Investigation into the circumstances surrounding the death of a man at hospital in August 2010, while in the custody of HMP Dovegate

Report by the Prisons and Probation Ombudsman for England and Wales

September 2011

This is the report of an investigation into the circumstances surrounding the death of a man in August 2010 at hospital, while he was in the custody of HMP Dovegate. He was 49 years old.

He was remanded in custody on 13 August 2010. He already had a heart condition which he reported on reception and he suffered a heart attack a week later. Prison healthcare staff treated him and he was taken to hospital. His condition deteriorated and he suffered further cardiac arrests on the morning of 22 August. Hospital staff could not revive him and he was certified dead at 9.51am. His family were with him when he died. The investigator and I would like to extend our condolences to the family and all those affected by his death.

The investigation was led by an investigator. An independent review of the man's medical care in prison was commissioned from the local Primary Care Trust and carried out by a clinical reviewer. I am grateful for their assistance.

It is regrettable that the lack of urgency, openness and commitment to the investigation by some staff at HMP Dovegate has significantly delayed my report. Regrettably my attempts to communicate my concerns with the Director did not receive a response. I am unaccustomed to being treated with anything other than complete openness and respect and so these comments are very unusual. However, I would like to thank those staff who did cooperate with my investigation.

Although I do not think that prison staff could have prevented the man's death, my investigation has found a number of failings within the short time that he was in Dovegate, in respect of his clinical care and the response of healthcare staff when he was first taken poorly. I am also disappointed with the poor healthcare staff attitudes that came to light. I am however pleased to note two areas of good practice. Because of his serious condition, the prison allowed him to stay in hospital without restraints. As well, the Director of the Therapeutic Prison went to great lengths to find his partner which meant that she could visit before he died.

I make nine recommendations about medical record keeping at Dovegate which is below acceptable standards, ongoing clinical care after the reception and induction procedures, the conduct of medical staff on his initial reception into the prison healthcare department, the maintenance of equipment and procedures surrounding the calling of emergency ambulances. Given that many of the matters have been raised previously by both the Independent Monitoring Board and the Chief Inspector of Prisons, I urge the Director to take prompt action on these longstanding issues**.**

My findings and my comments about the conduct of the investigation are such that I draw my report to the attention of the Chief Executive of the National Offender Management Service.

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

Thea Walton
Acting Deputy Ombudsman **September 2011**

CONTENTS

Summary

The investigation process

HMP Dovegate

Key events

Issues considered during the investigation

Conclusion

Recommendations and Responses

SUMMARY

1. The man, a prisoner at HMP Dovegate, died in August 2010 in hospital. He was 49 years old. He had been remanded in custody at the prison nine days before and taken to hospital two days before his death.

2. On reception, he was suffering from recently diagnosed angina, sciatica and depression. His community general practitioner (GP) had prescribed medication for his heart condition. He smoked and, by his own admission, was a binge drinker.

3. During the week following his reception, his medical records were not fully completed and some procedures were not carried out, principally referral to the doctor on reception and a secondary healthcare assessment. Information gathered during the induction was not passed to the healthcare department. In addition, it appears from the record that medication prescribed for his heart condition was not given to him in the first few days.

4. On the morning of 20 August, he became unwell and collapsed with chest pain and was taken to the prison's healthcare centre. I judge that his initial treatment by healthcare staff was characterised by a lack of urgency and was handled badly. Nevertheless he appeared to recover but then suffered a heart attack. Staff made sustained efforts to resuscitate him until the paramedics arrived. He was taken to hospital where he remained under prison escort, without restraints, until 22 August, when his health further deteriorated and he suffered a fatal heart attack. He died with his family at his bedside. During the period immediately before and following his death, his family were supported by prison staff.

5. The Deputy Director sent a letter of condolence to the family and his property was returned at a meeting on 2 September. His family raised no concerns about his care or treatment while at the prison. HMP Dovegate met the costs of the funeral.

6. After his death, the Coroner accepted a diagnosis of myocardial infarction and ischaemic heart disease and took the view that a post mortem was not necessary. An inquest took place on 17 November and a verdict of death by natural causes was returned.

7. The clinical reviewer concluded that once he had his heart attack there was little that staff could do to change the eventual outcome. However, both the clinical reviewer and my investigator identify serious shortcomings in his treatment which could have serious consequences for other prisoners in the future. Many of the failings had been previously identified by the Independent Monitoring Board and Her Majesty's Chief Inspector of Prisons.

8. I make nine recommendations which I am pleased to note have all been accepted. They cover record keeping, reception and induction procedures, the conduct of medical staff, the maintenance of equipment and the calling of an ambulance during a medical emergency.

INVESTIGATION PROCESS

9. My colleague visited HMP Dovegate on 27 August 2010, where he met the Director of the Therapeutic Prison and later the Deputy Director, who gave him a briefing about the circumstances surrounding the man's death. He also met the Operations Manager for healthcare, who briefed him on that department. A copy of the man's prison and medical records were made available to him.

10. The investigator offered to meet staff representatives and members of the Independent Monitoring Board, but neither accepted the invitation. Notices to staff and prisoners had been previously published inviting anyone who might have information relating to the man to make themselves known to the investigator. One prisoner spoke to the investigator and was interviewed formally during his initial visit. As Dovegate was either reluctant or unable to arrange interviews, the investigator interviewed relevant prison staff including members of the healthcare department over an extended period.

11. The investigator also spoke to Serco's Senior Investigating Officer about the lack of clinical notes by nursing staff on 22 October 2010. He provided a copy of those notes on 6 November. Notes of interviews were submitted to staff for validation and signature at Dovegate on 18 November, followed by a number of reminders and requests to the liaison officer and senior staff which resulted in most of the notes being returned by 24 February 2011. To date some notes of interview have not been validated and returned.

12. The lack of urgency, openness and commitment to the investigation process shown by some staff at HMP Dovegate during this investigation has delayed significantly the publication of this report. The investigator had an exchange of telephone calls and emails with the original liaison officer about the difficulty arranging to see staff for interviews and obtain their responses and validate the interview notes. The officer apparently left Dovegate suddenly on or just before 12 January 2011 and was replaced. Both officers were emailed at the appropriate times with reminders that the investigator wanted to interview staff or receive their signed notes.

13. The investigator then spoke on 14 February to and emailed the Head of Healthcare about these difficulties. He undertook to obtain signatures from healthcare staff and return their notes, which he did on 24 February.

