investigation. I had clearly identified systemic failures which, in turn, HMP Pentonville had accepted and sought to address.

I am grateful to the Governor of Pentonville and his staff for their co-operation with my investigation team. I regret that it has taken such a long time for this report to be completed.

My report makes five recommendations and I also endorse the eight recommendations made in the clinical review. I have concluded that, while in the custody of Pentonville, the man received a standard of healthcare that was unacceptable.

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Summary

The man died in hospital in March 2005, at the age of 37. He was serving a sentence of three years and three months imprisonment at HMP Pentonville.

After complaining of pains down the right side of his body on 22 January 2005, he was moved to the prison's Healthcare Centre for observation. He was reviewed on 23 January, and admitted to hospital on 24 January suffering from a spontaneous collapse of the lung (pneumothorax).

Following a short stay in hospital for treatment, the man returned to prison on 4 February. He was placed on normal location on D wing, despite the hospital discharge sheet indicating he should go to the Healthcare Centre. There is no record that medication prescribed for him at the hospital was administered, and he received minimal pain relief and virtually no nursing care for his surgical wound.

He suffered a further lung collapse and was returned by ambulance to the hospital on 9 February. He was moved to a specialist hospital on 15 February for an operation. After the surgery, he regained consciousness for only a short time before lapsing into a coma from which he sadly never emerged.

On 25 February, the man was released from custody on temporary licence. This was reviewed on 2 March when it was extended until 8 March. However, after a scan on the same day revealed no brain activity, he was pronounced dead. A post mortem carried out on 4 March found the cause of death was cerebral infarction (stroke).

Both my investigation and the clinical review panel found that the man received a less than acceptable standard of healthcare while in the custody of Pentonville.

My report makes five recommendations in addition to the eight recommendations made in the clinical review undertaken by the PCT.

Further to the issuing of my first draft report, Pentonville has made substantial progress in improving practice in those areas identified to have systemic failures at the time of the man's imprisonment. I have received copies of new *Clinical Nursing Guidelines for the Management, Treatment and Disposal of Patients Requiring Nursing Intervention within Pentonville Healthcare*, a new *Clinical Incident Reporting and Investigating Procedure*, a new *Medicines Policy* including a related training policy for staff, and a report on progress in clinical governance. In addition, I have received a report of an audit of compliance with Governor's Order 41/2006 *Correct procedures for the transfer of inmates to and from hospital* (a follow up to Governor's Order 10/2005 issued on 1 March 2005). The results of the initial audit were disappointing but an action plan for improvement has been put in place.

Investigation Methodology

The investigation was begun on 14 March 2005. It was led by one of my former investigators. He met with the Governor and with a representative of the local Independent Monitoring Board (IMB), and with the prison's chaplain. The local branch representatives of the Prison Officers' Association (POA) were not available at this time but were subsequently briefed on the nature and scope of the investigation. All relevant available documents and records were collected.

Prior to attending the prison, notices to staff and prisoners, terms of reference and the Governor's notification letter were sent for distribution and display. They announced the investigation and invited staff and prisoners to submit to my investigator any concerns or views they wished to express.

My investigator tried to contact two prisoners who shared a cell with the man while he was in Pentonville. One has left the country following his release from custody. The other has not replied to correspondence.

One of my family liaison officers telephoned the man's mother, to arrange a visit which took place on 5 April 2005 at the family home. This meeting was very informative and allowed his family to raise their concerns over his treatment both in prison and in the first hospital.

As part of my investigation process, the local Primary Care Trust (PCT) is required to undertake a clinical review of the care afforded to the deceased person whilst in prison. In this case Islington PCT appointed a doctor to lead a panel to review the man's care in Pentonville, and at the two hospitals where he was treated. The panel concluded that the care and management that the man received at Pentonville was of an "unacceptable standard". Once their report was received by my office, a number of Pentonville staff were interviewed by my initial investigators to explore further some of the issues the clinical review had highlighted, as well as to obtain more information about the man's time in Pentonville. These interviews took place on 20 September 2005.

On 28 September, my investigators discussed the clinical review with the Governor, the Head of Healthcare at the time of the man's death, and the In-patient Development Manager.

