Investigation into the circumstances surrounding the death of a man in November 2011 at the Alexandra Hospital, Redditch, while a prisoner at HMP Hewell

Report by the Prisons and Probation Ombudsman for England and Wales

October 2012

This is the report of the investigation into the death of a man at the Alexandra Hospital in Redditch in November 2011. He died, at the age of just 22, of acute promyelocytic leukaemia (a type of cancer of the blood) which led to an intracerebral haemorrhage (a large bleed inside the brain tissue). I offer my sincere condolences to his family and friends.

The investigation was conducted by a senior investigator. A doctor carried out a review of the clinical care the man received at HMP Hewell. Her review is attached as an annex to this report. Hewell prison co-operated fully with the investigation.

This is a long and sad report which does not reflect well on the prison's treatment of men with disabilities. Although that poor treatment was not a direct factor in the man's death it does call into question the prison's ability to provide appropriate individual care. The man had never been in prison before he arrived at Hewell on 18 October. He was involved in a car accident 18 months before in which he received serious injuries and which led to his prison sentence. As a result of the accident, he had a number of disabilities, and relied on a range of prescribed medications, including some for severe pain relief.

Despite his injuries and disabilities being well documented, the man did not undergo a full disability assessment at Hewell and his needs were not met. I think there can be little doubt that, as a result, life in prison was made even harder for him than necessary. He was not placed in the most appropriate cell, his medication was not always given to him on time and he was not provided with the special equipment that he needed. His family's attempts to ensure he was properly cared for did not receive an adequate response from the prison.

About two weeks after he arrived, the man began to complain of tiredness and feeling generally unwell. It seems that the combination of his existing physical conditions and his wish not to be a nuisance might have masked how unwell he was. Blood tests carried out on 7 November revealed that he was suffering with an aggressive form of leukaemia. By the time he was transferred to hospital his condition had deteriorated dramatically and he died two days later. The clinical reviewer finds that healthcare staff at Hewell missed some signs that should have made them, at least, suspicious that there was something seriously wrong with the man. However, she concludes that such omissions could have occurred if he had been in the community. She finds that his death was not foreseeable.

Notwithstanding that conclusion, we make eight recommendations for badly needed improvement at Hewell. Most are not related to the circumstances of the man's death but reflect the need for the prison to support prisoners with disabilities better, to enhance family liaison and to undertake more realistic risk assessments before applying restraints to sick and disabled prisoners. There is much to learn from this young man's short time in custody and his tragic death.

We are very grateful to the man's family for considering the report at the consultation stage. This final version of the report notes their remaining concerns about his treatment at Hewell. It also includes the National Offender Management Service's response to the recommendations made.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **October 2012**

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SUMMARY

1. The man arrived at HMP Hewell on 18 October, having been convicted of careless driving the previous month. The man had been involved in a car accident in which his friend was killed and he received significant injuries. As a result of the accident, the man was considered disabled, required special equipment and was prescribed a number of medications. He had also been diagnosed with depression and attention deficit hyperactivity disorder (ADHD) and was prescribed medication to treat both.

2. Although the man’s disabilities were recorded in a number of places and by different members of staff, his disability needs were never properly assessed. He was prescribed the correct medication and, aside from his disabilities, appeared to be a relatively healthy young man. The man was initially given a cell on the ground floor of houseblock 6. Although his disabilities were not formally considered when he was allocated a cell, this was, in fact, a reasonably appropriate location for him.

3. The man was monitored under suicide and self harm prevention measures for a short time. Staff involved in that process raised concerns about the impact his disabilities were having on his ability to cope. However, there is little evidence that any proper consideration was given to whether any adjustments were necessary.

4. The man had arrived in prison wearing formal shoes, which he found uncomfortable due to his injuries. On 22 October he was given a pair of prison issue trainers. His mother sent his own preferred pair of soft trainers (which were more suitable due to his disability) to Hewell on the same day but he was not given them until 5 November after the intervention of a governor, following a telephone call from his mother.

5. After he had been in prison for about a week, the man began to complain to his mother that he felt tired and unwell. On 31 October, he told a nurse that he was bringing up blood and he was given a doctor’s appointment that day. The doctor diagnosed a chest infection and prescribed antibiotics.

6. The man moved to the ground floor of houseblock 2 on 3 November. There is no evidence to suggest that his disabilities were taken into account when the decision to relocate him was made. Although he was on the ground floor, this was not a suitable location for him. On his first night in his new shared cell, he slipped while using the toilet and banged his head on the frame of the bunk beds, causing a large bruise on his forehead.

7. The man had another appointment with a doctor on Saturday 5 November during which the doctor diagnosed oral thrush and prescribed medication. He also asked for a blood test that was carried out on Monday 7 November.

8. Over the weekend, he seemed to get weaker and his cell mate and houseblock staff became more concerned about him. On the evening of 7 November, the man began vomiting and complaining of a bad headache. That same evening,

the local hospital which carried out the blood test, telephoned Hewell and asked for another blood test to be taken. The lead nurse on duty went to the man's cell to take another sample. She realised that he was not well and decided he should be taken to hospital. When he began to vomit again, healthcare staff ordered an emergency ambulance.

9. The man was admitted to hospital and told by hospital staff that he had leukaemia. In the early hours of 8 November, hospital staff diagnosed that the man had experienced a large bleed in his brain and it was not until that stage that his family were informed. His family were called to the hospital and were with him when he died at midday on 9 November. The post mortem examination revealed that he died as a result of the intracerebral haemorrhage, caused by leukaemia.

10. This investigation has found that the man's disability needs were not properly assessed or met while he was at Hewell. There is no evidence to suggest that this failure contributed to his death. The clinical reviewer finds that healthcare staff missed opportunities to recognise the seriousness of the man's condition, although she notes that such omissions could have occurred in the community. The majority of the eight recommendations made relate to improving the provision for prisoners with disabilities.

THE INVESTIGATION PROCESS

11. The Ombudsman's office was notified of the man's death on 9 November 2011 and the investigation was allocated to an investigator that day. The investigator visited Hewell to open the investigation on 15 November. During her visit she met members of the prison senior management team and the appointed family liaison officer. The investigator also met a member of the prison's Independent Monitoring Board. The investigator was provided with copies of the prison and medical records and other documentation relating to the man's time in custody.

12. Notices were issued to staff and prisoners at Hewell informing them of the investigation and inviting them to contact the investigator should they wish to talk to her about the investigation. No-one came forward in response to the notices.

13. A review of the clinical care the man received at Hewell was undertaken on behalf of NHS Worcestershire by a clinical reviewer (and is attached as the first annex of this report). The clinical reviewer was provided with a copy of the man's medical record.

14. The investigator carried out interviews with staff in December and January. The governor was provided with verbal and written feedback following the interviews and responded to the feedback in writing in March.

15. HM Coroner for Worcester was contacted and informed of the nature and scope of the investigation. The Coroner provided the investigator with a copy of the post mortem report and also shared some of the family's concerns with her. On completion a copy of the report will be sent to the Coroner to assist his enquiries into the man's death.

16. The Ombudsman's senior family liaison officer contacted the man's mother shortly after his death. She explained the investigation process and gave her the opportunity to raise any concerns or questions she wished to be addressed as part the investigation. The family liaison officer and the investigator visited her in November to discuss the investigation. During the meeting, the man's mother raised a number of concerns. In summary, she was concerned that:
    - Her son's disability needs had not been properly assessed or met by Hewell.
    - When she telephoned Hewell to raise concerns about her son, she was inappropriately directed to speak to staff in the chaplaincy team.
    - The man was not given access to special equipment, which he needed because of his disability, including a pair of trainers she sent to him.
    - The man was not given the correct doses of his prescribed medication.
    - Hospital appointments booked before he was sentenced were cancelled and not rearranged.
    - The man's disability needs were not considered when he was moved from houseblock 6 to houseblock 2.
    - Healthcare staff missed signs that the man was seriously ill, and therefore missed opportunities to diagnose the leukaemia earlier.
    - She was told that her son's "pupils had blown" when telephoned by prison staff at 3.45am on 8 November, which she felt was insensitive.

- The memorial service held for the man at Hewell was poorly attended, despite him having a number of friends in the prison.

17. We hope that this report provides answers to these questions and helps the man's family to understand his time at Hewell.

18. At the consultation stage, the man's family expressed their continued concern about the care and treatment that he received at Hewell. His family remain very concerned that healthcare staff at Hewell failed to recognise that he was seriously unwell, despite his symptoms. They submit that the man, because he was a prisoner, did not receive a standard of clinical care equivalent to what he would have received in the community. His family feel that he and his mother frequently raised concerns about his health and dispute that he downplayed his symptoms.

19. The man's family continue to be concerned about the general failure of staff at Hewell to record important information in his record. They remain highly critical of the prison's failure to identify and address the man's disability needs and his medication requirements. They have emphasised their disappointment that, despite their concerted efforts to alert staff to the man's disabilities and his ailing health, the prison failed to communicate effectively with them.

THE MAN

20. In July 2010, the man was involved in a car accident in which his friend was killed. Following the accident, he was charged with careless driving (while under the influence of alcohol or drugs). He was himself seriously injured in the crash. His injuries included an open dislocation of the left knee, with arterial damage, a closed dislocation of the right knee and a wrist fracture. He suffered acute kidney failure and received dialysis for four weeks. The man spent three months in hospital. As a result of the accident, he had a number of disabilities and used specialist equipment at home.

21. Information provided to the investigator and the Coroner by the man's mother detailed the extent of his needs. She wrote that he needed crutches to walk distances of up to 25 yards, but that he needed a wheelchair for anything further. She said that he had an adapted bath seat, adapted toilet seat and urinal bottle. He used a foot brace to support his ankle because he had foot drop (difficulty or inability to move the ankle and toes upwards) and cushions to ease the discomfort caused by severe nerve and muscle damage in his legs.

22. Following his discharge from hospital, the man suffered depression and was under the care of a psychiatrist. His community doctor wrote to the man's criminal defence solicitor summarising his mental and physical health problems. The doctor wrote that the man was receiving physiotherapy and was prescribed citalopram (an antidepressant), ferrous sulphate (to treat anaemia), gabapentin (commonly used for the treatment of epilepsy, but sometime used to treat nerve related conditions) because of the nerve damage he had suffered in his legs, lansoprazole (to treat excess stomach acid) and pain relief tablets containing morphine (known as MST). The doctor noted that the man had a history of depression and anxiety and had been diagnosed with ADHD for which he was also prescribed medication.