14. There are still some notes from discipline staff that have not been returned. The investigator made several telephone calls to speak to the Director or the Deputy Director but was unable to do so. He left three messages on 15, 16 December and 19 January with the Director's clerical support in an attempt to resolve the issues but got no response.

15. The Chief Executive of the local Primary Care Trust (PCT), commissioned a clinical review of the man's care from a clinical reviewer. The review was received on 26 January 2011 from a Senior Clinical Governance Manager at the local PCT. Having failed to contact either the Director or Deputy Director,

the investigator spoke to the Head of Healthcare on 10 and 25 November. They discussed the emerging issues principally medical record keeping and the policy for calling emergency ambulances. These matters are considered later in my report and urgent recommendations are made.

16. One of my family liaison officers was briefed regarding the man's family circumstances and contacted them. The family expressed no immediate concerns and have been involved in the investigation process, requesting and receiving a copy of the draft and final reports.

17. Staffordshire Police were informed of the death but were not involved as they do not consider the circumstances of his death to be suspicious. The Coroner for South Staffordshire accepted the hospital clinician's diagnosis as to the cause of his death and did not direct that a post mortem examination take place. An inquest took place on 17 November 2010 and a verdict of death by natural causes was returned.

HMP DOVEGATE

18. HMP Dovegate is a purpose built prison near Uttoxeter in Staffordshire, privately run by Serco Civil Government on behalf of the Ministry of Justice. It was opened in 2001 as a category B training prison holding convicted and remanded adult male prisoners. Since expansion, it has an operational capacity of 1133. A small number of lower category prisoners are held at HMP Dovegate awaiting relocation. Prisoners are risk assessed when they come into prison and given a category based on their offence and the risk that they pose to the public should they escape. There are four levels: A, B, C and D, with category A prisoners being the most dangerous. Category B prisoners do not require the highest security conditions but escape must be made very difficult.

19. Healthcare at Dovegate is provided by Serco Health. Unlike public sector prisons, the local Primary Care Trust (PCT) is not responsible for delivering healthcare. There is apparently a strong relationship with the local PCT, which provides managerial and clinical support. A new healthcare manager had been appointed and taken up his post a matter of days prior to the events leading up to the man's death and is currently reviewing existing policies and procedures

20. Each prison is required to have an Independent Monitoring Board (IMB). The IMB is a body of people appointed to each prison by the Secretary of State for Justice to be independent watchdogs of the public interest. They are not members of the Prison Service, nor are they part of the management team. They are required to produce an annual report on the prison to the Secretary of State, highlighting good practice and flagging up areas of concern. The IMB at HMP Dovegate wrote an overall judgement within their report for 2008/9, part of which is relevant to this investigation:

> "Healthcare continues to concern the Board. There have been too many personnel changes at all levels. Medication is dispensed erratically and often late; we have heard numerous incidents of repeat prescriptions not materialising. Appointments with the doctor fail to take place and outside hospital appointments are delayed for no apparent reason. All of this is unacceptable and the Board feels very strongly that the matter needs addressing without delay. A new and dynamic Healthcare Manager has now been appointed and the Board looks towards improvement."

Section 3.3 Healthcare and Mental Health of the same report contains the following extract which is also relevant:

> "Applications to the IMB regarding healthcare are the second highest number being 14.01% of all applications. The complaints are about medication, or lack of medication, long waits to see consultants and claims that they are ignored by staff."

21. HM Chief Inspector of Prisons (HMCIP) report of an inspection visit between 29 September and 3 October 2008 makes the following observations and recommendations which are also of relevance to this investigation:

> "4.19 The health services department held resuscitation equipment, including a defibrillator. There was limited equipment on the house blocks, and no defibrillators. The equipment was checked weekly and after use. Health staff attended mandatory cardio pulmonary resuscitation training through the PCT.
>
> "4.22 There was no clinical medical information technology system. This severely restricted the management and progress of services, including patient record keeping and clinical audit. Clinical records were still paper based and held in a secure room off the primary care nurses' station. The entries were generally satisfactory, but the identity of the health professional making the entry was often missing or illegible, and had to be checked against a list held by the healthcare manager. Care plans for inpatients were in place, and entries were of a high standard and made at least daily.
>
> "4.29 All new arrivals had a reception health screen, including a comprehensive mental health screen. They were given a booklet outlining the health services available and how to access them. New arrivals did not routinely see a doctor unless they requested to do so or the nurse felt there was a clinical need. There was no secondary health screening. The increasing number of prisoners arriving late affected other prisoners, as nurses had to attend reception to undertake the reception health screening."

HMCIP recommended that:

> "4.69 A clinical patient management IT system should be introduced as a matter of urgency.
>
> 4.71 Resuscitation equipment, including defibrillators, should be centrally sited in each house block.
>
> 4.72. All new arrivals should receive secondary health screening during their induction."

22. A defibrillator is a portable electronic device which measures electrical activity in the heart and advises on action to be taken. The defibrillator has electrocardiogram leads and paddles which during use are placed on the patient's chest. If fibrillation (a rapid chaotic beating of the muscle fibres in the heart) is present the defibrillator delivers a brief electric shock to the heart, which may enable its natural pacemaker to regain control and establish a normal rhythm.

23. Since 2004, when the Prisons and Probation Ombudsman took over investigation of deaths in custody, to the date of the man's death there have

been twelve deaths at Dovegate. Although several recommendations were made regarding clinical matters in previous investigation reports, the circumstances were not similar to those in his death.

KEY EVENTS

24. The man was arrested on the evening of 12 August 2010. A Person Escort Record (PER), completed by Staffordshire Police at their Northern Area Custody Facility that day at 10.01pm, indicates that he suffered from angina and had a glycerin trinitrate (GTN) spray (used to treat angina and heart failure) with him. He was also noted as suffering from depression. He was subsequently remanded in custody by magistrates for assault and the breach of a recently imposed conditional discharge. He was refused bail because it was thought he would commit further offences and he had previously failed to surrender to bail. The Escort Handover Details form does not indicate that he had prescribed medication in his possession or in police custody on 13 August. No property was listed by Reliance, the escorting contractor, who took him to Dovegate prison.

