PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man at outside hospital in February 2012 while in the custody HMP Wandsworth

Report by the Prisons and Probation Ombudsman for England and Wales

September 2012

This is a report into the death of a man at outside hospital in February 2012 while in the custody of HMP Wandsworth. The man was 65 years old and had a range of health problems. A post mortem showed that his death was caused by multiple natural causes linked to his health conditions. I offer my condolences to the man's family and friends for their loss.

The investigation was carried out by one of my investigators. South West London Cluster NHS appointed a clinical reviewer to review the man's clinical care in custody. Staff at Wandsworth fully co-operated with the investigation.

The man had complex health needs including obesity, poorly controlled diabetes and chronic leg ulcers. While in general the man received satisfactory care at Wandsworth, the clinical review found that the care and attention that he received, particularly in relation to the management of his diabetes was not as good as it should have been. There was a delay in verifying his community records and prescriptions, a delay in seeing a doctor and some gaps in record keeping.

The man was not at risk of escape or a risk to the public. He was virtually immobile when he was taken to hospital and was the lowest security category of prisoner. It is therefore hard to see how the prison's decision that he should be taken to hospital in restraints was justified. Sensibly, a later decision was made to release him on temporary licence when his prognosis became very poor, but this decision could have been made earlier. Wandsworth provided appropriate support to the man's family both before and after his death.

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 **September 2012**

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SUMMARY

1. The man was a South African citizen who had lived in the United Kingdom for 15 years. He was convicted of fraud and sentenced to 16 months imprisonment on 14 November 2011 and sent to HMP Wandsworth. The man, who was 65, had a number of health issues; he was clinically obese, suffered from diabetes, high blood pressure, high cholesterol and had leg ulcers.

2. During his time at Wandsworth the man was monitored regularly by healthcare staff and some care plans were put in place to manage his various conditions. Referrals were made to diabetic specialists but these were not followed up. He had a ground floor cell to assist his mobility.

3. On the morning of 3 February 2012, at approximately 8.10am, the man was found on the floor in his cell. Staff attempted to assist him to his feet but were unsuccessful. An emergency ambulance was called and he was taken to hospital. Following a period of assessment, a hospital doctor told prison staff that the man would remain in hospital for a few days. The prison contacted the man's niece, his nominated next of kin, to tell her the situation and let her know that she could visit the hospital at any time.

4. On the morning of 5 February, the man had a cardiac arrest and was transferred to the intensive care unit. By the 8 February, the hospital doctors gave a poor prognosis of the man's condition and said that he was unlikely to survive. The man's nieces were at his bedside when he died shortly thereafter.

5. In the days that followed, the prison family liaison officer maintained contact with the man's family and offered support and financial assistance towards the funeral expenses, in line with Prison Service policy.

6. The clinical review shows that the care and attention the man received at Wandsworth, particularly in relation to his diabetes, was not equivalent to what he could have expected to receive in the community. As a result we make recommendations concerning the verification of community medical records, chronic disease management and the medical record keeping. We also make a recommendation about the appropriate use of restraints and the need for consideration of release on temporary licence for low risk prisoners in hospital.

THE INVESTIGATION PROCESS

7. On 9 February 2012 the investigator issued notices announcing the investigation to staff and prisoners. He visited HMP Wandsworth on 15 February and was given copies of all documentation relating to the man and saw his cell. The investigator returned on 1 and 6 March and interviewed ten members of staff. Written feedback was given to the Governor on 3 April.

8. South West London Cluster NHS asked a clinical reviewer to review the man's clinical care. The investigator and the clinical reviewer discussed aspects of the man's treatment at Wandsworth.

9. The investigator contacted Her Majesty's Coroner to inform him of the investigation and request a copy of the post mortem report. The investigation report will be sent to the Coroner to assist his enquiries.