HMP HEWELL

23. HMP Hewell was formed in 2008 when three separate prisons based at the same site in the West Midlands, Blakenhurst, Brockhill and Hewell Grange, were merged. The prison now combines three functions: houseblocks 1-6 the original Blakenhurst prison, hold up to 1,074 adult male prisoners, on remand or sentenced. These houseblocks function as a local prison, taking prisoners from courts in the local area. Houseblock 7, formerly Brockhill, operated as a training prison, holding up to 170 male adult prisoners. In July 2011 it was announced that Brockhill was to close and it did so in March 2012. There had been no prisoners located in the building from the end of September 2011. Houseblock 8, the former Hewell Grange, holds 187 adult male prisoners in open conditions. The following section will focus on houseblocks 1-6, where the man lived while at Hewell.

24. Healthcare at Hewell is provided by Worcestershire Health and Care NHS Trust. The healthcare unit has 24 hour nursing staff, with in-patient care situated on the lower floor of the unit.

HM Chief Inspector of Prisons (HMCIP)

25. HMCIP inspected HMP Hewell in its new form for the first time in November 2009. The Inspectorate noted that houseblocks 1-6 were busy and had a high turnover of prisoners. Relationships between staff and prisoners in the houseblocks were reasonably good and prisoners surveyed as part of the inspection said that they were treated fairly and consistently.

26. The Inspectorate reported that the overarching diversity and race equality policy addressed issues of diversity. The regular diversity and race equality team meetings were well attended. Although disability liaison officers were based on each houseblock, the Inspectorate found their roles were unclear. At the time of the inspection, the prison had identified that six per cent of the population had a disability, less than the 15 per cent identified by the Inspectorate's survey. The Inspectorate also noted that there was no quality assurance system in place to ensure that the needs of prisoners with disabilities were met. When surveyed, prisoners with disabilities had more negative views of the prison regime than able bodied prisoners and they had no representative forum.

27. At the time of the inspection, health care services were judged "good overall" although prisoners on houseblocks 1-6 could wait for up to two weeks for an appointment with a doctor. Reception healthcare screening of new arrivals was described as good, with secondary healthscreens carried out within 48 hours. At the time of the inspection, a senior nurse was responsible for disabled and older prisoners, although the service was described as "developing".

28. The Inspectorate reported that prisoners had access to lockable cabinets to store their medication and so most medication was issued "in possession" (when the prisoner keeps the medication in their cell and is responsible for taking the correct doses). Medicines were dispensed twice a day and the Inspectorate had

"significant concerns" that prisoners prescribed medication to be taken at night had the medication dispensed as early as 3.30pm.

Independent Monitoring Board (IMB)

29. Each prison in England and Wales is monitored by a board of unpaid volunteers from the local community, appointed by the Secretary of State for Justice. Board members have access to all parts of the prison and all prisoners and are there to ensure prisoners are treated humanely and with dignity. The Board produces an annual report, the most of recent of which available for Hewell covers the period December 2009 to November 2010.

30. The Board was generally positive about the work of the diversity and race equality action team, although discussion of this focused mainly on race equality.

Previous deaths at Hewell

31. In total 25 prisoners have died while in the custody of what is now HMP Hewell since 2004, when the Ombudsman began investigating deaths in prison. This number reflects that the prison was formed by merging three prisons. In 2006, this office made a recommendation that staff be reminded to make entries in prisoners' files. Otherwise, there are no particular similarities between the circumstances of the previous deaths and that of the man, or the recommendations made following our investigations.

Prison Service Instruction (PSI) 32/2011 – Ensuring Equality

32. PSI 32/2011 sets out the framework for managing equality in prisons. Under the PSI, the governor must ensure that all local policies are formulated and implemented in line with legal obligations such as the Equality Act 2010.

33. Disabled prisoners must be encouraged to disclose their disability status, and procedures must be in place to make sure that such information is recorded and treated confidentially. The PSI instructs that Governors *"must consider whether prison policies and practices, the built environment, or a lack of auxiliary aids and services could put a disabled prisoner or visitor at a substantial disadvantage and if so must make reasonable adjustments to avoid the disadvantage."* (All mandatory instructions are printed in italics.) The PSI further instructs that, if a prisoner or visitor requests reasonable adjustments, then the request must be considered and the outcome documented. NOMS (the National Offender Management Service) has an obligation to make reasonable adjustments to avoid placing the disabled prisoner at a "substantial disadvantage".

34. The PSI provides guidance on where disabled prisoners should be located and notes that it is "not normally appropriate" to house the prisoner in the healthcare centre, unless their medical needs require it. This is because living in healthcare centres can prevent the prisoner from accessing aspects of the normal regime. Instead, reasonable adjustments should be considered to help disabled prisoners live on normal location. The prisoner should always be invited to discuss their specific needs.

35. Under the PSI, governors do not have to appoint a Disability Liaison Officer (DLO). If they wish, they may distribute the tasks formerly carried out by DLOs amongst other managers and staff.

Hewell's local equality policy

36. The investigator was provided with a copy of Hewell's local equality policy, dated June 2011. The policy includes an Action Plan to ensure that the prison acts in line with PSI 32/2011.

Assessment, Care in Custody and Teamwork (ACCT)

37. ACCT, the Prison Service process for supporting and monitoring those prisoners thought to be at risk of harming themselves, was introduced in 2007. An ACCT plan can be opened by anyone working in the prison if they have any concerns that a prisoner might have tried, or, in the future, might try to harm himself. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of observations (where staff must check the prisoner) and interactions (where staff must have a conversation with the prisoner) are flexible and can be set according to the perceived risk of harm. If staff perceive the risk of harm to be very high, the prisoner may be constantly observed, with a member of staff positioned outside their cell at all times. Where the perceived risk is lower, the level of observations may be several times an hour or day. Observations also take place during the night.

38. Part of the ACCT process involves drawing up a Caremap. A good Caremap will identify the prisoner's most urgent and pressing issues, set achievable goals to help resolve the issues and identify who is responsible for resolving each goal. The ACCT plan should not be closed until all of the actions on the Caremap have been completed.

KEY EVENTS

39. On 19 September 2011, the man was convicted of careless driving and on 18 October he was given a 21 month custodial sentence, initially to be served at Hewell. He had never been in prison before. His mother told the investigator that the man normally wore soft trainers, which were more comfortable given his foot drop and the ankle brace he used. However, on the day he was sentenced, he wore smart, leather shoes to court. The man was told that he could not take additional clothes or shoes in to the prison, instead, staff from his firm of criminal defence solicitors told his family that they could deliver items to the prison for him to collect. The man's mother was told that her son would be provided with any special equipment he needed as a result of his disability.

40. At 4.00pm on 18 October, the man underwent the first reception healthscreen with a nurse. The purpose of the healthscreen is to identify any immediate physical or mental health needs. The nurse recorded that the man was prescribed a number of medications. She also noted that he was physically disabled as a result of the injuries he had received and had a number of upcoming specialist appointments. The nurse wrote that he had no concerns about his physical health but that he should be examined by the doctor in any case. The man brought documents about his medical problems with him into the prison which were scanned in to his electronic medical record on 27 October.

41. The nurse was interviewed during the investigation. She remembered assessing the man because he was "one of the nicest, politest" prisoners she had met. She said that she could see that he used crutches and he showed her the ankle brace. However, she said that otherwise he seemed "fine" and he had no concerns about his physical health. His primary concerns were his upcoming hospital appointments. The nurse said that the man did not tell her that he needed any specialist equipment such as a wheelchair or adapted toilet seat. She confirmed that blood tests are not routinely performed on all new prisoners, but are carried out on the instructions of prison doctors, if they consider one is necessary.

42. In interview, the nurse was asked about the links between healthcare staff and the prison's Disability Liaison Officer (DLO). She explained that the secondary healthscreen (which occurs within 5 days of arrival at the prison) includes a question about disability and referral to the DLO.

43. The nurse also assessed the man's mental health and recorded that he had never tried to harm himself in the past and had no current thoughts of harming himself. He said that he was prescribed medication for ADHD and that he was also prescribed antidepressants. She referred him to the mental health team for assessment. The nurse noted that the man needed to be prescribed MST 10 milligram (mg) tablets, concerta XL 18mg (for ADHD), oramorph 5mg (a strong liquid pain relief medication containing morphine), gabapentin 300mg, citalopram 10mg, paracetamol, ibuprofen, ferrous sulphate 200mg, lactulose (to prevent constipation) and polyfax ointment (which treats skin infections).

44. Officer A and the nurse who carried out the healthscreen completed the cell sharing risk assessment (which assesses whether the prisoner is suitable for sharing a cell). The officer recorded that it was the man's first time in prison and that he would like to share with "someone sensible". The two members of staff assessed him as a standard risk prisoner, suitable for sharing a cell. The nurse completed the healthcare aspect of the assessment and recorded that the man needed to be given the bottom bunk in a cell. She gave no other guidance about the most appropriate cell location for him.

45. While in reception, the man completed the disability questionnaire, which every prisoner arriving at Hewell is asked to do. He indicated that he had a disability which affected his day to day living. He wrote that he had suffered damage to both legs in a car accident and that he had reduced mobility. Both the man and Officer A signed the form.

46. As part of the investigation, Officer B was interviewed. She was the prison DLO between September and December 2011 (the tasks formerly carried out by the DLO have since been allocated to two other members of staff). Officer B explained that, at the time, she had oversight of disability issues in the prison. However, she said that she was only given five hours a week to devote to the role and so she had to rely on Assistant DLOs (ADLOs) on each of the houseblocks to carry out most of the work for prisoners with disabilities.

47. Officer B explained that, at the time, completed disability questionnaires were passed to her. She identified prisoners with disabilities and informed the ADLO on the relevant houseblock by way of a weekly email. The emails were also copied to a member of healthcare staff (although Officer B could not remember the name of the person she emailed). Officer B said that, having received the email listing prisoners with disabilities, she expected ADLOs to meet the prisoner and assess their needs. (Officer B said that she emailed the houseblock 6 ADLO, Officer C, on 24 October to inform him that the man had arrived.)