25. He was received into Dovegate at 2.10pm on Friday 13 August. A nurse assessed him and recorded that he suffered from angina pectoris (the inability of the coronary arteries to fully meet the demand for blood by the heart) for which he was taking aspirin and had a GTN spray. He told other reception staff that he also suffered from sciatica (nerve damage in the spine resulting in a pain felt down back and outer side of the thigh, leg and foot) and depression. No information regarding these ailments was recorded on his Personal Summary Sheet (Medical Statement). Other than a note made by the reception nurse that he had a GTN spray with him, there is no documented evidence that the spray was brought into Dovegate. His property card does not show it in his possession although a Nitromin spray (brand of GTN) and a box of aspirin were placed in his stored property on 23 August, the day after his death.

26. At the initial screening, he also said that he was an occasional drinker which he later amended (during an induction interview on 16 August) to being a periodic (every two to four weeks) binge drinker. He was also a smoker but denied using illegal drugs except for when he experimented with cannabis as a teenager. The reception nurse referred him to the doctor about his angina and noted that he appeared fit and well. There is no evidence that he ever saw a doctor as a result of this referral.

27. Various healthcare forms were filled in with varying degrees of accuracy and completeness:

- Although the signature date inaccurately shows 13 June instead of 13 August, he signed the Consent to receive Healthcare form.
- He also signed the medication contract setting out his responsibilities regarding the receipt of medication. This was also dated 13 June.
- His Prescription and Administration Record Chart indicates that a GTN spray was authorised and sufficient aspirin for 28 days at a dosage of 75mg daily was available for him, both of which were allowed to be kept in his possession. The form also shows that the pharmacy staff noted the entries on 16 August. The “items issued” column is left blank.
- The Assessment for In Possession Medication is also blank.

- The Medication Issued to Inmate form is signed and dated 18 August by him and Nurse A but is only partially complete.

The Healthcare Manager told the clinical reviewer that the man received the prescribed medication on 16 August but an error resulted in this not being recorded until two days later. This explanation has not been substantiated, but even if it is accurate, it appears that he did not receive the medication until three days after it was recorded as being in his possession.

28. He was not considered to be at risk of harming himself. His cell sharing risk assessment (CSRA) indicates that he was a low risk and suitable to share a cell. The CSRA process is designed to assess the risks posed by an individual to other prisoners which includes taking into account the situational context of any previous violence or mental health issues. An assessment takes place before a prisoner spends their first night in custody (with the exception of open prisons) and triggers a plan to minimise risk for those identified as high or medium risk which is reviewed at regular intervals).

29. He saw an Insider (a fellow prisoner who meets new arrival and gives advice on what to expect after reception and where to obtain help). The Insider noted that he needed to see the chaplaincy, legal service staff and a peer support worker. He was issued a smokers' pack (given to new reception smokers to tide them over until the following day when they can buy tobacco from the prison shop), declined access to a telephone to contact his family and was allocated to cell 44 on N wing.

30. Prisoner A was already living in cell N44 and he did not know the man before. He was unhappy about him sharing his cell because he was the third man in quick succession to be allocated there and all of them had borrowed personal items such as soap and tobacco from him. During an interview with the investigator, he said that the man was very quiet and reserved and did not eat anything that first evening or on the two following days (Saturday and Sunday) because the food was greasy and unhelpful to his heart condition. However, he ate the meal provided on the wing on Monday because he was hungry. During their first evening together in the cell, he told Prisoner A that he was an alcoholic suffering from angina for which he took aspirin daily and used a spray. He was also a heavy smoker.

31. Over that first weekend, he told Prisoner A that he had not been given any aspirin but had received paracetamol from healthcare staff. No record of that medication is evident in his medical record. The prisoner said that on Sunday he had helped him order his meal menus for the following few days via the computer on the wing. He also encouraged him to explain his problem to healthcare staff and on Sunday went with him to collect his medication. The prisoner spoke to the nurse but the man was again given paracetamol. Again there is no record of this.

32. On the evening of Tuesday 17 August, the prisoner moved out of the cell. The man remained in N44 but the two men still spoke and visited each other. (The prisoner had no contact with him after Thursday 19 August, but saw staff

clearing his property on Friday and concluded something had happened to him.)

33. During the man's induction assessment interviews on 16 August with staff from the Offender Management Unit (OMU), he asked the BASS staff to help him find accommodation at an approved premises in the Stoke on Trent area, should he be granted bail at his next court hearing. (Approved premises, formerly known as probation or bail hostels, provide controlled accommodation for offenders under the supervision of the Probation Service.) He was unable, due to the nature of the allegations against him, to return to the home he shared with his partner. The solicitors named by him were contacted to provide information but they had no file on him at that time. A note in the activity log indicates that they undertook to return the contact with Dovegate later.

34. In connection with his bail application, the induction co-ordinator circulated an email on the morning of 16 August to four departments, including healthcare, seeking any relevant information regarding the man. Healthcare replied the following morning, saying that:

> "There are no worries from Healthcare re: the man. Seen by our nurse at reception on 13/8/2010. Was noted that he looked fit and well. MEDS [medication] ---- GTN spray and aspirin (angina)."

On 19 August, his cell sharing risk was reviewed and he remained a low risk.

35. On 20 August, Prison Custody Officer A (PCO) escorted the man from the prison education department (known locally as the New Training College). She told my investigator that this was at about 9.30am. She searched him before leaving the building and he had a GTN spray in his pocket which she left in his possession. She said that he looked well and made no comment to the contrary. They left the college and went to houseblock 2 (HB2) where she was to collect another prisoner for a visit. When they got there, she left him locked in the entrance area, between the outer and inner doors, which is normal procedure in these circumstances. She then went on to K wing to collect the second man and returned to the houseblock entrance a few minutes later.

36. The man collapsed during the short time that she was away. PCO B saw him and called for help from PCO C, who in turn called Nurse B who was working in the HB2 Medication Room. She and a Healthcare Assistant (HCA) A crossed the 20 yards to the houseblock entrance. The nurse recorded this later in the medical record as being about 9.15am. The HCA brought the "grab bag" (a bag containing medical supplies to deal with an emergency) and a blood pressure machine.

37. The man was on the floor propped up against the wall, and the nurse thought that he looked pale and clammy. In response to her questions, he told her that he had chest pains which were radiating down his left arm and had recently been diagnosed with angina. He had the GTN spray in his pocket

and, on her instructions, sprayed two puffs of it into his mouth, which eased the pain. She placed him in the recovery position and took his blood pressure, a reading of 220/140. She also recorded his other vital signs, entering them later in his medical record, at about 10.30am. His pulse was 102 beats per minute and his respiration rate was 20 per minute.