A key purpose of my investigations is to identify learning opportunities, and good practice if applicable, to prevent a further death in similar circumstances. It is not to apportion blame or identify civil or criminal liability. In the case of this man, whilst both the panel review and my investigator identified that the care he received was of an unacceptable standard, these were due to systemic failures rather than any one individual.

Following a pre-inquest hearing on 11 September 2006, the Coroner, directed I undertake further investigation into the circumstances of the man's death. This further investigation was undertaken by my Deputy Ombudsman assisted by a registered clinician. They decided there was little point in re-interviewing all those who had spoken to the original investigators. Instead, they met with the new head of

healthcare on 23 October 2006, and with the pharmacist and one of the prison's doctors on 24 October. They also re-interviewed the in-patient development manager and a prison officer. The aim of these discussions and interviews was to gather more information about the man's reception back into custody following a period in hospital, and the circumstances of the apparent missing medication. (My remit does not stretch outside the criminal justice system and I have no express authority to interview staff beyond the prison, probation and immigration services.)

During their further investigation, it came to the attention of my deputy Ombudsman and the registered clinician that there might have been a breach of the Code of Professional Conduct issued by the Nursing and Midwifery Council (NMC). Whilst this had no material bearing on the circumstances of the man's death, it was highlighted to the deputy governor and head of healthcare who immediately ordered an investigation.

Following the pre-inquest hearing, I was made aware of a substantial number of concerns raised by the family through their legal team. The vast majority of the concerns relate to the role of the NHS and fall outside my terms of reference. Where the concerns are properly within my remit, I have tried to address them within this report.

HMP Pentonville

Pentonville is a Victorian prison. Its primary function is to serve the courts of North London. The prison holds sentenced prisoners, together with those on remand for all Magistrates' Courts and Crown Courts within the area. Pentonville has a certified normal accommodation of 897 and an operational capacity (maximum crowded capacity) of 1,175.

There have been six other deaths at Pentonville since June 2004. None of these raised issues similar to those arising from the man's death.

The HM Chief Inspector of Prisons last inspected Pentonville in February 2005. Her subsequent report said that:

"... there was a new and impressive inpatient facility. However, primary healthcare was limited and prisoners did not have confidence in the system. In our survey, 23% of prisoners rated the overall quality of healthcare as good or very good, while 45% said it was bad or very bad. The care of newly arrived prisoners was a concern. GPs were task-orientated; nursing plans were poor; there was a lack of health promotion; and there were serious deficiencies in primary mental healthcare. There was poor handling and storage of medicines including controlled drugs; no clinical supervision, no chronic disease work and poor management of waiting lists."

"The most recent health improvement plan was dated 2002, although we were assured that this had been updated. Islington Primary Care Trust (PCT) now commissioned healthcare services. The PCT understood the issues and was striving for improvement: a multidisciplinary clinical governance committee had been established."

(In respect of a quite separate investigation, I have seen for myself how impressive the new inpatient facility at Pentonville is.)

Events prior to the man's death

The man was sentenced to three years and three months imprisonment in August 2004 for the offences of burglary, receiving stolen goods and going equipped for burglary. He had been on remand at HMP Brixton and returned there after sentencing. In late August 2004, he was transferred to HMP Hollesley Bay.

At the 7.30am roll check on 9 September, the man could not be found. He had absconded and was unlawfully at large for eleven days. He was taken back into police custody on 20 September 2004 and sent to Pentonville the next day.

The man was assessed by the prison medical team and referred to the substance misuse and aftercare team for treatment of his drug and alcohol dependency. From the age of 20, the man had been using heroin and crack cocaine regularly. He said this was because of the financial, physical and psychological problems that he was experiencing at that time. He said that he had been drinking a large amount of alcohol since he was 16 years old. His family have clearly indicated that he was not a heavy drinker; they think it is likely he said he drank large amounts of alcohol in order to obtain a prescription of diazepam. They have also informed us that after his death the man's liver was transplanted so must have been healthy for this to have taken place. His family feel that this shows he was not a heavy drinker as he had stated.