48. The man was examined by Dr A at 7.50pm on 18 October. The doctor recorded that the man had come to prison with a number of medications because of the car accident he had been involved in. Dr A wrote that the man walked with crutches. He prescribed all of the medications that the man was on. In the community, the man took certain of his medications more frequently than twice a day. Dr A altered the prescriptions to twice daily doses.

49. Nurse B and Nurse C, both clinical development leads in the healthcare department were interviewed. They explained that medication is dispensed by nursing staff on each houseblock or in the healthcare centre twice a day – once in the morning and once in the afternoon. They said that because of the prison regime, periods when the prisoners are locked in their cells and staffing levels, it is difficult for healthcare staff to dispense medication more frequently. As a result, the prison doctors normally adjust prescriptions so that the same overall dose is received each day, split between two doses.

50. Later that evening, Nurse D offered the man paracetamol and ibuprofen to keep in his cell. However, according to the entry Nurse D made in the man's medical

record, he refused the offer because he did not have a secure place to keep the medication. Instead, the man was given a one-off dose.

51. That evening, while the man was still in the reception area, Officer D completed the first night assessment with him. Officer D was interviewed as part of the investigation. He explained that the purpose of the first night assessment is to give the prisoner a chance to ask questions about the prison, as well as for staff to gather more information about them.

52. The man said that it was his first time in prison and told Officer D about the offence that had led to his prison sentence. He said that he had spoken to his mother by telephone already and had no family worries. The man said that he had never tried to harm himself or take his life before, and had no such thoughts now he was in prison. The officer explained the support available to prisoners at Hewell. Officer D recorded that he had no concerns about the man's risk to himself.

53. In interview, Officer D said that he asked the man whether he had any disabilities. The man told him that he did not. Officer D explained that he had seen that the man used crutches. However, he said that, when carrying out the first night assessment, he relies upon the prisoner to tell him whether he has a disability. Officer D said that officers conducting the first night assessment do not have access to any of the prisoner's medical information. (In prison, as in the community, medical records are treated as confidential. This means that information is only shared in certain limited circumstances, normally only with other medical professionals and only with the patient's consent.)

54. The officer knew that the man had seen both Nurse A and Dr A and expected that he would have discussed any health issues with them. The man said that he had no immediate concerns. The investigator asked Officer D whether the man had mentioned needing trainers. The officer could not remember whether he had, but said that he would have told him that he needed to complete a written application once he was on the wing requesting either access to his own shoes or for a pair of prison issue trainers.

55. On his arrival on houseblock 6 (the first night and induction block), the man was placed in a double cell on the ground floor. Staff from houseblock 6 who were interviewed during the investigation explained that prisoners collect their food from the servery on the ground floor. The showers are also on the ground floor. However, medication is dispensed on the second floor. The houseblock is the only one with disabled access cells. There are two such cells, which have a wider doorway to accommodate a wheelchair and are slightly larger. In all other aspects, the disabled access cells are the same as normal cells on the wing although adjustments can be made depending on the needs of the occupant. Houseblock 6 is also the only wing with a lift. Staff told the investigator that the lift can only be used when the prisoner is accompanied by a member of staff. There is nothing in the man's file to indicate that staff considered whether he should be able to use the lift and no evidence he was allowed to do so. Officer B was not involved in the initial decision about where best to locate the man. Officer C had not yet been advised of the man's disability needs.

56. On 19 October, a member of healthcare staff rescheduled the man's imminent hospital appointments. (Existing appointments that are considered routine are normally rescheduled for security reasons, so that prisoners do not know in advance when they will be attending hospital. This process is designed to prevent attempted escapes.) The man's appointment at the hospital fracture clinic was changed from mid-December to the beginning of January 2012 and his appointment with the trauma and orthopaedics consultant was rescheduled from mid-November to mid-December 2011. Staff recorded that they were awaiting a new appointment from the physiotherapy team (an appointment for 24 November was received on 7 November).

57. At about 10.30am that day, the man had an appointment with Nurse E at the houseblock 6 treatment room. (Nurse E left Hewell during the investigation and it was not possible to interview her.) The nurse carried out the secondary healthscreen. As well as recording the prisoner's weight, blood pressure and other vital statistics, this assessment also provides an opportunity to identify any health problems not raised during the first reception healthscreen. Nurse E recorded that the man was disabled, had mobility problems and was prescribed medication. Nurse E recorded further details about the extent of the man's injuries, noting that he suffered "severe damage to both legs, kidneys failed, left arm broken … left leg injury and no ligaments in either leg, nerve damage to both." The man also said that he smoked about ten cigarettes a day but was keen to give up.

58. The man told Nurse E that he sometimes had thoughts of suicide or self harm, but that he would never act on the thoughts. He said that he had been feeling very low for some time. As a result of this admission, the nurse opened an Assessment, Care in Custody and Teamwork (ACCT) plan.

59. There is nothing in the medical record to suggest that Nurse E discussed the man's needs with the DLO or referred him to her. Nor is there any mention of the man needing, or being assessed for, special equipment due to his disabilities. Officer B said that it would be up to the healthcare department to ensure that a disabled prisoner was provided with most equipment, including wheelchairs, toilet raisers, grab bars or mattresses. She said that the DLO is responsible for obtaining equipment such as magnifying screens or teletext televisions for the hard of hearing.

60. Nurse B explained if the prisoner indicates that they have a disability during the secondary healthscreen, the nurse conducting the screen should refer the prisoner to the DLO. However, she said that healthcare staff did not always know who the DLO was or where they were based. Nurse B did not think that there was a formal procedure for referring disabled prisoners to the DLO.

61. In interview, Nurse B said that prisoners with disabilities could be admitted to the inpatients unit on their arrival at Hewell. She explained:

> "If somebody comes in with an obvious disability, such as mobility problems, then we would more than likely admit them into our healthcare centre and

make an assessment then of their ongoing needs, with a view to getting them onto normal location as soon as we can."

62. Nurse B told the investigator that healthcare staff have a role to play in making sure that the prisoner is housed in the most appropriate location. She said that if the prisoner needs special equipment in the cell, such as grab bars, they can be housed in the inpatients unit until the necessary adjustments have been made to a normal cell. Nurse C said that, if necessary, healthcare staff can arrange for a physiotherapist to carry out an assessment of the prisoner's disability needs. There is nothing in the man's record to suggest that any of the healthcare staff who had contact with him considered whether he should be admitted to the inpatients unit.

63. At 11.00am, Officer C made an entry in the man's ACCT plan. He wrote that the man had asked several times about getting some trainers. The officer noted that because the man used crutches, this should be made a priority. Officer C was interviewed during the investigation. He could not remember the precise details of his conversation with the man or whether the man explained why he needed them. The officer said that he told the man that he would help to resolve the problem for him. Officer C thought he had probably tried to get the man a pair of prison trainers from the stock kept on houseblock 6.

64. Officer C said that, from his recollection, the man did not seem to have any trouble collecting his food from the servery. The officer explained that, if a prisoner is unable or finds it difficult to collect their food (for example because of a disability) either an officer or another prisoner will normally be asked to collect it for him. Officer C said that the man did not complain to him about any difficulties collecting his food or his medication.

65. After the interview the investigator was told that Officer C was the ADLO on houseblock 6. She spoke to him again, by telephone, to discuss the role. Officer C said that he had been given the role of ADLO in March 2011, but that he had not volunteered for it. He said that he spoke to one of the houseblock 6 managers and the prison fire officer to find out whether there was any training for the role and to try and understand his responsibilities. Officer C said that he was not aware of having any particular responsibilities when a disabled prisoner moved onto the houseblock.

66. Officer C said that he had never had any contact with Officer B, the DLO, and had never been called upon in his role as ADLO. He told the investigator that 'he keeps an eye on' disabled prisoners on houseblock 6 in any case.

67. Senior Officer (SO) A was the senior officer on duty and that afternoon, he signed the ACCT immediate action plan, designed to keep the prisoner safe until they have undergone a more detailed assessment. The SO agreed that the man should be monitored once an hour until the ACCT assessment interview had taken place. (The ACCT assessment interview must be carried out within 24 hours of the ACCT plan being opened. It is conducted by a specially trained member of staff and the purpose is to explore the prisoner's concerns and the risks they pose in greater detail.) SO A was interviewed as part of the

investigation. He explained that he went to see the man as a result of the issues raised in the immediate action plan. The SO said that he considered whether the man was in the most appropriate cell, given his injuries. He said that he thought it best that he be on the same landing as the servery and showers.

68. In general, prisoners at Hewell must collect controlled medication from the upper landing of the healthcare centre. (Controlled medication is strictly regulated and dispensed in line with tight regulations. Morphine is a controlled medication.) Non-controlled medication is collected from the treatment rooms located on each houseblock. However, on houseblock 6, both controlled and non-controlled medications are dispensed from the treatment room on the second floor.

69. SO A said that, at this point, the man gave no signs that he was in pain. The SO said that he was not worried about the man collecting his medication as he knew it was all dispensed on the wing.

70. The man's mother said that she telephoned the prison on 19 October and spoke to the family support worker. She said that she told the support worker that her son did not have the correct shoes. His mother explained that his balance and gait were impaired and that she had concerns about his disability needs. His mother asked to speak to the head of healthcare but was told that the man would need to request this himself. There is no record of this telephone conversation in his file.

71. At some point on 19 October, a member of staff completed the induction officer assessment with the man. It has not been possible to identify which member of staff carried out the assessment because the form is not signed and there is nowhere on the form for staff to record their name. The assessment consists of 17 tick box questions which cover a range of subjects. Two of the questions relate to disability. The first asks "Do you consider yourself to have a disability of any kind?" and the member of staff has ticked 'yes". The second question asks "Any staff concerns relating to disability?" and again, the member of staff has ticked "yes". Notes on the form direct that staff must inform the DLO and update the prisoner's file accordingly if the answer to either question is yes. There is nothing in the man's file to indicate that the member of staff carrying out the assessment referred the man to the DLO, nor is any information about his disability recorded. In any case, the form the man had completed the day before highlighted his disability needs to Officer B.

72. Although Officer D did not carry out the man's induction officer assessment, he was asked questions about the process. He said that the ADLO is responsible for liaising with the prison DLO. Officer D did not think that there was a formal process for referring prisoners to the ADLO or prison DLO, but thought that induction staff might do this by way of an email or telephone call if they had any concerns.