38. On the nurse's instructions, he lay flat on the floor and she raised his legs. The nurse decided that he should be taken to the healthcare centre (HCC). A wheelchair was collected from G wing and he was helped into it. PCO A with PCO D and the nurse took him to the HCC, a short journey which took less than five minutes. Nursing Team Leader A recalls that she received a telephone call in the HCC nurses station at about 9.00am to say that a man was being brought there following his collapse.

39. The staff took the man directly to the Accident and Emergency (A&E) room, arriving a few minutes after leaving the houseblock. PCO A understood from Nurse B that an electrocardiogram (ECG) would be carried out soon afterwards. PCO D spoke to Nursing Team Leader B, who had just come downstairs and into the outpatients' area, asking for assistance for the man. The Team Leader was unsure if a doctor was available and he returned upstairs. PCO A followed the nurse upstairs, but could not find him. She saw another member of healthcare staff, who she is unable to name, with a doctor. On returning to outpatients she asked if the doctor could examine the man and was told that he could not because he was a psychiatrist. At that point, PCO D and Nurse B returned to HB2 and their normal duties. PCO A remained, saw Team Leader B again and asked if he could attend to the man. The PCO said that the nurse refused, saying that he was looking for Team Leader A so that she could deal with him. A nurse, who the PCO cannot name, then arrived to treat the man. The PCO left HCC returning to her work in another part of the prison.

40. PCO A raised concerns about the man's treatment with the Head of Healthcare on a subsequent visit to the HCC and wrote a memorandum to the Deputy Director about the matter on 22 August. She said there appeared to be little urgency from the healthcare staff when they arrived. She remembers hearing Nurse B discussing personal matters with PCO E, who was the outpatient's officer on duty that morning, and later with Team Leader A who also discussed a healthcare staff social event they had attended the previous evening. In her memorandum to the Deputy Director, she said that she and PCO D had tried to bring the man's needs to the attention of the nursing staff, but without success.

41. Other nursing staff remember events that morning differently. Nurse B said that on her arrival in HCC, she went directly to the nurse's station and spoke to Team Leader B telling him that the man needed urgent help and what she knew of his case. The Team Leader responded, using an expletive. She thought that his response was inadequate, terse and very unsatisfactory. She expressed her dissatisfaction at the lack of help and returned to the man who told her that the pain he was experiencing was intermittent. She raised the bottom of the bed to elevate his legs and administered oxygen at a rate of four

per cent. She was unable to use the ECG machine to monitor his heart as there were no pads with which attach the electrodes to his chest. Team Leader A then came into the room and, in what she described as a brusque and inappropriate manner, told her that HCC had run out of the pads. She told Team Leader A that she was not happy at the lack of pads and gave her a handover briefing after which she returned to HB2.

42. The nurse said that she was in the nurse's station when the man arrived in outpatients. She spoke to one of the staff who brought him from the houseblock but cannot remember who that was. Her memory is that she went into the A&E room where Team Leader B was already talking to the man. Team Leader A went over his symptoms and history with him and he told her that he had been diagnosed with angina three weeks before and been prescribed a GTN spray and aspirin. Team Leader A gave him 75mg of aspirin which he put under his tongue to dissolve. The two nurses took basic clinical observations, of his blood pressure, pulse and respiration rates. Team Leader A recorded her actions and the administration of aspirin in note form on a piece of notepaper which she kept. She said that she transferred the information to a continuous clinical record sheet for inclusion in his medical record, by her account, some seven days later. The notes were not included in the copy of original medical record given to the investigator and the clinical reviewer had no access to those notes.

43. On 22 October, my investigator raised the issue about the lack of clinical notes with the SERCO senior investigating officer. This resulted in the investigator receiving copy of Team Leader A's retrospective notes, written on four continuous clinical record sheets, on 6 November.

44. Team Leader A recorded in those notes that at 9.40am she was asked to see the man who was suffering from chest pain. She observed that he was fully conscious and that his blood pressure was 200/100, his pulse was 84 bpm and strong, his respiration rate was 16 and normal. She also recorded that an ECG was not done because the HCC had run out of ECG pads. She told the investigator that supplies of the pads ran out that day and the HCC was expecting a further supply on the following Monday. A short time later, the man told her that his chest pain had gone. She re-checked his vital signs which were all within normal limits. He said that he wanted to return to his wing to which she agreed, telling him to return to HCC if he had any more chest pains or felt unwell. She and Team Leader B planned to review him again later in the day. He got off the bed unaided, walked into the main corridor where PCO E locked him in a waiting room to await an escort back to his wing. The two nurses returned to their normal duties.

45. PCO E said that within a few minutes, the man knocked on the window of the waiting room complaining that he was experiencing pain in his chest. He looked unwell and was clutching his chest. The PCO unlocked the waiting room door so that he could come out into the corridor and sit on a chair where he immediately collapsed to the floor. The PCO could get no response from him and shouted for help. Team Leader B responded to the shout, leaving the pharmacy and arriving beside the man a few seconds later. He checked

his breathing, pulse and ensured that he had a clear airway. His belief was that he had suffered a myocardial infarction, commonly known as a heart attack.

46. Team Leader B immediately started chest compressions on him and shouted for assistance. Nurse C responded and went to where he lay. He was in the recovery position, his head was towards the far end of the corridor and his back was against the wall, he was breathing but unresponsive. The Team Leader, who was trying to get help from other staff, immediately rejoined her and started cardio pulmonary resuscitation (CPR) chest compressions. The nurse supported his airway and administered oxygen using the ambu-bag and face mask which she thought was brought to the scene by the Team Leader. He thought the nurse brought it with her. Shortly after the oxygen was given, the man stopped breathing independently and his pulse was faint. He slipped in and out of spontaneous breathing. When he was able to breathe independently, he was placed in the recovery position whilst continuing with oxygen, and when unable to do so, CPR resumed.

47. PCO F responded to a "Code Blue" medical emergency call on his radio at about 10.18am and went to HCC. (Emergency codes allow the medical staff to respond with appropriate equipment. Code blue indicates that a patient is experiencing breathing difficulties.) He immediately started a time line of events on the instructions of the orderly officer (the person in charge of the routine operation of the prison).