10. Before visiting Wandsworth the investigator spoke by phone to the man's brother who lives in South Africa. The investigator explained the investigation process and that one of our family liaison officers would contact the family about any issues he and his family might wish to raise. The man's brother subsequently emailed the investigator outlining a number of concerns his family had. He also provided the investigator with excerpts from some of his brother's letters and phone calls. The investigator and the family liaison officer met with the man's brother on 22 February during a visit to the UK, to discuss his concerns further. His family had the following concerns which they wanted explained:

    - That the prison did not appear to take good care of their relative's health.
    - The circumstances leading to their relative's admission to hospital as they had been provided with conflicting information.
    - They believed that Wandsworth was not able to cope with their relative's health needs and he should have been referred to hospital sooner.
    - The events following his admission to hospital. They wanted to know exactly when their relative suffered a heart attack. They did not understand how a heart attack would result in brain death if responded to quickly and appropriately as they would have expected in hospital. These matters relate to clinical aspects of his care in hospital and are not within the remit of the Prisons and Probation Ombudsman.
    - The family did not believe the trial judge took sufficient account of their relative's health before sentencing him, but they accepted that this was also outside the remit of this investigation.

HMP WANDSWORTH

11. Wandsworth is a large local prison, holding up to 1,665 convicted and remanded adult men. Its catchment area includes courts in central and south west London and neighbouring Home Counties. Some prisoners serve the whole of their sentence at Wandsworth, while others will move to other prisons, according to their security categorisation, as appropriate. The man was a Category D prisoner (Category D prisoners are those who can be reasonably trusted not to try to escape) and was waiting for a move to an open prison.

12. Healthcare services are commissioned by Wandsworth Primary Care Trust with most primary care services provided by St George's Healthcare NHS Trust.

HM Chief Inspector of Prisons (HMCIP)

13. HM Chief Inspector of Prisons last inspected Wandsworth in March 2011. In relation to healthcare the Inspectorate found that primary care services were available to prisoners on each wing and in the health centre. The services on the wings were hampered by the volume of patients receiving medication and the lack of additional clinics in which patients' needs could be considered. The Inspectorate noted that all prisoners had an effective initial health screen and all were seen the following day for secondary screening, with an opportunity to see the GP. There were long waits for routine GP appointments. The inspection report also commented that prisoners at Wandsworth did not have access to the range of clinics for lifelong conditions that were available in the community.

14. The Jones Unit, a six-bedded, in patient facility for physically ill men was judged by the Inspectorate to be an excellent facility with well equipped cells to help manage patients.

Independent Monitoring Board (IMB)

15. The IMB is made up of unpaid members of the local community whose role is to help ensure standards of care and decency are maintained. In their most recent annual report for the year to May 2011, the IMB for Wandsworth noted about healthcare:

> "Waiting times for appointments are variable and on occasions unacceptably long due to high demand especially for GP and dentist with inadequate processes to prioritise appointments effectively.
>
> "Implementation of a health promotion strategy and clinics for long-term conditions continues to be slow as facilities are not yet available.
>
> "Dedicated senior nurses have continued to provide high standards of care."

Previous deaths at Wandsworth

16. Since January 2011, there have been five other deaths of prisoners at Wandsworth and there are no similarities between those deaths and the death of this man.

KEY EVENTS

17. The man was born in South Africa in August 1946. He had lived in the UK for many years, latterly living in the Aylesbury area. He was single and a qualified chartered accountant. He was clinically obese and suffered from diabetes, high blood pressure and high cholesterol and had been prescribed medication for these conditions by his doctor. He also suffered from ulcerated legs (wounds to the skin caused by poor blood circulation).

18. On 14 November 2011, the man appeared at a Crown court charged with theft and fraud. A doctor from the Portobello Clinic conducted a medical assessment as part of the pre-sentence report which outlined the seriousness of the man's health conditions. The man was convicted of the offences and given a 16 month custodial sentence. He was sent from court to HMP Wandsworth.

19. On arrival at Wandsworth, the man saw an officer who completed the personal summary documentation. He told the officer that this was his first time in custody, that he was single and that his next of kin was his brother who lived in South Africa and he also had two nieces living in the UK. He gave the officer his brother's contact details.

20. The man then saw a nurse who conducted the initial healthscreen (a first reception healthscreen takes place every time a prisoner arrives at a prison to determine any immediate physical and mental health conditions that require treatment, substance misuse matters that need to be addressed, and any risk that the prisoner may pose of harming himself or attempting suicide.) The man told the nurse that he suffered from diabetes, high blood pressure and high cholesterol but had never suffered from any mental illness. He could not remember what his medication was. The nurse recorded that he was obese and had ulcers on both legs.