73. At 10.05am the following day (20 October), the Reverend A, one of the prison chaplains, carried out the ACCT assessment interview. She recorded details of her conversation with the man in the ACCT plan. She wrote that he was not receiving his medication as prescribed and that the physical stress was "causing

him much distress". The man told the Reverend A that he had been given his medication on 18 October when he first arrived but had not received any since then. The Reverend wrote that mentally, the man was "very strong" but that physically "it's really difficult for him to cope" (the word was underlined in the ACCT plan). She continued that he was "getting exhausted" just moving around the prison and that carrying food back to his cell from the servery was "really difficult". The Reverend A recorded that the man "must" get his medication and that he "needs a wheelchair and to be in a location with as few stairs as possible". She also noted that he was finding the hard mattress very painful on his legs.

74. Prisoners who are prescribed medication should be unlocked at dispensing times and must go to either the wing treatment hatch or the upper landing on the healthcare centre to collect it. It is normally the prisoner's responsibility to make sure that he is unlocked and collects his medication. As part of the investigation, the investigator requested the man's prescription charts to see when he received his prescribed medication. She was told that Hewell uses SystmOne, the electronic medical record system and staff no longer complete paper prescription charts. There was some confusion among healthcare staff about whether it was possible to find out if a prisoner has missed medication and the prison did not confirm whether the man collected his medication as prescribed while at Hewell.

75. Nurse B explained that the staff response if a prisoner misses doses of medication depends on the medication. She said that, generally, no further action will be taken if the medication is for pain relief. If it is prescribed for a specific condition, such as epilepsy, staff will normally try to discuss the missed dose with the prisoner and check why they did not collect it. If the medication is prescribed for a mental health condition, the nurses will inform the mental health team who should take action.

76. Shortly after the ACCT assessment interview, SO A arranged the first ACCT case review. Officer E was also present. The SO explained that he went to the man's cell and found he was in bed. The man told the SO that he was in a great deal of pain and had not had his medication. SO A described him as "a really pleasant lad" who said that he did not want to "be an issue". He said that he reassured the man that this was not the case and that it was important that his medication problem was resolved quickly. The SO did not know why the man had not received his medication. SO A said that he immediately spoke to the nurse in the houseblock 6 treatment room and asked them to see the man in his cell. The nurse who went to see the man did not make an entry in his medical record to indicate that the medication issue had been resolved. It seems that the man did not complain to staff about missed medication again after this date.

77. SO A returned to see the man at 2.40pm on 20 October and continued the ACCT case review. He wrote that the man's medication had taken effect and that he was consequently "in a much happier frame of mind". SO A recorded that the man's main issue was making sure that he received his medication, particularly the pain relief medication which he needed twice a day. The SO wrote that the man "realises there is an onus on him" to collect his medication, but that staff needed to support him and make sure he received it during periods of lock up. In

interview, the SO explained that he expected staff working on the man's landing to have read the ACCT plan in full and, therefore, to be aware of how they could help him.

78. In interview, SO A described the man as a "positive" person who wanted to make progress while in prison. During the case review, the man told SO A that he was able to collect his own food. He said that he would tell staff if he was having a bad day. SO A told the investigator that he considered whether the man was in the most suitable cell or whether he needed to move to the second floor, which would be closer to the treatment room. He said that, at the time, he was happy that the cell on the ground floor was appropriate, but that it was a "fluid" situation, which could be reviewed if the man was having problems. SO A was asked whether the ADLO or DLO had been involved in any of the decisions made about the man. He said that, to his knowledge, the DLO had not had any contact with the man at that stage.

79. SO A explained that if a prisoner is unable to move easily around the wing, or collect their food, a management plan can be put in place to help support him. As part of that plan, other prisoners might be asked to collect another's food or, in cases where the prisoner is a wheelchair user, wheel the prisoner to appointments. However, he said that although the man "found things difficult at times" and sometimes got tired, he thought that the man "wanted to progress and get better" and be more independent.

80. The man did not tell SO A that he needed trainers or that he required any other special equipment. The SO made one entry on the ACCT Caremap which referred to his having missed medication. He wrote that healthcare and houseblock staff were to "ensure" that the man received his medication as prescribed. He had no other concerns about the man at any time.

81. The man's family came to visit him on 21 October. They said that he was only wearing one shoe during the visit, because he still did not have any trainers and found his shoes too uncomfortable. He told his family that he had asked for a pair of prison trainers but had been told that none was available. He said that he was finding it difficult and painful to climb the stairs to the treatment room. The man's mother said that, at the end of the visit, she spoke to a member of staff who she thought was the DLO. She said that she repeated her concerns that her son's disability needs were not being met. She said that the member of staff rang houseblock 6 and was told that there was no suitable footwear available. The member of staff told the man's mother to post his trainers to him "marked for the attention of medical services" and he would be allowed to wear them. The member of staff made no entry concerning the conversation in the man's prison file. In interview, Officer B said that she had not met the man's mother during his time in prison. Because there is no entry in the prison file, it has not been possible to identify the member of staff who the man's mother spoke to that day.

82. The following day, 22 October, the man's mother posted his trainers to him at Hewell, along with a letter marked for the attention of medical staff outlining his medical conditions and disability needs. (She discovered after the man's death that he had been given the letter instead of healthcare staff.) The trainers were

held in the reception area when they arrived. At this point, the man had been given some prison trainers and an entry in his ACCT plan notes that he told staff they helped him to walk more comfortably.

83. At 12.20pm on 23 October, Officer F noted in the man's ACCT plan that the man was "sociable and chatty" during association (when prisoners are out of their cells and can socialise with each other and use the telephones and showers). The officer wrote that the man seemed "a lot happier" now he had trainers and was spending more time out of his cell.

84. Later that afternoon, Nurse D carried out a mental health assessment. The man said that he had no thoughts of suicide or self harm, although he had experienced such thoughts in the past, following the accident. The nurse recorded that he had "minor concerns" about the man's "basic living skills/participation in activity" (although he did not explain what the concerns were). Nurse D wrote that he had reminded the man of the support available to him at Hewell. The nurse recorded the man's history of ADHD and noted that during the assessment he had seemed a "little flat" in mood. The nurse decided to refer the man to the mental health team.

85. At 4.20pm, Officer F recorded that the man had mixed with other prisoners during the afternoon association period and was "in high spirits".

86. SO B and the man met for the second ACCT case review at 10.00am on 24 October. Officer G (one of the houseblock officers) provided verbal information about the man prior to the case review. The SO wrote that the man made "very good eye contact" and said that he had "settled down". The man also said that he had spoken to healthcare staff about increasing his medication (no further details about this are recorded in the ACCT plan). He said that he had no thoughts of harming himself and wanted to "get on with his sentence". SO B and the man agreed that the ACCT plan could be closed. The man's medical record makes no mention of him having discussed increasing his medication doses with healthcare staff.

87. In interview, Officer B said that about six days after the man arrived at Hewell she saw him on the wing. She remembered that he was walking without his crutches and she commented on this. The man said that he was "a lot better". He told Officer B about the trainers that his mother had sent in and said that he thought they were in reception. Officer B telephoned reception to ask that he be given the trainers. She found out that she was "about the third" wing officer to do so. Reception staff told Officer B that they could not release the trainers to the man without authorisation from the healthcare department. Officer B said that her colleague, Officer H, had already spoken to the nurses in the treatment room on houseblock 6 to ask them to write a letter giving the man permission to wear the trainers. Officer B said that was the last time she heard about the trainers. Nurse B told the investigator that, if a member of healthcare staff had written such a letter, she would have expected it to be filed in the man's medical record. There is no evidence that any member of healthcare did write a letter to reception staff.

88. At 6.23pm on 24 October, the man telephoned his mother. All telephone calls made by prisoners are recorded. Prison staff can monitor calls either on a random basis or if there is any information suggesting monitoring is necessary. As part of the investigation, the investigator was provided with a copy of the calls the man made while in prison. There is nothing to indicate that prison staff monitored his telephone calls. During the call, the man told his mother that his trainers had arrived in reception but that he had been given prison trainers in the meantime. He said that they were “okay” but not as comfortable as his own. (His mother told the investigator that she telephoned and spoke to a member of the chaplaincy team that day. That person confirmed that the man’s trainers had arrived and that he should get them within a couple of days. No entry reflecting the call was made in the man’s prison file.)

89. The man told his mother that he had a cold. She asked him if he had had any more problems getting his medication. He said that he had not. However, he said that he felt like his medication was not as effective as it had been before he came to prison. His mother suggested that this might be because he was having to do more and so was tired. She told him to get the doses increased if he was in pain and to see if he could receive his medication at different times. The man said he would try to get an appointment with the doctor the following morning. His mother asked him if he had met the DLO yet and he said he had not.

90. The man spoke to his mother by telephone again at 6.30pm on 25 October. He said that he would not be able to get his trainers from reception until the weekend. His mother asked him if he had seen the doctor again yet and the man told her that he had made an application for an appointment and was waiting to hear. His mother suggested that he speak to Nurse B about the healthcare “plan” for him. The man and his mother then discussed his medication doses. His mother said that, according to his prescriptions, he was allowed more than two doses of certain of his medications. He agreed but said that he was unable to collect more doses during the day because the treatment room was closed. He told his mother that healthcare staff were trying to arrange for him to keep some medication in his cell.

91. Nurse B and Nurse C both explained that there are no facilities for prisoners on houseblocks 1-6 to keep medication in their cells. None of the cells are fitted with lockable storage. This is particularly difficult when the prisoners are sharing cells and in such cases, medication is not normally prescribed in possession.

92. At 7.12pm on 26 October, Dr B made an entry in the man’s medical record. The doctor wrote that the man had “walked into” the consulting room on houseblock 6 asking to see the doctor. However, Dr B wrote that he was busy seeing newly arrived prisoners. He told the man that he needed to make an appointment. According to the entry, the man then returned, accompanied by an officer, again asking to be seen. The doctor did not examine the man that evening or record any further information about why he wanted to be seen. Nurse C told the investigator that healthcare staff had been told that the doctors examining new prisoners during evening reception surgeries could not be interrupted. The nurse said that there was no facility for the reception doctor to see other prisoners during this time, unless it was an emergency.