48. Team Leader A wrote in her notes of events that at 10.20am she went to the door of the office she was working in. She saw the other Team Leader and nurse kneeling on the floor beside the man at the far end of the corridor. She ran to them stopping off in the A&E room to collect the "grab bag". She joined the other two nurses. Team Leader B was performing chest compressions and the nurse was administering oxygen. Team Leader B remembers telling PCO E to call the communications office and ask for an ambulance. The response by the communications officer was that the ambulance could not be called until the orderly officer had authorised it. Team Leader B, in turn, responded that the ambulance was needed immediately. In her interview, Team Leader A mentioned to her colleagues that the ambulance was taking a long time. In response to being told that the orderly officer had to authorise the request, she shouted that it was needed immediately. PCO E said that soon after Team Leader B spoke to him, the orderly officer and the Director arrived and the ambulance was called. A screen was then put in place to give the man some privacy. PCO F's time line records that the orderly officer arrived at 10.22am. In contrast, Appendix 7A of Dovegate's contingency plan for a death in custody has been partially completed in regard to the man and indicates that the ambulance was called at 10.15am.

49. The Healthcare Manager and Nurse D, who was attending training in HCC, responded to a telephone call about the heart attack. They left their offices and went downstairs. The nurse joined in the resuscitation attempts, he and Team Leader B taking it in turns to perform chest compressions. According to the Team Leader's account, the defibrillator had by then delivered several

shocks to the man as part of its automatic cycle after detecting a shockable rhythm in his heart. He also remembers that ambulance service control staff were in touch with Dovegate and he spoke to them on the telephone in the corridor. Ambulance control staff asked to land the air ambulance helicopter in the prison. Permission was not granted for prison security reasons but it did land outside the prison at 10.46am. The crew helped to treat the man.

50. PCO G told my investigator that she reached outpatients at about 10.10am, where they were trying to resuscitate the man. While she was talking to PCO E, the orderly officer arrived and instructed her to telephone the communications officer to contact the ambulance service. The communications officer subsequently returned the call and connected her to the ambulance service staff who asked to speak to the nurse in charge. She handed the telephone to Team Leader A and remembers her saying that this was a “Code Blue”.

51. Team Leader A monitored the man’s condition while Nurse C continued giving him oxygen. The Team Leader used a suction device to keep his mouth and throat clear of obstructions and inserted an oropharangeal airway (a medical device used to maintain an open airway) into the man’s throat. When his heart started, he was placed in the recovery position and when it stopped cardio pulmonary resuscitation (CPR) was re-started, which happened several times.

52. Team Leader A noted that there was no output from his heart for about two to two and a half minutes and decided to use the defibrillator to re-start his heart. His tee shirt was cut away to give access to his chest for the defibrillator paddles. It was connected and went through its automatic cycle three times delivering an electric shock at the end of each cycle. At about the same time, the ambulance service first responder paramedic arrived at HCC. The log keeper’s time line indicated this was 10.35am, followed five minutes later by an ambulance with two crew members. She gave them a detailed handover including his known medical history, details of CPR, defibrillator cycles and outcomes. The ambulance service personnel disconnected and removed the prison defibrillator and other equipment from him and replaced it with their own life support equipment. They also gave him intravenous fluids via his right leg.

53. Once he was stabilised, the ambulance service staff took him to the ambulance at 10.55am and, with two PCOs escorting him, left the prison at 11.03am. The escort route order is endorsed with a stamp indicating that he was a category B prisoner (a prisoner who does not require maximum security, but for whom escape must be made very difficult) and that he should be handcuffed at all times. In view of his physical condition, either the Director or the orderly officer (staff could not remember which) overrode the risk assessment and instructed that handcuffs should not be used. He remained without restraints of any form until his death.

54. The ambulance arrived at hospital at 11.35am and doctors there took over his care. PCO G noted at 12.00pm that doctors said that he had been starved of

oxygen for too long. The doctors told the PCO that "there was nothing more they could do for him other than to make him comfortable and that it was a matter of just waiting". This information was passed to senior staff at Dovegate.

55. Following the diagnosis the Director of the Therapeutic Prison at Dovegate tried unsuccessfully to contact the man's partner, his named next of kin. He was given information as to her whereabouts by people who knew her but, having visited the addresses, he and the prison chaplain were unable to find her. He left a series of messages and his mobile telephone number in case she arrived later. She made contact as he returned to the prison and he broke the news of her partner's condition and his whereabouts. He understood that she was going to visit the hospital.

56. Later that day, the Head of Healthcare held a debrief for the medical staff and the care team also spoke to them and offered help. The care team consists of staff that are trained to support other staff during and after stressful events such as a death in custody. A further debrief was held about a week later.

57. The doctors continued to work on the man throughout the afternoon. At 4.45pm his partner arrived at the hospital. There was a delay before she was allowed in to see him while the bedwatch staff checked that she was allowed in. In the meantime, at 4.50pm his parents and sister arrived to see him. His family went into the resuscitation room at 4.55pm and his partner, after confirmation from the prison, ten minutes later. At 6.15pm, he was moved to a ward and his partner and family remained at the hospital. During the weekend, he was sedated and his condition remained unchanged.

22 August

58. The man's condition remained unchanged until about 7.00am on 22 August, when nursing staff told the bedwatch staff that his condition was deteriorating. At 7.35am, he had a cardiac arrest and hospital staff gave emergency treatment. He was resuscitated again at 8.20am, just after the escorting staff changed shifts. Hospital staff told the family of his deteriorating health and they remained at his bedside until he died at about 9.20am. His death was certified at 9.51am and his family left the hospital at about the same time after declining any assistance from PCO E on behalf of the prison.

After the man's death

59. On confirmation of the man's death, Dovegate staff initiated the prison contingency plan for a death in custody which was modified as he had died in hospital. All the necessary actions were taken, including the notification of the police. The police concluded that there were no suspicious circumstances surrounding his death. Prisoners and staff at Dovegate were notified by the publication of notices in the prison later that morning. The two PCOs who had been with him returned to Dovegate where they were offered support from the care team but declined.

60. Dovegate's family liaison officer, was unable to contact members of the man's family on the day of his death as their telephone contact details were either incorrect or calls were not answered. She finally spoke to his brother-in-law the following day, 23 August, and offered support for the family from the prison and chaplaincy. He declined all offers of support and did not give any information correcting the contact details for the rest of the family. She finally received the correct details for the man's parents from the Coroner's Officer on 25 August and immediately made contact with them. She was able to assist with information and reassurance. On the following day, she arranged to visit the family on 2 September to return his property. She also confirmed that Dovegate would contribute to the funeral costs. His funeral and cremation took place on 3 September.

