Investigation into the circumstances surrounding the death of a man at hospital November 2011 while in the custody of HMP & YOI Norwich

Report by the Prisons and Probation Ombudsman for England and Wales

July 2012

This is the report of an investigation into the death of a man, a prisoner at HMP Norwich. He died at hospital in November 2011, having been taken ill at court the previous morning. He was 67 years old. The cause of death was found to be acute heart failure due to occlusive coronary artery atheroma (build up of fatty lumps in the artery supplying blood to the heart), with secondary conditions of diabetes and acute renal (kidney) failure. I offer my condolences to his wife and family, and to all who have been affected by his loss.

The investigation was carried out by an investigator. Norwich prison cooperated fully with the investigation. A review of the man's clinical care in custody was carried out by a clinical reviewer on behalf of the local PCT.

The man had a significant medical history when he arrived at Norwich in October 2011. Although he was reported to be reasonably well during his time in prison, we comment and make recommendations for improvement in several areas of his care which fell below the standards he might have expected had he been in the community. These include the need to maintain continuity of care, improve medicines management, ensure appropriate care planning and the making of regular clinical observations, and enhancing assessments of 'fitness for court' in cases of prisoners, such as he, who have a significant medical history. I acknowledge the clinical reviewer's comment that some of these weaknesses might have contributed to his collapse at court, but also note that his serious underlying heart disease and the stress of the court appearance might also have been contributing factors.

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.

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Prisons and Probation Ombudsman **July 2012**

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SUMMARY

1. The man arrived at HMP Norwich on 4 October 2011, having been sentenced to three years imprisonment earlier that day. He had a significant medical history which included a previous stroke and diagnosis of heart disease. He took a number of different medications to manage these conditions. His medical history was outlined in a letter from his solicitor which accompanied him to prison. His community GP was not contacted for further information, even though his prescription for furosemide (medication to treat water retention due to heart failure) was higher than the normal dose. We recommend that community records are requested for new arrivals into prison with a significant medical history.

2. During his time at Norwich, the man lived on the prison's specialist unit for older prisoners. The clinical reviewer comments that various clinical observations, such as his blood pressure and weight, were not checked as regularly as they ought to have been. We recommend that care plans are tailored to an individual's care needs and that these include provision for such ongoing assessment.

3. The man reported no serious problems with his health in his first weeks at Norwich but was assessed by the prison doctor on the morning of 21 November after experiencing a dizzy spell. The doctor requested that an electrocardiogram (ECG, a test to detect abnormal heart rhythms) be carried out. This did not happen. We recommend that the head of healthcare ensure there is sufficient equipment and trained staff to carry out such tests.

4. The man was due to appear at Crown Court on 25 November, for a confiscation hearing (to determine whether and, if so, how much money he should pay to deprive him of the proceeds of his offence). As is standard practice, his health was assessed the evening before the court appearance. The nurse who carried out the assessment had never met him and based her assessment on his electronic medical record. She discussed his current health over the telephone with the night nurse on the older prisoner unit, where he lived, although this conversation was not recorded. We recommend that a local policy to assess a prisoner's 'fitness for court' is developed, to include provision for those with a significant medical history to be assessed in person.

5. When he arrived at court, the man collapsed and soon lost consciousness. An ambulance was called and he was taken to hospital. The following morning, his health deteriorated and his life support machine was disconnected. He subsequently died.

6. Along with those noted above, we highlight several other areas of practice that could be improved at Norwich. These include medicines management for patients with complex prescriptions and ensuring that there are sufficient resources to allow tests requested by the prison doctor to proceed. Nevertheless, we cannot say with certainty that these omissions contributed to the man's death.

THE INVESTIGATION PROCESS

7. The investigation was opened on 28 November 2011 when the investigator issued notices announcing the investigation to staff and prisoners. These notices included an invitation to those who wished to submit information relating to the man's death to make themselves known. No one came forward as a result.

8. The investigator visited Norwich on 2 December. During the visit he saw the cell where the man had lived. The investigator spoke to staff who knew the man on the unit in which he lived, and met the prison's family liaison officer. He was provided with copies of his prison records. He later contacted the Head of Business Support at Serco Prisoner Escort Custody Services (the contractor who provides escort services for prisoners to and from court and employs staff at Ipswich Crown Court). The Head provided statements and related information from those staff involved when the man was taken ill at court.

9. The investigator returned to Norwich on 24 January and 8 February 2012, and interviewed five members of staff. A clinical review of the man's time in custody was carried out by a clinical reviewer on behalf of the local PCT. She visited Norwich with the investigator and participated in the interviews.

10. One of the Ombudsman's family liaison officers wrote to the man's son, his nominated next of kin, on 16 December 2011. She explained the purpose of the investigation and provided the opportunity for the family to raise any concerns about his care at Norwich. The man's son subsequently wrote to her and raised a number of questions for the investigation to address. These questions covered a number of areas of his time in custody, including his continuing clinical care, assessment ahead of his court appearance and the events that took place at court. We have addressed these questions where appropriate in the 'Key events' and 'Issues' sections of this report.