93. The man had an appointment with Nurse Practitioner A, a mental health nurse, at 11.50am the following day. (Nurse practitioners have undergone post-graduate education and are more highly qualified than general nurses.) The nurse recorded that the man was to be placed on her caseload for “low level support”. She wrote that he was waiting to see the doctor for a review of his pain relief medication.

94. The man’s family visited him on 27 October and noticed that he was not wearing his own trainers. He told them that although a nurse and the wing manager had agreed that he should be able to wear them, permission was needed from a “higher level of authority”. He said that he had applied to see Nurse B but had not yet got a response. (Nurse B told the investigator that she was not aware that the man was trying to get an appointment with her.) The man’s mother said that her son “looked ill” at the visit and said he was not eating.

95. Following the visit, the man’s mother contacted the chaplaincy team again. She told them that her son looked unwell and that she was worried about him. She said that given his medical history, she was concerned that he had not yet seen the doctor. Again, she expressed her concerns about how his medical and disability needs were being met. The member of the chaplaincy team she spoke to made no note of the conversation in the man’s file. There is nothing in the file to indicate that any further action was taken as a result of the conversation.

96. Officer B said that Officer H told her that the man was not eating very much (she could not recall the exact date she was told this). As a result, she went to speak to him. She said that she and other staff had a “little nag” and told him that he needed to eat. Officer B said that the man looked quite pale.

97. On 29 October, the man telephoned his mother at 3.56pm. He told her that he had still not been able to collect his trainers from reception but that staff had said “it would be sorted out” the next day. They spoke again at 2.39pm the following day. He told his mother that he was not going to collect his trainers after all because healthcare staff had not confirmed that he needed them. The man said that he had put in another application to see the doctor and was waiting for an appointment. He also said that he had an appointment with Nurse B. (As noted earlier, Nurse B was apparently unaware of this.) The man told his mother that he had spoken to the ADLO but that “he did not know what was going on”. He said that he had been feeling ill and that his kidneys had been hurting, which he thought might be a bacterial infection. His mother told him that he needed to see the doctor.

98. On 31 October, Officer C carried out the ACCT post-closure review. (The purpose of the post-closure review is to check that any issues identified during the ACCT process have been resolved and that the prisoner does not pose a risk to themselves.) The officer recorded that the man had felt supported by staff while the ACCT plan was open and that goals identified on the Caremap had been resolved. The man said that he was feeling more relaxed and understood the regime better. He said that his negative thoughts about the accident would “always be with him” but that he was learning to live with them. Officer C

recorded that the man was “in a very positive mood”. In interview, the officer said that the man raised no concerns with him, either about thoughts of self harm or about struggling with life in prison. The officer was asked whether the man had seemed unwell that day. Officer C said that he did not seem unwell.

99. At 4.56pm that day, Nurse E made an entry in the man’s medical record. She wrote that he had approached her at the treatment hatch and said that he was “bringing up blood”. Nurse E took his pulse, which she noted was “slightly raised” at 108 beats per minute. She also took a blood oxygen reading, which was 99 per cent (this is a normal reading), and recorded that he was breathing at a rate of 15 breaths a minute. His blood pressure was 135/69mmHg (which is within the normal range). The man told Nurse E that he had “had the problem” for five days but had not told the doctor because he thought it was a chest infection. He was able to produce a sputum sample, which the nurse confirmed had fresh blood in it. Nurse E wrote that the man did not have any blood in his stools although he complained of bowel pain, which he thought might be the result of constipation. He said that he had no chest pain but that his chest felt “strained”. The man also complained of head aches and feeling dizzy. The nurse recorded that she would seek advice from the doctor and arrange for the man to be examined by a doctor that evening. She wrote that he should be “monitored for change”.

100. Dr C examined the man at 7.16pm that evening. She recorded details of the examination in the man’s medical record. She noted that he was “feeling unwell with flu like symptoms” and was coughing up phlegm with blood in it. The man told the doctor that he felt feverish and had not eaten very much that day. The doctor recorded that his chest was “clear”, his pulse was regular at 90 beats per minute but that he felt hot (she wrote that she did not have a thermometer to take his temperature). Dr C diagnosed the man as having a chest infection and prescribed antibiotics and paracetamol.

101. While examining him, Dr C also recorded details of the man’s mobility. She wrote that he needed to be referred to the physiotherapist because he had been receiving physiotherapy in the community to help strengthen his left leg. There is nothing in the man’s medical record to indicate whether a referral to the physiotherapist was made.

102. The man’s mother telephoned the prison again that day and spoke to a member of the chaplaincy team. She again raised concerns that her son’s disability needs were not being met and that he had not yet been given his trainers. She was worried that he had not yet seen the doctor. Later that day, the person rang her back and confirmed that the man had been examined by the doctor and given antibiotics for a chest infection. Again, no record of the conversation was made in the man’s file. Members of the chaplaincy team have access to the prison record system, P-Nomis, and could, therefore, have made entries in the man’s case notes.

103. On 2 November, Dr C noted in the man’s medical record that the sputum sample he had provided had been examined under a microscope and was normal.

104. On 3 November, the man was moved from houseblock 6 to houseblock 2. There is nothing in his file to indicate that his disabilities were taken into account when the move was arranged. In fact, in interview, Officer B commented that houseblock 6 was more suitable. He was given a cell on the ground floor of C spur (known as C1). His cell was close to the servery, healthcare treatment room and showers but he was no longer able to collect his controlled medication from the wing treatment room. He now had to walk to the upper landing of the medical centre. The investigator walked the route that the man used to collect his medication while on houseblock 2. It involves four flights of stairs and a walk of approximately 200 metres.

105. On his arrival on houseblock 2, the man was placed in a double cell with Mr A. Mr A was interviewed as part of the investigation. He said that it took the man between 10 and 15 minutes to walk to the upper healthcare landing to collect his controlled medication.

106. Mr A told the investigator that prisoners on C1 had their association time on A spur. This is because the rest of C spur houses vulnerable prisoners kept separate from other prisoners either because of their offences (usually sexual) make them likely to be victimised or they have sought protection for issues such as being in debt to other prisoners. The two groups of vulnerable prisoners are also kept separate from each other at Hewell and so have different association periods. As a result, the few prisoners from the general population housed on C1 are not able to associate on C spur.

107. During association, cell doors are left open. This means that prisoners can use the telephones and showers and mix with other prisoners, but can return to their own cell at any time. Mr A explained that this made it difficult for C1 prisoners who do not know anyone on A spur, as they have to “stand around” on the landing until they are escorted back to their cells. Mr A said that the man found it tiring to associate on A spur and therefore after the move to houseblock 2, he chose not to leave their cell during association.

108. Officer I, a houseblock 2 officer, said that from his limited contact with the man, he could see that he “wasn’t a well man”. The officer said that the man walked “agonisingly” slowly, even with crutches. He said that houseblock 2 staff had tried to get a wheelchair for him but were told that there were no spare ones in the prison. Officer I told the investigator that the man did not come out of his cell much, because there was “nowhere for him to go”. The man told the officer that associating on A spur was difficult because he could not relax and sit down. The officer said that he told the man that he would let him return to his cell as soon as he got tired, but he turned down the offer.

109. Officer J, the houseblock 2 ADLO, told the investigator that she had not volunteered for the role, had not been told that she was being given the role and had received no relevant training. She said that she found out that she was the appointed ADLO only after reading this on a notice board in the senior officers’ office. Officer J said that she received monthly emails from the then prison DLO, Officer B, but that she did not attend any disability related meetings. She also said that she had no contact with other ADLOs.

110. Officer J said that part of the email she received from Officer B was an up to date list of prisoners with disabilities on houseblock 2. She did not know whether she was supposed to have any contact with the prisoners named on the list. Officer J did not know who should be contacted if a prisoner with disabilities needed a wheelchair or any other specialist equipment but would probably refer this to healthcare staff. Officer J did not have any contact with the man in her role as the ADLO and was not involved in any of the decisions about which cell he should be given.

111. Mr A told the investigator that the man found it difficult to move around the wing. He said that the man was not able to use crutches in their cell because it was too small, so he tended to use the furniture to help steady him. Mr A said that on his first evening on houseblock 2, the man slipped while using the toilet and banged his head on the bed frame. At the time, Mr A was at work, but when he returned he saw that the man had a bruise on his forehead.

112. On 4 November, the man's family visited him again. His mother said he looked "clearly unwell" and was walking slowly and with great difficulty. She noticed that he had a large bruise on his forehead, a large bruise on his arm and unusual "purple markings" on his tongue. He told his family about having fallen as he used the toilet. He said he felt very ill and described being breathless with no energy, having a headache and feeling sick. He said he had suffered a nosebleed and felt dizzy.

113. The man's mother was very worried about him after the visit so she telephoned the prison once more on her return home. She asked to speak to the DLO, who was not available. She then asked to speak to someone who was "medically trained". She was told that she could speak to someone from the chaplaincy team, she refused this offer.

114. Mr A told the investigator that the man did not collect his dinner that day, saying he was not hungry. Mr A offered to collect his food for him, but the man said that he did not want any. Officer I said that he knew the man was not eating very much. When he encouraged him to eat, the man said that it made him feel sick.

115. At 9.30am on Saturday 5 November, the man had an appointment with Dr A. Dr A made an entry in the man's medical record, noting that he was taking antibiotics for a chest infection. He wrote that the man felt weak and "like passing out". The man did not have a fever, but had lost his appetite. Dr A wrote that the man had a "sore tongue" and that there were "some spots" on it. The doctor diagnosed that the man had oral candidiasis (commonly known as thrush). As part of the investigation, the clinical reviewer spoke to Dr A by telephone. Dr A said that the spots on the man's tongue were white (which is consistent with the appearance of oral thrush). He told the clinical reviewer that the man did not appear to be very unwell.

116. Dr A recorded that the man looked pale, had a regular pulse (of 84 beats per minute) and was not having any problems breathing. Dr A told the clinical reviewer that he removed the man's top in order to carry out a basic chest

examination. He recorded in the medical record that he heard “mild crackles” on both sides of his chest (which would be consistent with a chest infection). Dr A did not apparently notice any bruises on the man’s body and he made no note of the bruise on his forehead. Dr A prescribed medication to treat thrush and also ordered a blood test. Nurse C and Nurse B both said that the doctors can request urgent blood tests, which will be carried out that day. Dr A did not indicate that his request was urgent.