61. The Deputy Director wrote a letter of condolence to the family on 26 August. HM Coroner for Staffordshire (South) confirmed in a letter dated 27 August that he had not ordered a post mortem examination or commissioned toxicological tests. He accepted a certified cause of death as:

    1a. Myocardial infarction and
    1b. Ischaemic heart disease.

62. An inquest into the man's death on 17 November 2010 returned a verdict of death from natural causes.

ISSUES CONSIDERED DURING THE INVESTIGATION

Clinical care

Reception screening procedure

63. The man had been in prison custody for just nine days when he died in hospital. On reception, he reported that he had been diagnosed with angina, sciatica and depression. A nurse conducted an initial health screening and he told her he used a GTN spray and took aspirin daily. She took sketchy details of his community doctor and referred him to the prison doctor. There is no evidence that the referral interview took place or that his home doctor was contacted or any attempt made to contact him/her. Prison Service Order (PSO) 3050 requires that:

> "In the week following first reception, every prisoner must be offered a general health assessment. This assessment is equivalent to a primary care assessment when registering with a new practice in the community … however the general health assessment should act as an opportunity for … gathering further medical information …"

There is no evidence of this secondary health screening taking place during his first week at Dovegate. During his reception (the signature dates show 13 June rather than 13 August which I assume is a mistake), he signed consent forms to receive healthcare, which indicates that information can be sought from sources outside the prison, and a medication contract detailing his responsibilities regarding the receipt of medication while in custody.

64. The clinical reviewer makes a number of comments and observations in her report:

> "He was 49 years old; this is an unusually young age to suffer from angina and should have alerted staff to a possible increased risk of cardiac events. At the least he should have been booked for a GP [general practitioner] review early the next week and attempts should have been made to gain more information from his GP as soon as possible after the weekend."

She also observed:

> "On the 'Consent to receive healthcare' form, signed by him and a nurse on 13/08/10, a blood pressure and pulse reading of 190/113 Pulse 90, is scribbled in the corner. It is not clear if this reading was taken from him. If this reading was taken from him it should have been repeated within 30-60 minutes and if it remained this high he should have been seen by the reception doctor that afternoon. If the reading was not from him it should have been deleted from his record."

65. His Prescription and Administration Record Chart shows that a GTN spray and a daily dose of 75mg of aspirin for 28 days were authorised in possession

and pharmacy staff noted the entries on 16 August. The Items Issued columns are blank as is the Assessment for In Possession Medication, although the Medication Issued to Inmate form has been signed and dated 18 August by him and a nurse but is incomplete. The healthcare manager later confirmed to the clinical reviewer that he did receive the medication but an error led to it not being recorded. In any event he did not receive the medication for at least three days after reception into Dovegate.

66. The clinical reviewer wrote:

> "The man arrived at HMP Dovegate with important and potentially life-saving cardiac medication. Aspirin is not a known drug of abuse, GTN has been used in conjunction with some illicit substances but he was not a known drug user. It is entirely right that his own medication should have been taken from him unless it was in the manufacturer's box with his name and details on it. In this case it may have been appropriate for staff to keep the medication and to give him daily doses of aspirin. Both aspirin and GTN are standard drugs used in the treatment of ischaemic heart disease and angina.

Like the reviewer, I agree that what is wholly unacceptable is that he was left without the GTN spray in his possession and was not given a daily dose of aspirin whilst his medication was verified by his general practitioner. Fortunately the reviewer does not think that the failure to give the medication caused any undue harm. However, as the clinical reviewer says:

> "This does not detract however from the principal that some medications are too important to withhold whilst awaiting verification. Both aspirin and GTN fall into this category and, as they are not commonly drugs of abuse, there was far greater risk introduced by with holding the medication than by giving it."

67. The man had a GTN spray with him when he collapsed on 20 August and evidence from his cell mate indicates that he had it before that date. However, his cell mate also suggests that he did not receive aspirin during the week prior to his death.

68. When he went to N wing he went through Dovegate's normal induction programme. Information supplied by him on 18 August confirmed that he was a regular if not frequent binge drinker, information that was never apparently given to healthcare staff. Consent to disclose information regarding his medical history exists in the declaration appended to the Offender Management Unit, Assessment Disclosure signed by him on 16 August.

69. There is no clear, contemporaneous account of the course of events between his initial arrival in the healthcare centre on 20 August and his collapse in the corridor some time later. Recollections by the nursing staff present were not documented for many weeks and remain confused.

70. The clinical reviewer makes several recommendations about the healthcare procedures at Dovegate, notably regarding the supply of medically important drugs over nights and weekends, arranging for a review by a prison doctor in the event of a significant medical problem and contacting a prisoner's community doctor quickly for additional information. Accordingly, I make the following recommendations.

The Director must ensure, as a matter of urgency that the requirements of Prison Service Order (PSO) 3050 are adhered to regarding new prisoners, their healthcare assessment and their clinical needs.

The Director must, as a matter of urgency, review the procedures to ensure that healthcare staff are aware of their responsibility to provide clear and comprehensive records of every interaction, consultation and outcome in accordance with Nursing and Midwifery Council Guidelines on record keeping. The review should include the procedures for the documentation of prescribed medication and the proper completion of such documentation.

The Director must ensure that sufficient quantities of medically important drugs are available out of normal dispensing hours. A clinical judgement must be made as to whether these drugs should be given prior to confirmation by a doctor.

The Director must ensure that healthcare staff are aware of the requirement to contact a new reception's community doctor as a necessary part of ensuring continuity of treatment. Those efforts and outcomes must be recorded (PSO 3050 Chapter 2 paragraphs 2.1 and 2.2 refers.)

The man's initial reception into the healthcare centre on 20 August

71. It is evident to me that there was confusion and less than professional handling of the man when he was admitted to the healthcare centre on the morning of 20 August. It is regrettable that there seems to have been a lack of urgency by healthcare staff some of whom were apparently focussed on a social event that had taken place the previous evening. This was coupled with inappropriate and disrespectful responses from two senior nursing staff members to other staff.

72. A verbal complaint about the way he was treated was made by one of the PCOs present to the Deputy Director and Head of Healthcare, followed two days later by a memorandum to the Deputy Director. I have been unable to establish whether any action resulted from this complaint.

The Director should remind nursing staff of their responsibility to treat prisoners and staff in an appropriately professional and respectful manner.