21. Later that evening the man saw an Advanced Nurse Practitioner (a nurse who is qualified to prescribe medication), who obtained the man's consent for the prison to contact his community doctor to obtain his medical history and prescribed medication details. The nurse also noted that the man was tired and shocked to be in prison but he said he had no thoughts of harming himself. He told the nurse that he had been diagnosed with type 2 diabetes 10 years previously and that the diabetes was stable. The nurse recorded that he was 1.77m (5' 10'') and 150kg (23.5 stone) and his blood sugar level was 12.8mmols, which was high. She recorded that the man said he had no mental health issues.

22. The next morning a further nurse saw the man and conducted a more in-depth second healthscreen. The nurse confirmed his medical conditions, and that the dressings were last changed on 13 November, three days before he entered custody. He was offered but declined a routine Hepatitis B vaccination (for protection against hepatitis which is a condition that affects the liver). The nurse referred him to be seen by a further nurse for an assessment of his leg ulcers and dressings.

23. Later in the afternoon the nurse saw the man as arranged. The nurse recorded that he had four-layer dressing on his right leg and a dressing on his left shin. He told the nurse that he had seen the chiropodist before he entered custody. The nurse cleaned and redressed his legs and referred him to be visited by the Community Tissue Viability nurses (skin care nursing specialists).

24. That same afternoon the man's details from his community doctor on the outside, were received. These confirmed that he was prescribed metformin (for diabetes), gliclazide (for diabetes), pioglitazone (for diabetes), candesartan (for high blood pressure) and atorvastatin (for high cholesterol). In addition on 8 November 2011 he had been prescribed flucloxacillin (antibiotic) as it had been assessed that his ulcerated legs were infected and he had been receiving treatment for leg ulcers for a number of weeks. The man's medication required the authority of a prison doctor.

25. The man saw healthcare staff each day for the next nine days to monitor and change the dressings on his legs and regular blood glucose tests. On 22 November, he was moved to a cell on the Jones Unit (a dedicated part of the prison for those prisoners with health conditions that require close monitoring). During this period there were occasions where he declined to have the dressings changed and, despite encouragement, refused to attend to his personal hygiene.

26. On 23 November a prison doctor recorded that the man's community doctor's medical record had been received on 15 November and authorised the community prescribed medications to remain unchanged. Therefore, there was a delay of nine days between the information being received from the man's community doctor and a prison doctor authorising the prescribed medication. This meant that he did not have any of his prescribed medication for nine days.

27. On the same day, two members of the mental health team saw the man to conduct a mental health assessment. The man told the nurses that he had no mental health problems, but he had found it stressful being in prison and having to wait for his medication to be sorted out. The nurses' assessment was that he did not have any mental health issues. They advised him how to contact them should he want their support in the future.

28. Two days later on 25 November, the man saw a diabetic nursing specialist who also conducted a blood glucose test with the result recorded as 8.6 mmols. The nurse noted that the man's blood glucose was to be checked every two days and to consider a referral to the vascular clinic. The nurse referred him to be seen by a doctor later that day.

29. Later that same afternoon, the man saw a prison doctor. This was the first time he had seen a doctor at the prison. The doctor examined the man's legs and changed the previously prescribed antibiotic to ciprofloxacin as this was better suited for ulcers caused as a result of being diabetic. The doctor prescribed a ten day course of antibiotics, one tablet to be taken three times a day. The doctor advised that he was to rest and nurses were to change the leg dressings

regularly. The doctor also recorded the man's blood glucose level as 12 mmols.

30. Over the next seven days the man was seen regularly by nurses to monitor and change the dressings on his legs and have blood glucose tests. Again there were occasions where he refused to have the dressings changed and, despite encouragement, did not attend to his personal hygiene.

31. Blood tests were carried out on 29 November and the results indicated that the man's diabetes was poorly controlled. On 30 November his blood pressure was recorded as 172/89 (significantly above normal range), but there is no record of any further action or monitoring taking place. On the 1 December, he was moved from the Jones Unit to E Wing as it was assessed that the level of nursing intervention he required could be managed on a normal wing.

32. On 6 December, a visiting Tissue Viability nursing specialist saw the man to assess his legs. The nursing specialist was accompanied by two prison nurses. The nursing specialist noted that the man had an ulcer on his left heel and on his right leg. The nurse's assessment was that he had severe swelling to both legs, lipodermatosclerosis (a skin and connective tissue disease caused by obesity and high blood pressure) and hyperkeratosis (excessive thickening of the skin). The nursing specialist recorded that there was no obvious signs of infection and that the sore on the heel could have resulted from the man not wearing well fitted shoes. The nurse also noted that he was neglecting his personal care and hygiene.