117. The man’s mother telephoned the prison again that day, 5 November. She spoke to the family support worker who suggested that she speak to the duty governor. (Every day, one member of senior staff acts as the duty governor. It is their responsibility to resolve issues that arise in the prison, although they may, if necessary, refer matters to more senior governors.) Ms A was duty governor that day.

118. During their telephone conversation, the man’s mother discussed all of her concerns with Ms A. She told the governor that she was worried that her son’s disability needs had not been met, that he still had not been given his trainers, that he had requested appointments with healthcare staff which had not been forthcoming and that he currently looked very unwell.

119. Ms A told the man’s mother that she would go and see him that day and, at about 2.00pm, she did so. She explained that she was unable to look at the man’s electronic prison file before visiting him because the computer system was not working. Ms A saw the bruise on the man’s forehead and asked how he had got it. He explained that he had fallen and assured the governor that he had not been assaulted.

120. The man told Ms A that he had not been feeling well that day and so when he went to collect his medication in the morning, he had talked to healthcare staff who had made an emergency appointment for him with the doctor. (None of this is noted in the man’s medical record.) He said that, as a result of his doctor’s appointment, he was going to have a blood test the following Monday (7 November). Ms A said that she did not ask very many questions about his physical health because this is confidential between the patient and clinical staff. However, he told her that he found the walk to the upper medical landing exhausting.

121. Ms A said that she asked him whether he used a wheelchair at home. The man said that he had one, but did not often use it. In any case, following their meeting, the governor tried to find a wheelchair for the man to use. None was available that day, but she continued to look into this. She said that he did not say he was struggling with other aspects of life on the wing and she found him to be in “good spirits”. Ms A asked the man if he had seen the prison DLO. He told her that he had not.

122. The investigator asked Ms A whether she thought that he was in the most appropriate cell. She said that she asked the man if he was coping on houseblock 2 and he told her that he was. She said that she did not think that he

needed to be in a disabled access cell. However, Ms A emailed Officer B later that day to check whether he was located in the right cell.

123. Ms A realised that the man did not have a Personal Emergency Evacuation Plan (PEEP). Such a plan is required for anyone who will need help in the event of an emergency or evacuation so that staff working on the wing know what action to take. Ms A arranged for a member of staff to carry out the PEEP assessment the following Monday.

124. Having talked to the man, Ms A arranged for his trainers to be collected from reception for him. Later that afternoon, she telephoned the man's mother to update her. His mother told the investigator that Ms A had arranged for the man to see the doctor "immediately" because of his tongue. There is nothing in the man's file to suggest that he saw the doctor again that day.

125. Mr A told the investigator that the man did not eat his dinner again that day. However, he said that, in the evening, the two men did some exercises in the cell. The man told Mr A that he wanted to train every evening.

126. The following day, 6 November, Officer I made an entry in the man's prison file. The officer described some of the man's mobility problems and wrote that he "must not overdo it". Officer I wrote that the man "must be escorted" by staff to collect his medication from the healthcare centre. The entry continues "moves afoot to get wheelchair for him and consideration being given to suitability of current location". The officer recorded that the man was not feeling very well and did not want to eat any lunch or dinner, despite another prisoner offering to collect his meals for him. Officer I wrote that the man "spends all of his time in his cell, feels unable to associate due to injuries" and that he felt "isolated". The officer wrote that staff were doing their best to support him but that the "current C spur regime offers little alternative at present".

127. A member of the chaplaincy team telephoned the man's mother that day. They said that they had visited the man and that he had been upbeat. His mother was told that her son's medication was being brought to his cell so he did not have to collect it from the healthcare centre. (There is no record of this having been agreed in the man's medical record or information to confirm that it happened.)

128. Mr A told the investigator that, as the weekend progressed, the man became quieter and seemed to have less energy. He said this was particularly noticeable on the Sunday evening when they watched television together. He described the man as seeming "drained". However, he said that the man did not complain about being unwell. When asked, Mr A said that, to his knowledge, the man did not vomit over the weekend.

129. At 10.52am on Monday 7 November, Nurse F wrote in the man's medical record that he was drinking plenty of water but was not eating very much. The man told the nurse that he felt "rough and weak" and that he had "never felt so exhausted" before. Nurse F took a sample of the man's blood to be tested, as instructed by Dr A. She offered the man another appointment with the doctor but recorded that he was happy to wait until the blood test results had come back. Nurse F

recorded the man's vital signs, writing that his blood oxygen level was 99 per cent, his blood glucose was 5.8, his pulse was 108 and his blood pressure was 119/69mmHg. These readings are all within normal ranges. His temperature was 38.7 degrees, which is slightly higher than normal.

130. Nurse C and Nurse B told the investigator that blood samples are normally taken in the morning and are delivered to the local hospital by taxi at lunch time. The results arrive electronically on SystmOne, normally within a few days.

131. Officer K, the fire officer, visited the man on 7 November and completed the PEEP assessment. Officer K concluded that the man had reduced mobility which meant that he was deemed "high risk" for the purpose of the PEEP. The officer also noted that the man might suffer heart or breathing problems as a result of the stress of an evacuation situation. Officer K wrote that the man would need to be unlocked early and given assistance in an emergency evacuation.

132. Mr A told the investigator that he returned from work in the early evening of 7 November. He found that the man was still feeling very unwell and had been sick a couple of times. At about 5.00pm, the man went to collect his medication. Mr A described him as stumbling as he walked and being unsteady on his feet. Mr A said that he told staff on the houseblock that the man was not well, however, he thought that they were more concerned about getting the wing locked up for the evening.

133. That evening, Nurse G was the lead nurse on duty and told us that she was dispensing evening medication when her colleague told her that the hospital had telephoned asking for another sample of the man's blood. Nurse G did not speak to anyone from the hospital herself so did not know why another blood sample was needed, however she thought her colleague said that the first results were not right. She went to the man's cell at about 7.50pm.

134. Nurse G said that the man was very pale and looked unwell. She took a sample of his blood but, having done so, found that the needle entry site would not stop bleeding. The nurse said that she was concerned about the man and decided that he should be taken to hospital. She returned to the healthcare unit and requested a non-emergency ambulance. Two of Nurse G's colleagues returned to houseblock 2 with a wheelchair to move the man to the healthcare unit while they waited for the ambulance.

135. However, at about 8.30pm, Nurse H recorded that the man was being sick again and was complaining of a very bad headache. Nurse H and Nurse G decided that the ambulance request should be upgraded to an emergency. The ambulance arrived at the prison at 8.50pm.

136. Officer L had just arrived at the prison to carry out a night duty. He was told that he would be part of the escort team accompanying the man to hospital. (It is standard procedure for a prisoner to be escorted by prison staff when they go to hospital.) Officer L said that when he met the man in the healthcare unit, he was coherent and able to stand and walk to the ambulance. The ambulance left the

prison at about 9.30pm once the paramedics had carried out some preliminary examinations.

137. According to the man's medical record, Dr B and Dr D reviewed the man's blood test results at 11.05am (only 15 minutes after Nurse F took the blood sample) which is not correct. It has not been possible to fully explain why SystmOne records the wrong time, but the doctors' entries indicate that the results were actually received on SystmOne some time later that evening, after the man had gone to hospital. The results were strongly suggestive of acute promyelocytic leukaemia (a type of blood cancer).

138. Before the man left the prison, a risk assessment was carried out to decide whether he needed to be restrained. The assessment noted that he posed a low risk to the public and was not likely to try to escape. His history of substance use was noted and information provided by the police indicated that he had received a warning for assault in the past. Healthcare staff recorded that they did not think the man should be restrained because of his disabilities. However the authorising officer decided that the man should be restrained by an escort chain which could only be removed in an emergency. (An escort chain is a length of chain, approximately eight foot in length, with a handcuff at each end. One cuff is worn by the prisoner, the other by an officer.) During the ambulance journey to the hospital (which Officer L said took about 15 minutes), the man talked to the paramedics, however, he was also sick again.

139. Once at the Alexandra Hospital, the man was moved to a cubicle in the accident and emergency department. He was sick again and Officer L said that it looked like he was bringing up blood. The officer said that, at some stage, a nurse came to the cubicle and told the man that he had leukaemia. He asked what that meant and the nurse told him that he would probably need to be treated with unpleasant drugs and stay in hospital for some time. Officer L thought that the man had understood what he was told.

140. The man was moved from the accident and emergency department to the medical assessment unit. Officer L and his colleague kept a log of events while the man was in hospital. According to the log, the man was taken for a chest x-ray at about 11.30pm. At 1.45am on 8 November, the officers were told that he would be given a blood transfusion that night.

141. At about 3.10am, hospital staff became increasingly concerned about the man's condition. At 3.30am, they told the officers that his next of kin should be contacted. The officers contacted the prison and the officer in charge (known as the night orderly officer), SO C telephoned the man's mother. The escort chain was removed (and was not reapplied) and the man was taken to the operating theatre.

142. The man was admitted to the Intensive Treatment Unit at 5.25am. Hospital staff said that he would be moved to Walsgrave Hospital later that day for further treatment. However, at 8.20am, the officers recorded that the man was too ill to be moved.

143. The man underwent a computerised tomography (CT) scan (a kind of x-ray which is often used to examine a patient's head). The scan revealed a large bleed on his brain (known as a haemorrhage). His family was with him throughout the day. At midday on 9 November, medical treatment was withdrawn and he died half an hour later, with his family at his side.

Results of the post mortem examination

144. Following the man's death, a post mortem examination was conducted with input from a specialist in forensic neuropathology (the study of nervous system tissue, including the brain). The conclusion of the examination was that the man died as a result of a spontaneous intracerebral bleed caused by acute myeloid leukaemia.

145. The pathologist noted that the man had received bruising to his forehead some days before his death, which had led to a small amount of bleeding between the brain and the skull. However, this was found not to have caused or contributed to the intracerebral bleed which led to his death.

Contact with the man's family

146. The man's mother told the investigator that, when she was telephoned in the early hours of 8 November, she was told that her son's "pupils had blown" (this is often a sign that the patient has suffered a serious brain injury). She felt that this was an insensitive way to inform her of her son's condition.

147. At about 9.30am on 8 November, Ms B, the appointed family liaison officer, was told that the man was in a critical condition in hospital. Ms B went to the Alexandra Hospital and met members of the man's family there. Following his death, Ms B and Mr C, the then governor in charge of Hewell, returned to the hospital and talked to his family.