73. It is of particular concern that there were no contact pads for the ECG machine, rendering it unusable. I do not know what the ECG would have shown had it been used and whether an emergency ambulance should have been called at that stage, but in any event the opportunity was missed. The lack of such commonly used, minor yet vital, medical supplies is an unacceptable oversight.

The Director must ensure that sufficient supplies of consumable medical supplies, such as ECG pads are available to medical and nursing staff.

74. Some time later, the man received treatment and felt better. He was waiting to return to his houseblock, with instructions to rest and that should he feel unwell again he should return to the HCC. However, he suffered a major heart attack a few minutes later. Thankfully his treatment by healthcare staff when he was taken poorly a second time was focussed and determined, a feature commented on by the clinical reviewer in her report.

Access to defibrillators

75. During the course of the man's cardiac arrest, the defibrillator was brought to him in the corridor. It is not clear exactly when this was done or by whom, each of the three nursing staff believe it was one of the others. There is also no clear record of when the defibrillator was brought into use. The clinical reviewer commented in her report that there appeared to have been a problem locating the defibrillator.

76. However, in this instance it is the clinical reviewer's opinion that any delay did not make a significant difference to the outcome in his case. She made a recommendation that the location of all defibrillators should be clearly visible to ensure nursing and prison staff are able to find them quickly which I am happy to endorse.

The Director should ensure that defibrillators at Dovegate are located in prominent accessible positions, are clearly signed and nursing and prison staff are made aware of their location.

Calling the ambulance service

77. It is the policy at Dovegate that an emergency ambulance is not called until the request has been approved by the orderly officer. It is unclear how many of the nursing staff attending the man on 20 August asked for an emergency ambulance to be called. It is however clear that at least one of them did so and the decision to call the ambulance was delayed by several minutes due to the policy. The exact length of the delay is unclear because of a lack of accurate data.

78. It has been a requirement since September 2004 that each Governor must ensure that their prison has a protocol in place with their local ambulance service. A letter from the Department of Health to Prison Service Governing

Governors, dated 22 March 2004 noted, "… internal procedures should not waste undue time in summoning emergency assistance …". The letter added that a subsequent 999 call to the Ambulance Service should be made to cancel the response if, after the original 999 call, it is deemed that an emergency ambulance response is not required." More recently than the man's death, this advice has been repeated in a letter to Governors from the Director of Offender Health.

79. In this case, I do not believe that the delay had an effect on the outcome. Nevertheless, there may well be circumstances in the future where a delay of this nature could be detrimental and severely reduce the patient's chances of survival. The possibility of that happening should be minimised.

The Director must urgently amend the emergency response policy to allow staff, particularly medically qualified staff, to call an ambulance in the event of a medical emergency without waiting until permission is given by the orderly officer.

Record keeping

80. It is clear that medical record keeping at Dovegate falls well below the standard required of Nursing and Midwifery Council guidelines. Few records detail the care the man was given by healthcare staff and they are only partially complete.

81. Similarly there is little accurate information recorded about what happened to him when he was admitted to the HCC on 20 August, with the exception of the notes made by Nurses B and C in the medical record later that day. The information contained in Team Leader A's notes was only given to my investigator many weeks later, on 6 November, by the SERCO senior investigating officer. During her interview with my investigator on 25 November, she said that she made rough notes on the day which she transferred to the continuous clinical record sheets about seven days after he was admitted to hospital. I am conscious that this was several days after his death and, in any event, the notes were not part of the medical record given to the clinical reviewer and my investigator.

82. The clinical reviewer was given no information by the prison as to the timing of the arrival of paramedics and inaccurate information about the departure of the ambulance to hospital. She wrote that she had been:

> "… unable to find out what time the paramedics arrived and took over the arrest. On questioning HMP Dovegate 'Comms' Department I was informed the man left the prison in the emergency ambulance at 12.15pm, 3 hours after the initial episode of chest pain. There is minimal information in the medical record about this 3 hour period."

Documents provided to my investigator contain the timings for the arrival of the paramedics and their later departure. However, the departure time differs significantly from the information given to the clinical reviewer. The man was

taken to the ambulance at 10.55am and left the prison at 11.03am arriving at the hospital at 11.35am. There is a discrepancy of about an hour and ten minutes. This does not invalidate the clinical reviewer's observation regarding the lack of notes about what happened to him but it does highlight Dovegate's unreliable and inconsistent recording of events.

83. The clinical reviewer also observed that there is nothing in the medical record regarding the two days he spent in hospital including the failure to record the time and date of his death. She commented:

> "… healthcare staff should be in contact with hospital departments when a prisoner is admitted to hospital, this should be recorded in the medical record. The lack of a computerised system has made data recording in this case patchy and unreliable."

84. It is pertinent to acknowledge that the man was under prison escort and the communication between bedwatch staff and Dovegate was entirely acceptable. There was, however, no contact between healthcare staff and the hospital during those two days.

85. The clinical reviewer made two recommendations about record keeping:

> "Medical records should be timely, accurate and comprehensive. This is difficult with a paper record and Dovegate should look to installing a computerised healthcare records system as soon as possible."
>
> "Healthcare staff should be in contact with hospital departments when prisoners are admitted to hospital. These contacts should be recorded in the medical record."

I make the following recommendation:

The Director should give urgent consideration to the installation of a computerised healthcare recording system (Recommendation 4.69 of the HMCIP 2008 inspection report).

Informing the man's next of kin

86. The man's prison records show that his partner was his named next of kin. The address he shared with her was given but the telephone number was not known. Owing to the nature of the charges for which he was remanded, he was unable to return to that address.

87. When he was admitted to hospital on 20 August efforts were made personally by the Director of the Therapeutic Prison to find her. He and the prison chaplain were given information about her likely whereabouts and visited those places without success. He left his contact details at the locations with a message for her to contact him. His partner made contact as he and the chaplain were returning to the prison and he told her that he was in hospital. It is unclear who informed his parents of his condition but in any event they

and his partner arrived at the hospital during the afternoon within a few minutes of each other.

88. It is commendable that the Director of the Therapeutic Prison took the initiative and proactively looked for the man's partner. The telephone was not the ideal way for her to receive the information about his condition but, on this occasion, I think that it was unavoidable.

Use of restraints

89. The initial risk assessment indicated that because of the man's remand status and the nature of his offence, he should be handcuffed during his journey and admission to hospital. However, because of the seriousness of his medical condition, no restraints were used. It is unclear who made the decision not to use the restraints but, in the circumstances I think that it was the correct one, which I recognise and commend.