33. The visiting Tissue Viability nursing specialist gave advice on the most appropriate dressings to be used and amended the care plan for managing the man's legs. This included washing and redressing the legs every two days, to refer him to the vascular clinic at outside hospital and the dietician to assist with weight loss. The referral to the dietician was not followed up.

34. Between 7 December 2011 and 28 December, the man saw nurses in accordance with the care plan given by the visiting Tissue Viability nursing specialist. There was only one entry made in the man's medical record of a blood glucose test taken on 9 December with the result recorded as 3.8 mmols.

35. On 14 December the man moved to C Wing from E Wing and an officer was allocated as his personal officer (a nominated officer and first point of contact, with whom a prisoner can raise issues and concerns). When interviewed by the investigator, the officer said that the man was a polite and articulate man who was respectful to staff but kept himself to himself, mostly remained in his cell and did not mix with other prisoners.

36. The man's personal officer explained that due to the man's size he had difficulty moving around and staff arranged for his meals to be taken to him. The officer said that the man was encouraged to attend to his personal hygiene but he would often decline. He was given permission to use the showers when the other prisoners were locked in their cells but he would still decline. Staff said it

was not unusual to find him asleep on the floor as he said he found this more comfortable.

37. On 29 December, the man saw the Chief Podiatrist at outside hospital. A risk assessment was completed which authorised him to be accompanied to hospital by two officers with the use of an escort chain (2 metre chain with single cuff at either end) which was to be removed for treatment purposes. At the time the man was a category D prisoner, the lowest security category, and regarded as suitable for open prison. The Chief Podiatrist recorded that the man had an X-ray and arterial duplex (an ultrasound technique used for looking at body structures including tendons, muscles, joints, vessels and internal organs). He noted that the man was no longer on antibiotics and prescribed a two week course of co-amoxiclav (antibiotic). He also noted that arrangements would be made for him to be seen again at the hospital in the near future. There is no record that this recommendation was followed up.

38. Four days later, on 3 January 2012, the Tissue Viability nursing specialist visited Wandsworth and saw the man to conduct a follow up assessment. The nurse noted that the ulcer on his heel was improving although he still suffered from swollen legs. The nurse maintained the advice that the dressings on the man's legs were to be changed every two days and he was advised to relieve the pressure off his heel as much as possible.

39. From 4 January to 2 February, the man continued to receive treatment from nurses in accordance with the care plan given by the Tissue Viability nursing specialist. There was one recorded blood glucose test taken on 12 January with the result recorded as 4.1 mmols. On occasion he continued to refuse to attend to his personal hygiene.

40. The man completed two complaint forms on the 6 and 10 January asking about delays with his transfer to an open prison. He had been assessed as category D and suitable for an open prison, on 14 November. He was given written responses on 11 and 16 January which confirmed that he was on the waiting list for an open prison and would transfer as soon as a place became available.

41. During the night duty of 2 and 3 February, an Operational Support Grade (OSG) was on duty on the man's wing. At interview the OSG said that on his first roll check, at approximately 9.00pm, he recalled that the man was lying in bed. At the next check at 5.20am, he found the man on the floor with his arm resting on the bed. The OSG said he asked him if he was alright and he replied he was fine but had trouble sleeping. The OSG said that he was concerned about the man so returned to his cell at 7.01am. Again he found him in the same position on the floor. He asked the man if he wanted or needed any help but he said not.

42. Later that morning, a nurse went to the man's cell at 9.10am to change the dressings on his legs. The nurse found him on the floor and he told the nurse that he said he had slept on the floor and was now unable to get up. The nurse sought assistance from wing staff and requested additional healthcare staff to

attend. The nurse recorded that he was fully conscious and orientated and there were no apparent injuries.

43. The Senior Sister, one nurse and uniformed staff responded to the call for assistance. Despite their efforts they were unable to lift him from the floor. To prevent the risk of injury to the man, a decision was taken to call an ambulance to get the assistance of paramedic equipment to lift him.

44. The paramedics arrived and using their specialist equipment, with the assistance of prison staff, the man was moved out of his cell and onto an ambulance trolley. He told the paramedics that his left arm was numb and he was unable to keep it raised. The paramedics and nurses agreed that the man needed to be transferred to hospital for further assessment.