He told the substance misuse and aftercare team that, after he absconded from Hollesley Bay, he had used heroin and crack cocaine as well as drinking strong alcohol. This was confirmed by a positive test result of his urine. He was placed on a detoxification programme of diazepam and methadone together with carbamazepine.¹ There was no record of any methadone being administered. The diazepam reduction was completed on 2 October and the carbamazepine was not administered after 19 October. After that date, he did not come to the attention of the healthcare staff until 22 January 2005.

On 22 January, a healthcare officer was called to see the man who was complaining of a sudden onset of chest pains and tightness down the right side of his chest. He was admitted to the prison's Healthcare Centre. The man was examined by a duty nurse. He told the nurse that he had suffered with heart problems since the 1990s as a result of his 'crack' habit.² He was prescribed atrovent, salbutamol and flucloxacillin.³ Hourly observation and assessment of his condition was ordered but there is no documentary record of these observations taking place.

The duty nurse noted that the man had completed the detoxification programme two weeks earlier, but this was not borne out in the clinical records made available to my investigators. His family told my investigators that the man achieved a number of certificates for progress on a drug rehabilitation wing. They were concerned that,

¹ Diazepam is a benzodiazepine widely used in detoxification in prisons. Methadone is an opioid analgesic recommended for treatment of heroin addiction. Carbamazepine is an anti-epileptic drug used to prevent or reduce seizures.

² As his family has pointed out, the information the man gave is likely to have been incorrect as his heart was offered and accepted for transplantation following his death.

³ Atrovent and salbutamol are each a different type of bronchodilator which treats breathlessness and flucloxacillin is an antibiotic.

when he completed the programme, he moved to a different wing where he had access to illicit drugs. The man told Healthcare staff on 22 January that he had been using heroin on D wing for the previous two weeks, but this was not substantiated by any recorded drug tests.

A review of his condition was carried out by the in-patient development manager on 23 January. He recommended continued monitoring and observations. These were carried out, but the clinical review finds that the assessments were poor. The in-patient development manager suggested a course of medication, but there is no record that this was considered.

A prison doctor also carried out a review of the man's case on 23 January. He suggested that a chest x-ray should be carried out to rule out a pneumothorax (collapsed lung). An x-ray was not taken until 24 hours later when it was discovered that the man had in fact suffered a collapsed lung. At this point, the prison doctor contacted the Medical Registrar on duty at the hospital, about a possible right-sided pneumothorax. Subsequently, the man was admitted to hospital for treatment. A chest drain was inserted to remove fluid from his lung and assist re-inflation. The man was referred to a consultant thoracic surgeon, at a specialist hospital.

On 4 February, the man was discharged back to Pentonville from hospital to wait for a bed to become available at another hospital for the surgical examination by the consultant thoracic surgeon. A prison officer told my investigator that prior to leaving the hospital the man had said that he did not want to go onto the Healthcare Centre but would prefer to go back to his own cell on D wing. The officer said that he discussed this with the consultant, who said that he had no problem with him going onto the wing as long as he took things steadily. However, the first hospital discharge sheet said the man was expected to be placed in the Healthcare Centre. The prison officer told the man that, if the medical staff at the prison agreed, then he would be taken back to his cell instead of to the Healthcare Centre.

The man was escorted back to Pentonville by two prison officers. On arrival, he was taken to the reception area to see medical staff before being allocated a cell. However, due to staff shortages, no medical staff had been detailed to work in the reception area that afternoon and the man was taken back to his previous cell on D wing. My investigator could find no documentary evidence that the man was seen by any member of the medical or nursing team, even though the reception and escorting staff say that he would have done so. There are no records of any monitoring of his condition in the six day period that he was located in his cell on D wing.

The man was discharged from the hospital with paracetamol tablets (one gram, four times a day) and codeine phosphate tablets (30mg, four times a day). My investigator could find no record of what happened to the medication with which he left hospital, although the prison officer is sure he handed it to the reception staff. There was no record of this medication in the man's prison prescription sheet. It was not until 7 February that he was prescribed 1g paracetamol twice daily. There are four entries on his prescription chart indicating he received paracetamol on the morning of 7 February, morning and afternoon on 8 February, and morning on 9 February. There are no entries in the clinical record referring to any reason for his

pain. The clinical review suggests that this level of pain control may have been inadequate. It is therefore possible that the man could have been in pain throughout this time.