CONCLUSION

90. When the man went into Dovegate prison on 13 August 2010, he reported during his initial health screen that he had been diagnosed with angina, as well as other ailments. He had been prescribed a GTN spray and aspirin by his community doctor for this condition. No secondary health screen assessment took place and although a referral was made to a doctor, he never saw one. He did not have access to his GTN spray for at least three days after his reception into prison and it seems that he was not given aspirin at all.

91. A week later, on the morning of 20 August, he collapsed with chest pains. Nursing staff eventually treated him but it is clear that this situation was not handled well. Staff attitudes and the speed of their response left a lot to be desired and essential medical supplies were not in stock. A few minutes later, he collapsed again with a suspected heart attack. This time, I am satisfied that the staff gave a high standard of care during the emergency resuscitation procedures, which enabled him to be taken to hospital alive.

92. The clinical reviewer mentioned that the survival rate in cases of sudden, major heart attacks outside hospital is low and concluded that there was nothing staff at the prison could have done to prevent his death. I concur with her conclusion. Nevertheless, my investigation has identified serious shortcomings in the healthcare provided by Dovegate, consistent with the findings of both the IMB and HM Inspectorate of Prisons. It is conceivable that such failings could lead to adverse consequences in the future for prisoners in similar circumstances.

RECOMMENDATIONS

1. The Director must ensure, as a matter of urgency that the requirements of Prison Service Order (PSO) 3050 are adhered to regarding new prisoners, their healthcare assessment and their clinical needs.

   HMP Dovegate accepted this recommendation, directing it to their Healthcare Manager and commented that:

   "System One has now been implemented which allows for the effective co-ordination of all initial screenings in Reception through to a time where a prisoner is either transferred or discharged. All staff have been made aware of the importance in ensuring that System One is used and maintained accordingly."

   The target date for the completion of this action is 31 August 2011.

2. The Director must, as a matter of urgency, review the procedures to ensure that healthcare staff are aware of their responsibility to provide clear and comprehensive records of every interaction, consultation and outcome in accordance with Nursing and Midwifery Council Guidelines on record keeping. The review should include the procedures for the documentation of prescribed medication and the proper completion of such documentation.

   HMP Dovegate accepted this recommendation, directing it to their Healthcare Manager and commented that:

   "System One has now been introduced. This is a system used nationally by Healthcare professionals and supports their responsibility in recording accurate and timely information relating to patients care, treatment and referrals to interventions – in line with the NMC guidelines. Nursing staff at HMP Dovegate are all now trained in using System One, and staff at a management grade take the responsibility in ensuring that the system is used effectively and that records provide an accurate account of all interactions completed with all Healthcare staff."

   The target date for the completion of this action is 31 July 2011.

3. The Director must ensure that sufficient quantities of medically important drugs are available out of normal dispensing hours. A clinical judgement must be made as to whether these drugs should be given prior to confirmation by a doctor.

   HMP Dovegate accepted this recommendation, directing it to their Healthcare Manager and commented that:

   "Policies to be written identifying medically important drugs, and detailing procedures for dispensing these drugs outside of normal dispensing hours. This will include a protocol detailing when a clinical judgement can be made prior to any confirmation by a doctor."

The target date for the completion of this action is 31 July 2011.

4. The Director must ensure that healthcare staff are aware of the requirement to contact a new reception's community doctor as a necessary part of ensuring continuity of treatment. Those efforts and outcomes must be recorded (PSO 3050 Chapter 2 paragraphs 2.1 and 2.2 refers.)

   HMP Dovegate accepted this recommendation, directing it to their Healthcare Manager and commented that:

   "It should be noted that not all prisoners either have a GP or know the contact details of their GP. However, wherever possible, when contact details are established, Healthcare staff contact the prisoners community GP to ensure that continuity of care is continued whilst in custody.
   System One again supports this policy."

   The target date for the completion of this action is 1 January 2012.

5. The Director should remind nursing staff of their responsibility to treat prisoners and staff in an appropriately professional and respectful manner.

   HMP Dovegate accepted this recommendation, directing it to their Healthcare Manager and commented that:

   "All Healthcare staff to receive a reminder, (which is documented in their personnel files), relating to the expected standards of conduct as detailed in the Nursing and Midwifery Council guidelines.
   Any deviation from this will be challenged by the line manager and action taken as necessary."

   HMP Dovegate report that this action has been completed.

6. The Director must ensure that sufficient supplies of consumable medical supplies, such as ECG pads are available to medical and nursing staff.

   HMP Dovegate accepted this recommendation, directing it to their Healthcare Manager and commented that:

   "Supplies are readily available; however, there are no measures in place to record stock levels. A system is to be implemented to record and monitor levels of stock, and to also act as a prompt to re-order when minimum stock levels have been reached. An audit will take place to monitor the effectiveness of this system."

   HMP Dovegate report that this action has been completed.

7. The Director should ensure that defibrillators at Dovegate are located in prominent accessible positions, are clearly signed and nursing and prison staff are made aware of their location.

HMP Dovegate accepted this recommendation directing it to their Healthcare Manager and commented that:

"The Primary Care lead will identify the number of defibrillators required and liaise with Estates and Serco Health to gain funding to secure additional equipment that can be secured in all high risk areas. The location of this equipment will be clearly marked and a notice issued to all prison and healthcare staff advising them of its whereabouts. Regular checks will be made to ensure that the equipment is in the right location and that it is ready for use should the need arise."

The target date for the completion of this action is 31 July 2011.

8. The Director must urgently amend the emergency response policy to allow staff, particularly medically qualified staff, to call an ambulance in the event of a medical emergency without waiting until permission is given by the orderly officer.

   HMP Dovegate accepted this recommendation and commented that:

   "The emergency response policy has now been reviewed and updated with advice relating to who can take the responsibility to summons an ambulance in the event of a medical emergency. Under normal circumstances, this responsibility would be undertaken by the Orderly Officer, however, it is recognised that it is also appropriate for medical staff to have the autonomy to call for emergency assistance if they deem it necessary."

   HMP Dovegate report that this action has been completed.

9. The Director should give urgent consideration to the installation of a computerised healthcare recording system (Recommendation 4.69 of the HMCIP 2008 inspection report).

   HMP Dovegate accepted this recommendation directing it to their Healthcare Manager and commented that:

   "System One has now been introduced and staff made aware of the importance in using it effectively by recording all appointments, actions, interventions and referrals as required."

   HMP Dovegate report that this action has been completed.