45. The man was taken to outside hospital and a risk assessment was completed which authorised him to be accompanied to hospital by two officers with the use of an escort chain which was to be removed for treatment purposes. Hospital doctors decided that he needed to remain in hospital for a few days to have further tests and assessment. Wandsworth contacted the man's niece to inform her that her uncle had been admitted to hospital.

46. On the morning of 5 February, hospital records show that the man went into cardiac arrest, he was resuscitated but remained unconscious and was transferred to the intensive care unit. The initial risk assessment was immediately amended which authorised no restraints to be used and the officers to remain at the hospital at a discreet distance from where he was being treated.

47. Prison healthcare staff maintained contact with staff at outside hospital to obtain an update on the man's condition. On 8 February, the man's condition deteriorated and the doctors at the hospital gave a poor prognosis of recovery. The prison appointed a family liaison officer who met the man's nieces at the hospital.

48. On 8 February a Governor authorised the man to be released on temporary licence from Wandsworth to outside hospital. This removed the requirement for him to be accompanied by two uniformed officers but an officer in civilian clothes remained to provide a communication link between the hospital and prison.

49. Shortly thereafter the man died with his nieces at his bedside. In the days that followed, the prison's family liaison officer maintained contact with the man's family to offer support. Financial assistance towards funeral expenses was offered, in line with Prison Service policy. Arrangements were also made for the man's brother to visit Wandsworth, where he saw his accommodation and met staff.

Post Mortem

50. A post-mortem carried out on 10 February 2012 showed that the man's cause of death was:

1(a) Hypoxic ischaemic encephalopathy (the brain is deprived of an adequate supply of oxygen) following cardiac arrest.

1(b) Muscle necrosis (death of cells in the muscle), acute kidney injury, hypoglycaemia (low blood sugar), obstructive sleep apnoea (obstruction of the upper airway)

1(c) Morbid obesity (excess body fat has accumulated to the extent that it has an adverse effect on health)

2 Hypertension (high blood pressure) and Type II Diabetes

ISSUES

Clinical care

51. The clinical reviewer has considered the care and treatment that the man received from healthcare at Wandsworth and outside hospital. When considering the care provided to the man the clinical reviewer said:

> "[The man] had been in a poor general state of health prior to be transferred to HMP Wandsworth. His main health problems were morbid obesity, poorly controlled diabetes and chronic leg ulcers associated with lymphoedema and peripheral neuropathy. Management of his complex health problems would have proven challenging in any healthcare environment because of the severity of his problems, his self neglect and lack of personal care and the requirement for a multi-disciplinary approach with specialist input.
>
> "On 23 November [the man] was seen by a mental health worker when he stated that he had no mental health problems."
>
> "The staff at HMP Wandsworth made significant efforts to treat his leg ulcers. He was transferred to the high dependency unit [the Jones Unit] of the prison healthcare system for closer observation. They sought specialist input and acted upon the recommendations of the specialists. They dressed his wounds regularly and prescribed antibiotics when indicated.

52. On reviewing the management of the man's diabetes the clinical reviewer said:

> "However, his general health, particularly, his diabetes was not managed optimally. He was not seen by a diabetic nurse specialist following the recommendation by the doctor on 6 December and his blood sugar level was not monitored regularly. Monitoring and improving the control of his diabetes should have been considered a priority given the poor state of his legs."

53. The man had ten blood glucose tests between 14 November and 30 November 2011. From 1 December 2011 to 3 February 2012 only two blood glucose tests were conducted. This did not comply with the instructions of the diabetic nursing specialist. We are concerned that on arrival he did not receive any of his medications (previously prescribed in the community) for nine days. His diabetic medication would have been critical to him maintaining healthy blood glucose levels. We agree with the clinical reviewer that the man's diabetes was not appropriately managed (in accordance with the National Institute for Health and Clinical Excellence (NICE) guidelines on the management of type 2 diabetes) and make the following recommendation:

The Head of Healthcare should ensure that prisoners who have complex and chronic health problems have a coordinated single case management

plan (in accordance with relevant NICE guidelines), regularly reviewed and updated, and correctly followed by all staff.