My investigator interviewed the man's landing officer who was on duty every day that the man was there. She said that the man did not appear to be in pain. My investigator also interviewed two nurses who are based on D Wing. They told him that the man did not complain of any pain and was in high spirits. On the other hand, his parents say that, on their visit to him on 8 February, he was in considerable pain.

When the man returned from the hospital, no clear instructions about wound care were sent with him. This particular nursing problem therefore went unidentified, primarily because of the lack of clinical assessment on his return to prison. The first D wing nurse told my investigator that she had placed a dressing over the man's existing dressing whilst he was on the wing. There is no entry in his medical records to verify this.

On 8 February, the man received a visit from his parents. They reported that he cut the visit short because he felt unwell. They also raised concerns with a principal officer (PO) about some of the man's belongings that were missing from his cell when he had returned from hospital. The PO agreed to make enquires to try to find them. The man's mother says that she also asked about her son's medication because he was in pain. She says that the PO told her that sometimes medication is not given because it can cause an adverse effect on the prison drug testing programme. My investigator discussed this with the PO who has no recollection of saying this. He also said that this was not the case as prescribed medication is always given.

At 8.40am on 9 February, the landing officer was called to the man's cell by his cellmate. She found the man sitting on the floor. She immediately called for the nurses to attend. The two D wing nurses went straight to the cell to see him. He appeared to them to have suffered a second spontaneous lung collapse. He was taken immediately by ambulance to the first hospital, where he was admitted and again referred to the specialist hospital.

On 15 February, the man was transferred to the specialist hospital under escort by two prison officers. He underwent an operation on his right lung and had a chest drain inserted on 17 February. Shortly after the operation, he spoke to his family and complained of being in pain. The nurses said this was due to the operation. The man then became unconscious and was moved to the Intensive Care Unit. He never spoke with his family again. On 23 February, a prison manager visited the hospital and said that the escort was being reduced to one officer from that evening. On 25 February, the man was released on a compassionate temporary licence, with a review scheduled for 2 March when his temporary release was extended until 8 March. However, after a scan on 2 March revealed that there was no brain activity, the man was pronounced dead. A post mortem carried out on 4 March 2005 found the cause of death to be a cerebral infarction.

On 1 March 2005, a Governor's Order (10/2005) was issued by the governor, giving detailed instructions about the procedure when a prisoner returns to prison from

outside hospital. He wrote that, without Healthcare staff involvement, 'a number of prisoners' had been placed on ordinary location rather than in the Healthcare Centre after being in-patients at outside hospital. The Order requires that all prisoners returning from outside hospital be referred to Healthcare staff for an assessment.

Clinical review

A clinical review into the care of the man who died was conducted in July 2005 by a panel which met formally on 1 August to discuss its findings. This panel was led by a clinical reviewer on behalf of the Islington Primary Care Trust. During the course of their review, the panel had access to all the man's prison medical records, as well as his medical records from the two hospitals he was admitted to.

Their report concluded that the care and management that the man received at Pentonville was of an "unacceptable standard". Their main concern was that, when the man returned from the first hospital with a discharge summary sheet saying that he should be located in the prison's healthcare department, this did not happen. Instead he was returned to his cell on D wing. The report is also critical of the lack of any record that his condition was monitored whilst on D wing.

The reviewers identified that the level of record keeping and the lack of robust local procedures resulted in a sub-optimal level of care. There was no evidence of any clinical reassessment once the man had returned to the prison. On the contrary, there was evidence of poor pain relief and a lack of nursing care in relation to observations and wound care.

The review panel said that these deficiencies contributed to a delay in accessing timely specialist intervention, and denied him access to basic nursing care. They said it was difficult to be conclusive as to whether or not the lack of nursing care was directly linked to the cause of death without the opinion of a Consultant Chest Physician.

The panel considered the care and management of the man at both hospitals to have been of an acceptable standard.

Family concerns

My investigator and my family liaison officer attended a meeting with the man's family at their home on 5 April 2005. During this meeting, his parents raised concerns about the treatment their son received both in prison and in the first hospital. Most of the family's concerns about the prison have been covered in this report, but their remaining questions are set out below. My investigation has not looked at the actions of the first hospital, although the clinical review has covered some of the issues raised by the man's parents.