148. In line with prison service guidance, the prison offered to help the family with the cost of the man's funeral. The prison also organised a memorial service for him, which members of his family came to. His mother told the investigator that there were not very many prisoners at the service and she was surprised by this, because he knew a number of people at Hewell. Mr A said that the memorial service was not very well publicised and the date was changed at short notice. Staff said that notices about the memorial were posted around the prison ahead of the service.

Support for prisoners and staff

149. Mr A was told that the man had died on 10 November. He said that wing staff offered him support and reminded him of the Samaritans' telephone and Listeners service. (Listeners are prisoners trained and supported by the Samaritans to offer a confidential listening service to other prisoners.) All other prisoners were informed of the man's death by way of a notice from the Governor.

150. The staff interviewed as part of this investigation said that they knew how to access support if they needed it. A debrief was held for staff at Hewell after the man's death.

ISSUES

Clinical care

151. The man's death from acute promyelocytic leukaemia (APL) raised some complicated clinical issues for investigation. His existing physical health problems and disabilities further complicated our consideration. The clinical reviewer carried out a review of the clinical care the man received at Hewell. The review includes a great deal of useful detail about APL and considered discussion about whether the illness should have been diagnosed earlier. It is not possible to repeat all of that detail in the following paragraphs and so we advise all those to whom the report is sent to read the review in its entirety. The reviewer also makes three recommendations. One relates to the care offered to prisoners with disabilities and is covered in the discussion on whether the man's disability needs were met. The other two have not been repeated in this report because they did not have a direct bearing on the man's death.

152. The clinical reviewer writes that, on his arrival, the man had a range of physical problems (resulting from his car accident) which were "not all well catered for" at Hewell. She notes that his family was concerned that he was not receiving the correct doses of his prescribed medication and that he sometimes received the medication at the wrong times. The clinical reviewer concludes that:

> "These issues arise frequently within prison settings and some of the issues are determined by national and local medication policies. Most prisons try hard to accommodate individuals with particular needs but the process can be slow and cumbersome. None of these issues were causative in the development of the man's APL or played a part in his catastrophically rapid decline in health and his sudden death."

153. The clinical reviewer notes that APL is commonly diagnosed in young adults. The symptoms are "non-specific" and can include tiredness, shortness of breath, abdominal and muscle pain. APL is consistently associated with a condition known as disseminated intravascular coagulation (DIC). In DIC, the patient's blood begins to form numerous small clots in the blood vessels, which can lead to large blood clots in the organs and uncontrolled bleeding. The clinical reviewer writes that "up to 85 per cent of patients with APL develop bleeding or haemorrhages secondary to DIC. Intracranial haemorrhage is the second commonest cause of death after DIC in patients with APL." The clinical reviewer explains that patients with APL can go from first symptoms to death in less than four weeks. Once bleeding and DIC have begun, 40 per cent of patients who are not treated die. However, she notes that "the prognosis for APL has improved greatly in the last two decades due to new drug combinations and it is now considered to be one of the most treatable of the acute leukaemias."

154. While at Hewell, the man saw healthcare staff at least twice a day, when he collected his medication. The clinical reviewer notes that the man was prescribed strong pain relief medication which might have made his threshold for reporting further symptoms or pain "unusually high".

155. It seems that the man began to experience the first obvious signs that his blood was not clotting normally when he developed haemoptysis (fresh blood in his sputum). He told the nurse about this symptom on 31 October but said he had first noticed it five days earlier. He was examined by Dr C who diagnosed a chest infection and prescribed antibiotics. The clinical reviewer writes that haemoptysis “demands further investigation”, normally blood tests and/or a chest x-ray. She continues that, in her view, “most clinicians” would have requested further tests to explore the haemoptysis on 31 October, particularly when they learnt that it had begun five days earlier. The clinical reviewer notes that such investigations might reasonably have been considered non-urgent, although she writes that some clinicians might have referred the man to hospital at that point to rule out a pulmonary embolism (a blood clot on the lung, a potentially fatal condition, one indicator of which is haemoptysis).

156. As the days passed, the man continued to present as unwell, but not critically ill. However, on 5 November, he told Dr A that he felt “like passing out”. The clinical reviewer comments that Dr A examined the man’s chest but did not apparently question whether or not he had a cough (a common symptom of a chest infection) or why he had not responded to five days of antibiotics. The man had sores on his tongue, which Dr A diagnosed as oral thrush. The clinical reviewer explains that oral thrush in adults, when no other obvious cause is found, is highly characteristic of a suppressed immune system “until proven otherwise”. On that basis, she writes that it certainly requires further investigation, although, again, this might not result in urgent investigations. Dr A ordered blood tests following his examination, the results of which confirmed that the man had leukaemia. However, the clinical reviewer concludes that Dr A could have taken a more detailed history from the man and carried out a more comprehensive physical examination. This might have revealed the abnormal bruising that the man’s mother said she saw when she visited him earlier that week.

157. The clinical reviewer notes that, whether or not the man was referred for urgent tests on 5 November depended entirely on the clinical judgement of the doctor. The situation would have been the same had he been examined by a doctor in the community. It appears that the man seemed quite well during the examination and so Dr A did not consider that any urgent tests needed to be carried out. Although it is impossible to know what the outcome might have been if a blood test had been carried out urgently on 5 November, it would certainly have revealed that the man had leukaemia. He would have been admitted to hospital that day and would have begun treatment for the abnormal blood clotting that eventually led to DIC and the bleed on his brain. The clinical reviewer explains that, even had the blood clotting problem been successfully treated, the man was suffering with an extremely aggressive disease and we cannot be sure that his death would have been prevented.

158. Reflecting on her findings in the review, the clinical reviewer writes:

> “Had healthcare staff looked more closely they may have questioned why such a young and otherwise well man should feel so tired and be short of breath as he suffered injuries to his legs and was not known to have other physical health problems. Had a medical practitioner with a high level of

suspicion and skill reviewed the man they may have recognised the presenting symptoms of a more serious underlying illness. Unfortunately no thorough physical examination was undertaken and clues to his real condition were either not reported by the patient, were missed or misconstrued. I believe that the medical staff at HMP Hewell had a low index of suspicion for a serious underlying illness and failed to view the man in context."

159. The clinical reviewer goes on to explain that, in her view, most community doctors would also have failed to diagnose the man with a serious illness. However, in the community doctors have easier access to a range of healthcare facilities. The result is that community practitioners may be more likely to refer a patient for further tests, even when they are not sure that such tests are medically warranted. In the community, a patient can present themselves at hospital if they are not satisfied with the treatment they receive from their doctor, an option not available for prisoners.

160. The man's health deteriorated at a startling rate. The time between him apparently first experiencing symptoms and his death was 14 days. The clinical reviewer concludes that his death was not reasonably foreseeable. Because she cannot be certain that a community doctor would have diagnosed a serious illness, she concludes that the standard of care he received at Hewell was equitable to that he might have received in the community. We are not so certain, particularly as the reviewer suggests that community practitioners are more easily able to refer patients for further tests.

161. It is regrettable that clinicians at Hewell missed significant symptoms, which should have resulted in the man being sent for further tests. There are a number of reasons which might explain why the signs were missed. He had a number of physical health problems and was prescribed various medications which might have masked some of his symptoms. He was, by all accounts, a quiet and unassuming man, who above all, did not want to be a nuisance and it is clear that he did not make a fuss. The clinical reviewer also raised the possibility with the investigator that staff at Hewell have become used to treating young men with drug and alcohol abuse related problems, which often present a range of similar symptoms, and are therefore not as alert to the wider clinical possibilities that might be considered. We conclude that there is no recommendation that we could usefully make which would avoid such a situation arising in future.

Assessing and meeting the man's disability needs

162. While ultimately we have concluded that this was not directly related to his death a substantial part of this investigation has focused on the extent to which Hewell assessed and met the man's well documented disability needs. His mother voiced concerns that his needs were not met both to prison staff while her son was alive and to our office after his death. It is very disappointing to find that her concerns were well founded. We conclude that Hewell failed in its responsibilities to the man as a prisoner with disabilities.

163. It is frustrating that the failure was not due a lack of information about the man's disabilities. Healthcare staff who saw him within his first two days at Hewell

made note of them in his medical record. The man brought into custody with him various medical documents which clearly set out his physical condition. In addition, on 18 October, the man disclosed his physical disabilities in the disability questionnaire he was asked to complete. The man's mother said that she telephoned the prison on numerous occasions, raising her concerns. The ACCT assessment interview carried out by the Reverend A on 20 October detailed the problems the man was experiencing. However, the extent to which his disabilities would affect his life in prison and whether he needed any reasonable adjustments to be made, either to the regime or to his physical surroundings, was never properly assessed. The saga of the man's access to his own trainers to make walking more comfortable is emblematic of the prison's failure to meet some of his basic needs. It is hard to understand why something as simple as ensuring that he had appropriate footwear became such a challenge and should be a matter of shame to all involved.

164. Interviews with both healthcare staff and officers indicated a lack of clarity about what the overall approach to prisoners with physical disabilities should be. Staff were not clear whether the responsibility for prisoners with physical disabilities rested primarily with the healthcare department or the DLO. Healthcare staff were not sure who the DLO was and there was little communication between healthcare and the DLO, or the wider diversity and equality function at Hewell. Staff mentioned various ways in which prisoners with disabilities could be offered additional support, including being admitted to the healthcare inpatient unit for assessment, referral to a physiotherapist for assessment or devising a management plan to help them with life on normal location. It is a great shame that, despite information about his disabilities being recorded in various places, none of these options was considered for the man.

165. The new Governor of Hewell, who took up post in February 2012, has outlined new procedures which have been introduced to identify and support prisoners with disabilities. We hope that these new measures are successful but to be effective all staff at Hewell have to understand it is their responsibility to ensure that needs are identified and met. It was a concern that neither of the assistant disability liaison officers we spoke to understood or had had any training for their role. We make the following recommendation.

The Governor should ensure that all staff understand their personal responsibilities and duty of care towards prisoners with disabilities and other special needs and that they know who to contact in the prison for specialist advice, information and practical support.