54. On 14 November, and by the following day, healthcare staff at Wandsworth had correctly requested and subsequently received the man's community medical records which clarified the medication and doses that had been previously prescribed. However it was a further nine days before a prison doctor verified and authorised the man's medication. Furthermore, he had been in custody for 12 days before he had a face to face consultation with a doctor. It is our opinion that these delays are unacceptable. We therefore make the following recommendations:

    The Head of Healthcare should ensure that all prisoners with chronic health condition are seen by a doctor within 48 hours of arriving into custody.

    The Head of Healthcare should ensure that the verification of a prisoner's community medical records is undertaken by a doctor within 24 hours of receipt so that any medications can be appropriately prescribed and any clinical needs met.

55. Healthcare staff at Wandsworth appropriately put in place a care plan for the management of the man's ulcerated legs and sought advice from community tissue viability nursing specialists. The care plan was a stand alone document, and was scanned into the computerised medical record.

56. Some of the nurses who treated the man's ulcerated legs made separate handwritten medical notes which were not easy to read and the signatures were illegible. Although there was a record of all the clinical interventions with the man there was not a contemporaneous and continuous record maintained in the computerised record. This does not meet the standards and requirements of nursing practice (as set out by the General Medical Council and the Nursing and Midwifery Council).

57. Effective record keeping is essential to ensure the proper administration of treatment and prescription of medication. We make the following recommendation:

    The Head of Healthcare should ensure that all healthcare staff accurately and contemporaneously record actions, in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.

58. The clinical review has also commented on the man's admission to hospital on 3 February as follows:

    > "[The man's] deterioration and collapse appeared to have been sudden. On 2 February he was mobile and had his leg dressings changed; his wound was noted to be clean. This is relevant as the cause of his subsequent acute deterioration was due to cellulitis of the legs which had

not been present on 2 February. Therefore, this acute infection and his subsequent deterioration could not have been foreseen and prevented.

"The cellulitis lead to him developing a fever and becoming too unwell to raise himself off the floor. By the time he was seen in [outside hospital] his condition had deteriorated to the extent that he had developed hyperglycaemia (high blood sugar), muscle breakdown and kidney injury. He subsequently had a cardiac arrest and developed severe hypoxic brain damage and died [in] February 2012."

Use of restraints

59. It is accepted that when a prisoner is taken to outside hospital the Prison Service has to undertake an assessment of security risks and the risk to the public. However, the man was a category D prisoner (the lowest security category for prisoners who can reasonably be trusted not to try and escape), and was judged suitable for an open prison. His offence meant that he was not a risk to the public, he was in a very poor state of health and was relatively immobile (indeed special equipment had been needed to raise him from the cell floor). In such circumstances it is difficult to see how the risk assessment which required him to be restrained by an escort chain was justified when he went to outside hospital on 3 February. We therefore make the following recommendation.

The Governor should ensure that risk assessments for escorts fully take into account the medical condition of the prisoner and are based on the actual risk the prisoner represents at the time.

Release on temporary licence

60. Wandsworth authorised the man's release on temporary licence after the hospital informed them of his poor prognosis. While we accept that Wandsworth acted promptly on being given the medical prognosis by the hospital, given the man's poor state of health and that he was a Cat D prisoner, we are surprised that this was not considered earlier.

The Governor should ensure that whenever a category D prisoner requires a hospital stay, consideration is given to release on temporary licence, taking into account the full circumstances and the risks.

Family liaison

61. Wandsworth appropriately contacted the man's niece immediately after the doctor assessed that he needed to remain in hospital. We are pleased that Wandsworth appropriately appointed a family liaison officer as soon as the hospital gave a poor prognosis for the man's recovery. The family liaison officer met members of the man's family at the hospital the day before his death.

62. In the days that followed his death, the family liaison officer maintained contact with the man's family to offer support along with the offer of financial assistance towards funeral expenses. Arrangements were also made for the man's brother, who had travelled from South Africa, to visit the prison where he met with staff.

CONCLUSION

63. It is clear that attention was paid to some of the man's health needs and appropriate care was provided. However we agree with the clinical reviewer, that the standard of care in relation to the management of his diabetes should have been better. There was an unacceptable delay in a doctor reviewing his community medical records and prescribing his medication, his blood sugar was not consistently monitored. Record keeping was not always consistent. However it is evident that he had not taken care of himself before entering custody, and continued to neglect his personal care despite encouragement from staff.