1. The parents say that no one from the prison told them that their son had been moved to the first hospital on the first occasion. The man instead had to ask hospital staff to do this for him.

There is no policy in place at Pentonville to inform a prisoner's family when they are taken from the prison to outside hospital. If the prisoner is taken out as a result of an emergency or their condition is considered life threatening, then the family would be informed at the earliest possible time.

2. The parents say that the hospital gave antibiotics to their son to treat an infection around his wound, and cream for a rash, to take back to the prison. They say these were not given to him when he returned to the prison.

There is no evidence on the discharge sheet that the hospital discharged the man with antibiotics or cream. This report has already commented on the fact that the paracetamol and codeine phosphate, which were issued on discharge, were not given to him at the prison. The man's mother subsequently told her legal team that what she had thought were antibiotics were codeine phosphate tablets, a prescription only analgesic for moderate pain.

3. The parents say that, when their son was readmitted to the first hospital, staff there said that another hospital had called the prison three times to inform staff that a bed was available between 4 and 9 February, but this information did not appear to have reached the Healthcare Centre.

My investigator can find no record of these calls from the hospital or at the prison. I am therefore unable to take this matter any further. The man's parents may wish to consider taking this issue up directly with the first hospital using the hospital's complaints procedure.

4. The parents felt that the prison's surveillance of their son in the outside hospitals was heavy handed towards the end and could have been reduced earlier. They gave as examples attempts by prison staff to handcuff him following an operation and to enter the operating theatre. They also said that he could have been released on compassionate licence earlier than he was.

My investigator was given access to the bed watch logs and found the surveillance and staffing levels to be of an acceptable level. Following a check at the hospital by one of the prison managers, the necessary paperwork was

commenced to release the man on temporary licence. He was released on temporary licence on 25 February 2005 and this was due to continue until at least 8 March. Prior to his operation on 15 February, he was still mobile and able to walk around. With a history of absconding from another prison earlier in his sentence, in my view it was not unreasonable to withhold temporary licence at that stage. However, a more speedy decision on the granting of a compassionate licence once the man was unconscious and sedated in the Intensive Care Unit might have avoided some of the distress to his family.

5. Some of the man's possessions went missing when he was moved to the Healthcare Centre after he collapsed the first time. His parents collected his possessions and a CD player was missing, but there were two radios that did not belong to him. On 28 March, his parents wrote a letter to the prison with the receipt in order to be reimbursed for the CD player.

My investigator has spoken to the prison and I understand that the man's mother received a cheque from the prison on 12 April 2005 to meet the cost of the CD player, thereby resolving this matter. However, the prison should ensure that, when a prisoner's personal property is removed from their cell, a cell clearance form should be completed and a copy of the form placed in the prisoner's file.

6. The parents say that they were not given a named liaison officer or contact telephone number at the prison. They also feel that the prison could have done more by way of informing them that the prison could help with the cost of the funeral.

My family liaison officer contacted the prison to enquire about the funeral costs and the prison has now made a contribution. My view is that the prison should have made sure that a family liaison officer had been identified to help and offer support to the man's family at this difficult time.

7. On a positive note, the man's parents wished it to be noted in this report that the care at the specialist hospital was 'second to none'. They also said the prison officers who were with their son in the outside hospital were good and had kept up his morale.

In conjunction with the pre-inquest hearing on 11 September 2006, I became aware of many other concerns raised by the family through their legal team. The majority of these relate to the NHS and fall outside my terms of reference as Prisons and Probation Ombudsman. Where the concerns are properly within my remit, I have tried to address them within this report.

Findings and conclusions

Upon his return to prison from the first hospital, the man was not assessed by Healthcare staff in reception. He was placed in normal living accommodation with no arrangements in place for his healthcare. This was a serious failure on the part of the prison. The Governor recognised the failure when, on 1 March 2005, he issued an Order to make sure that it did not happen again. From the wording he used, it seems other prisoners had experienced the same shortfalls in the reception process.