166. PSI 32/2011 notes that it is usually preferable for prisoners with disabilities to be located on standard prison wings with adaptations as necessary. The man spent all of his time at Hewell either on houseblock 6 or 2, in a normal cell, with no special adjustments or provision of any specialist equipment despite having relied on a range of equipment at home. There was no documentary evidence to indicate that his disabilities had been considered when decisions about where to locate him were made and none of the decisions involved either healthcare staff or the DLO.

167. When living on houseblock 6, the man was given a cell on the ground floor with access to the servery and showers. He collected all of his medication from the treatment room on the second floor. This was not ideal, as it required him to climb several flights of stairs and he does not seem to have been offered the use of the lift. The decision to move him to C1 spur on houseblock 2 was inappropriate and clearly took no account of his disabilities. He had a long and tiring walk to collect medication from the upper healthcare landing and had to associate on another spur (which seems an unreasonable arrangement for other prisoners too.) As a result, he chose to stay in his cell. No proper consideration was given to whether he should be moved to a more appropriate location. Until one of the governors identified the omission no personal emergency evacuation plan had been prepared.

The Governor should ensure that decisions about where best to locate prisoners with disabilities are made in consultation with the equality team and recorded in full on P-Nomis to ensure that all relevant information is taken into account, prisoners are located appropriately and any necessary adaptations are made.

The Governor should ensure that personal emergency evacuation plans are prepared at the earliest possible opportunity.

The ACCT process

168. On 19 October, Nurse E opened an ACCT plan for the man because he said that he sometimes thought about harming himself. The ACCT plan remained open until 24 October. The decisions to open and close the ACCT plan appear appropriate but there is little evidence of multi-disciplinary working. After the initial ACCT assessment only wing officers were involved. The second review was attended only by SO B and the man despite healthcare and disability issues having been identified.

169. PSO 2700, Suicide prevention and self harm management, provides guidance on the ACCT process. Part of that guidance suggests that ACCT case reviews should be attended by at least three members of staff, including the case manager (normally the wing senior officer), another wing officer and "an appropriate member of non-discipline staff". Because the investigator did not examine any other ACCT plans at Hewell, we are not in a position to comment on whether the lack of multi-disciplinary working in the man's case was unusual or more common across the prison but we note that the last inspection identified this as a concern.

The Governor should ensure that a representative from the equality team or a member of healthcare staff, or both, who have familiarised themselves with the circumstances of the case are present at ACCT reviews for prisoners with disabilities.

Record keeping

170. Throughout this investigation, we have identified a number of occasions when information should have been recorded in the man's prison or medical record and was not. Prison officers did not record their interactions with or concerns about him on P-Nomis and healthcare staff did not always record important information about their contact with him in his medical record. The man's mother told the investigator about numerous conversations she had with members of the chaplaincy team – none of which are reflected in his P-Nomis case notes. In some cases, this means that good work by staff is not recorded, and therefore, not reflected. In others, it means that opportunities to identify emerging issues or problems are lost.

171. All prison staff are expected to record relevant contacts and actions with prisoners on the P-Nomis system although the Governor explained that the chaplaincy team has been using its own system. Healthcare staff at Hewell have access to SystmOne and the Governor said "are trained to make entries as and when they deem it necessary for the care of that patient". She explains that "significant" information or interactions should be recorded, while "passing interactions" will not always be. We accept that is a reasonable position; our concern is that, in the man's case, significant interactions were not always recorded. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff who have contact with prisoners or their families are clear about the circumstances in which an entry on P-Nomis and SystmOne should be made and understand the importance of maintaining the fullest possible record of a prisoner's time at Hewell.

Contact with the man's family

172. While the man was at Hewell, his mother, who was becoming increasingly concerned about him, telephoned the prison a number of times. Most of her concerns centred on whether her son's disabilities and medical needs were being appropriately met. She told the investigator that, on most occasions when she telephoned, she was directed to speak to someone from the chaplaincy team. While the man's mother had no specific complaints about how members of the chaplaincy team dealt with her concerns, she felt that they were not best placed to help her.

173. The investigator explored this issue with Ms A in interview and with other staff during the investigation. She was told that, if a concerned family member telephones the prison, switchboard staff should offer to connect them to the duty governor. It seems that the man's mother was not offered this opportunity until she telephoned on 5 November. Nurse C and Nurse B also said that concerned family members could speak to healthcare staff – although the extent to which staff could discuss a prisoner's health was governed by confidentiality guidelines. The man's mother's experience suggests that staff operating the switchboard are not clear where to direct calls from concerned family members.

The Governor should clarify to staff how telephone calls from prisoners' families should be dealt with to ensure they are directed to the most appropriate person to assist them.

174. The man was taken to the hospital by emergency ambulance on the evening of 7 November when healthcare staff became very worried about his condition. During the wait in the accident and emergency department he was informed he had leukaemia. The man was clearly very seriously ill yet it was not until after 3.30 am on 8 November when hospital staff became increasingly concerned about his state of health that any thought was given to contacting his family. Prison Rule 22 requires that 'If a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of mental disorder, the governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed.' We consider that the very fact that an emergency ambulance was called to take him to hospital is indicative that the prison believed he was very ill and his family should have been contacted at that point. At the very latest the prison should have contacted the man's family when he was informed he had leukaemia so they could have had the opportunity to be there with him to support him at that stage.

175. The man's mother said that the member of staff who telephoned her in the early hours of 8 November told her that her son's "pupils had blown". We did not speak to the member of staff concerned during the investigation. Having to break bad news to prisoners' families, such as telling them that the prisoner has been admitted to hospital, is an unenviable task. It will not always be possible for staff contacting the family to be a nominated family liaison officer (who has normally volunteered and undergone specific training for the role). Nor will the person breaking the news usually have had any medical training and be in a position to fully understand the prisoner's condition. It is important, therefore, that any staff asked to contact the family in the event of a prisoner being admitted to hospital fully understand the need to do so sensitively.

The Governor should ensure that next of kin are notified as soon and as sensitively as possible when a prisoner becomes seriously ill.

The use of restraints

176. Before the man was taken to hospital on 7 November, a risk assessment was carried out which noted that he posed a low risk to the public and was unlikely to try to escape. He had never been in prison before and was convicted of careless driving. He had recognised disabilities that meant he needed crutches to walk and healthcare staff did not think he should be restrained. In addition to these factors, he was considered to be ill enough that an emergency ambulance was necessary. Nevertheless, the outcome of the assessment was that he was restrained by an escort chain which was only taken off once his condition had significantly deteriorated.

177. We are not persuaded that the risk assessment properly assessed the specific risks that the man posed. We think it is clear that, on the evidence, he did not need to be restrained.

The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents.

CONCLUSION

178. The man's was a tragic and untimely death. He had only been at Hewell for 20 days when he was admitted to hospital, seriously ill with leukaemia. The story of his time at Hewell is one of missed opportunities. Staff missed numerous occasions to properly assess and meet his disability needs. We have no doubt that this made his life in prison harder, even if it had no impact on his eventual death. Healthcare staff missed opportunities to diagnose that the range of symptoms he was complaining of were indicative of a serious underlying condition.

179. Our conclusion to this very sad investigation is that the man's death was not reasonably foreseeable. The clinical reviewer says that because clinicians in the community might also have missed the signs of leukaemia, the man received a standard of healthcare equitable to that he might have received in the community. We are not so certain. There are a number of important lessons for Hewell to learn and we hope that the man's family take some comfort in knowing that his death will result in changes.

RECOMMENDATIONS

The NOMS response is detailed in italics beneath each recommendation.

1. The Governor should ensure that all staff understand their personal responsibilities and duty of care towards prisoners with disabilities and other special needs and that they know who to contact in the prison for specialist advice, information and practical support.

   This recommendation was accepted: "The Equalities policy reviewed in July 2011 identifies staff responsibilities and indicates who should be contacted for specialist advice, information and practical support. A Staff information notice was issued informing staff of the Equalities policy when it was published. This notice will be reissued highlighting the specific issues raised in this recommendation."

2. The Governor should ensure that decisions about where best to locate prisoners with disabilities are made in consultation with the equality team and recorded in full on P-Nomis to ensure that all relevant information is taken into account, prisoners are located appropriately and any necessary adaptations are made.

   This recommendation was accepted: "All prisoners on Reception complete an Equality & Needs Monitoring form, this identifies prisoners with disabilities. Reception and First night staff ensure all prisoners are appropriately located on arrival. Any prisoners with disabilities will be visited by a member of the Equalities Team to undertake a full assessment of their needs."

3. The Governor should ensure that personal emergency evacuation plans are prepared at the earliest possible opportunity.

   This recommendation was accepted: "All prisoners with mobility issues have a Personal Emergency Evacuation Plan (PEEP). This is completed as soon as can be arranged following a prisoner's admission to the prison."

4. The Governor should ensure that a representative from the equality team or a member of healthcare staff, or both, who have familiarised themselves with the circumstances of the case are present at ACCT reviews for prisoners with disabilities.

   This recommendation was accepted: "The Local Safer Custody Policy will be reviewed to include this recommendation. Safer Custody Manager will ensure a system of management checks is developed to monitor compliance."

5. The Governor and Head of Healthcare should ensure that all staff who have contact with prisoners or their families are clear about the circumstances in which an entry on P-Nomis and SystmOne should be made and understand the importance of maintaining the fullest possible record of a prisoner's time at Hewell.

This recommendation was accepted: "Notices will be issued to all staff outlining the requirements for full and accurate recording of actions with prisoners on P-NOMIS. This will also be raised at staff briefings. The healthcare manager will email all healthcare staff to remind them of their responsibility for maintaining records on SystmOne. This will also be raised at staff briefings."

6. The Governor should clarify to staff how telephone calls from prisoners' families should be dealt with to ensure they are directed to the most appropriate person to assist them.

   This recommendation was accepted: A policy will be developed by the Safer Custody team that informs staff how to deal with calls from prisoners' families, this will include guidance on who calls should be directed to.

7. The Governor should ensure that next of kin are notified as soon and as sensitively as possible when a prisoner becomes seriously ill.

   This recommendation was accepted: "A policy will be developed that outlines when a prisoner's family is to be contacted, who by and the need for sensitivity when passing information."

8. The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents.

   This recommendation was accepted: "Escort Risk assessment documents currently include all the relevant sections to take account of any risk posed by a prisoner. Security Managers will be issued guidance on the completion of risk assessments for prisoners attending hospital with serious health conditions."