64. The inappropriate use of restraints meant that the man was not treated with dignity and respect by Wandsworth when he was first admitted to hospital. Although he was later released on temporary licence once the prison realised he has little prospect of recovering, this could have been considered earlier. Wandsworth supported the man's family while he was in hospital and following his death, appropriately followed Prison Service guidance in providing financial assistance towards the cost of his funeral.

The man's family, having had the opportunity of reading the report at the consultation stage of the process, made extensive comments some of which are reflected below:

The family expressed their ongoing concern that the Court sentenced their relative to prison despite receiving a medical report advising them of his complex medical needs.

The family believe that had he remained within the community under the care of his local NHS services their relative would still be alive today. They stated he was diligent in taking his medication and attending clinics to manage his care and that this supports their belief that he would not have declined to have his bandages changed.

It is the family's opinion that the prison was not equipped to manage the man's extensive health problems in a dignified manner and that placing him in their care was inhumane. They believe the prison staff should have recognised this and should have referred him to hospital sooner and by not doing this they acted negligently. They also believe that the nursing staff were not suitably qualified to treat him.

The family also raised some questions about the events which took place after their relative was admitted to hospital on 3rd February 2012. These are not within our investigative remit and the family have been advised to raise these matters with the Coroner.

RECOMMENDATIONS

1. The Head of Healthcare should to ensure that prisoners who have complex and chronic health problems have a coordinated single case management plan, (in accordance with relevant NICE guidelines) regularly reviewed and updated, and followed by all staff.

   Accepted
   In order to improve the standard of care and holistic approach to patient needs, formalised procedure for multi-disciplinary and multi-agency case reviews to be developed to identify patients with complex needs and formulate an action plan

2. The Head of Healthcare should ensure that all prisoners with chronic health condition are seen by a doctor with 48 hours of arriving into custody.

   Accepted
   As stipulated in the Reception and First Night in Custody Healthcare Operational Procedure, the reception GP/ANP sees all new and transferred receptions that he/she has been referred by the reception nursing team. All those patients prescribed medications for the following are seen on first night:

   - *Cardiac problems*
   - *Asthma*
   - *Hypertension*
   - *Diabetes*
   - *Epilepsy*
   - *Mental Health/Self Harm*
   - *Severe pain*
   - *Those prisoners with complex health needs identified during screening*

   In line with Second day screening procedures, the GP sees prisoners that have been referred by the nurse the next day, this includes reviews of IDTS prisoners who may require titration and review of any substitute prescription.

3. The Head of Healthcare should ensure that the verification of a prisoner's community medical records is undertaken by a doctor within 24 hours of receipt so that any medications can be appropriately prescribed and any clinical needs met.

   Partially Accepted
   Verification from community healthcare providers is requested (in most cases) within 24 hours of prisoner reception. Based on clinical assessment, certain medications can be prescribed without verification in-line with patient need.

   Whilst the verification form stipulates a 72 hour deadline for the return of the requested medical verification, the time in which this information is sent to Offender Healthcare is outside our control.

On occasions, (ie. when a patient has been admitted on Friday or Saturday), medications will be prescribed for short period (2-7 days) whilst verification sought.

4. The Head of Healthcare should ensure that all healthcare staff accurately and contemporaneously record actions, in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.

   Accepted
   The patient medical record system, SystmOne, is fully electronic and intervention/communications are recorded on SystmOne, with the exception of referral forms.

   The importance of accurate and contemporaneous record keeping, in line with Nursing and Midwifery Council (NMC) guidelines, was reiterated to staff in a memo on the 20th September 2011 from Acting Head of Healthcare.

   A system of peer review of GP records will be discussed to ensure the quality of clinical records.

   Discussion to take place with Trust Health Records Manager regarding the undertaking of an Offender Healthcare records clinical audit.

5. The Governor should ensure that risk assessments for escorts fully take into account the medical condition of the prisoner and are based on the actual risk the prisoner represents at the time.

   Accepted
   Staff and managers completing the risk assessment will be advised that where at all possible the medical information section of the risk assessment should be completed or the security staff or authorising Governor should aim to get a verbal account from Healthcare staff and update the risk assessment accordingly.

6. The Governor should ensure that whenever a category D prisoner requires a hospital stay, consideration is given to release on temporary licence, taking into account the full circumstances and the risks.

   Accepted
   If a Cat D prisoner attends hospital and has remained in hospital until the following morning, it will be discussed at the Governor's morning meeting, in liaison with healthcare, about whether ROTL should be considered.