The hospital faxed a copy of the discharge summary to Pentonville. This clearly documented his medication (codeine phosphate and paracetamol), but gave no wound care advice. The discharge summary is in the medical record but there was no evidence that it was acted upon.

According to his family and the discharge summary, the man returned to Pentonville with medication prescribed by the hospital doctor. There was no record of what happened to it. The loss of the medication is a serious matter. Not only did the man not receive it, and there is no record of it arriving at the prison, codeine-based medication could be used as illicit 'currency' by prisoners if not kept under proper control.

There was no evidence that the man received appropriate pain relief. The codeine phosphate and paracetamol were not prescribed immediately on his return to Pentonville. The records show he was eventually prescribed paracetamol three days after his return. Nursing staff on the wing said that the man did not complain of pain while he was there. The landing officer supported this, but his parents said that when they visited him he was in considerable pain. Given his physical condition, there is a possibility that the man had experienced pain.

Not only was the man left without pain relief, but there is no record that his wound was dressed in the six days he was on D wing. The first D wing nurse says that she placed a dressing over the man's existing dressing, but this could not be corroborated. She made no entry in his records to that effect.

The clinical review points out that the lack of documentation meant it was not possible to say how long the man was unwell before he was returned to hospital.

It is evident in the bed watch records for 21 February that the prospects for the man regaining consciousness were bleak. On 23 February, the officer who carried out the manager's monitoring visit at the hospital on 22 February wrote to the duty governor to update him on the man's situation. He wrote that the ward sister in the Intensive Care Unit had told him that the brain scans were showing considerable swelling of the brain. Until it subsided, they could not estimate how much brain damage the man had suffered. He was to have a further brain scan later on 22 February.

On 23 February, the prison manager (who had received the officer's note) went to the hospital and ordered that the bed watch be reduced from two officers to one. On that same day, the process for considering release on temporary licence (ROTL) on compassionate grounds was initiated. Unfortunately, due to the requirement to

consult quite widely, and giving due consideration to the risks posed by a prisoner who had previously absconded and had significant past convictions, ROTL was not granted until 25 February. For the parents, the delay from the time their son became dangerously ill until his temporary release was granted must have been very distressing.

The prison should at an early stage have ensured that a family liaison officer was assigned to help the man's parents. The failure to ensure that this happened only caused more stress for them and made effective contact with the prison difficult.

It is clear from both my investigation and the clinical review that the man received a less than acceptable standard of healthcare while in the custody of Pentonville.

The clinical review team are unable to say definitively whether or not the lack of nursing care contributed to the man's death. But it is a matter of great concern that the possibility that his death was avoidable cannot be discounted.

Recommendations

It is imperative that steps are now taken to ensure that the failings in the care provided to the man who is the subject of this report cannot happen again.

Operational

1. When prisoners are dangerously ill, assessment for release on temporary licence should be initiated at the earliest possible opportunity.

Health

I recommend that the governor and the PCT work together to ensure that the following recommendations are implemented:

2. There should be an audit of compliance to ensure the procedures for medical care of prisoners returning to prison from outside hospital are adhered to.
3. All medication returning to the prison with escorting staff is handed over to the healthcare department and signed for on the escort's paperwork.
4. A training package should be developed to ensure that all healthcare staff are fully trained in the correct procedures for records and record-keeping in accordance with the requirements of their professional bodies.
5. A thorough system of management checks should be developed to audit the standard of records and record keeping.

In addition I support the recommendations of the clinical review, namely that:

- There is a review of the educational needs of nursing staff, followed by appropriate updates/professional development to ensure competent physical assessment and diagnostic skills.
- Systems are developed to embed training and education into clinical practice through clinical facilitation and audit.
- There is a review of policies and procedures around the handling of unwell prisoners and the guidance around use of prison doctor services, use of prison 'hospital' and threshold for admission to external secondary care providers.
- A clinical assessment framework is established and implemented to support clinical decision making.
- There is a review of policies and procedures around prescribing, dispensing and administering of medications by nursing staff.
- There is a review of policies and procedures in the prison 'hospital' to support nurses working beyond standard parameters of clinical practice. It is not clear how care is provided or who is responsible.

- A pool of medical staff should be developed to provide expert clinical opinions for use in prison investigations and reviews.