11. The family and their legal representative received a copy of the Ombudsman's draft report. No further representations were made in response to the findings, their preference being to raise matters directly with the coroner at the inquest. The National Offender Management Service (NOMS) response to the recommendations is included in the report.

HMP & YOI NORWICH

12. HMP Norwich is a local prison serving the courts of Norfolk and Suffolk. It holds a maximum of 767 men including young adults between the age of 18 and 21. The prison contains a dedicated unit for up to 15 older prisoners with chronic or terminal diseases. Many of the prisoners on this unit require full nursing care. The man lived on the unit for most of his time at the prison.

13. Healthcare services at Norwich are commissioned by NHS Norfolk and Waveney and provided by a private company, Serco Health. An inpatient facility, situated above the older prisoners' unit, consists of 23 beds and 24 hour nursing cover is provided. Most occupants of the inpatient facility are admitted because of mental health problems. Prisoners on the healthcare inpatient and older prisoner units at Norwich receive medication administered by staff at appropriate times throughout the day, rather then keeping their own medication in their cell.

14. Her Majesty's Chief Inspector of Prisons carried out an unannounced inspection of Norwich in February 2010. The inspection found that staff on the older prisoners unit were "hard pushed to provide the required level of care despite their best efforts". However, patients on the unit to whom the inspection team spoke said they were "satisfied" with their care. Norwich was inspected again in January 2012. The Chief Inspector's report has not yet been published.

15. The Independent Monitoring Board's annual report for 2010 commented that there were insufficient activities for prisoners in the inpatient and older prisoner units. (IMB - a body of unpaid local people who independently monitor and report on the prison.) The IMB also reported that, other than those with asthma, prisoners with chronic diseases did not have care plans.

16. The Ombudsman has investigated a high number of deaths in custody at Norwich, many of which were of terminally ill men living on the older prisoners' unit. The man was the third of four residents of the unit to die in 2011. Our reports into the earlier two deaths found that the men in question received appropriate care that was equivalent to what they might expect to receive in the community.

KEY EVENTS

17. The man was sentenced to three years imprisonment on 4 October 2011. A person escort record (PER) was completed during his journey from Crown Court to Norwich. (A PER is a form that accompanies prisoners on all journeys to and from prison. It serves as a communication tool about risks a prisoner poses on escort and provides a chronological record of the escort.) The 'health risks' section of the PER was completed by a Prisoner Custody Officer (PCO), who recorded that he had previously had a stroke, had congestive heart failure (whereby the heart is not capable of supplying sufficient blood flow to meet the needs of the body) and suffered from mild dementia.

18. The PCO also recorded that the man had many additional health problems that were detailed on an attached sheet. (It is not clear what information this additional sheet contained, although it is possible that the PCO held a copy of the solicitor's letter referred to in the following paragraph.) A copy of the PER is given to the officer on reception when a new prisoner arrives at the establishment, so that they are immediately aware of any potential risks.

19. On the same day, the man's solicitor faxed a letter to Norwich in advance of his likely prison sentence. The letter contained a summary of the issues affecting his health. (We presume that the letter was the same as, or similar to, that prepared for the judge ahead of sentencing and referred to by his son in correspondence with our office.) These included obstructive sleep apnoea syndrome (a condition where breathing stops for short spells of around ten seconds during sleep), for which he required a special machine to help him breathe at night. The letter also detailed that he had type 2 diabetes (when the body does not produce enough insulin or is unable to effectively use the insulin that is produced to maintain a normal blood glucose level – usually managed by diet and medication), high blood pressure, congestive heart failure, atrial fibrillation (irregular heartbeat), cerebrovascular disease (conditions affecting the circulation of blood to the brain, in his case because of a previous stroke), and mild dementia. It was also noted that he had lost an eye and had difficulty walking on account of a missing toe.

20. In addition to the solicitor's letter, the man's wife submitted a memo in which she detailed his daily care arrangements. Alongside this was a list of his nine outstanding hospital appointments in the four months from October. These appointments were not rebooked.

21. Following his arrival at Norwich, the man saw a nurse for a reception healthscreen (a routine healthscreen for all new arrivals into custody). His medical history was noted, as described above, with the addition of chronic kidney disease. His medication was listed. This was extensive and included anti-diabetics, anti-hypertensives (for high blood pressure), furosemide (to treat water retention due to heart failure) and warfarin (to thin the blood and prevent clotting). His blood pressure was taken which, at 105/86, was within the normal range. Because of his medical history, he was allocated a cell on the healthcare centre's inpatient unit.

22. The following morning, the man saw a prison doctor. At interview, the doctor recalled that he was an intelligent, reasonable and likeable man. At the consultation, the doctor noted that he felt “stable” and had no complaints. He checked his blood pressure which, at 122/72, was within the normal range. The doctor also noted that he took a higher dose of furosemide than is normally recommended. He therefore halved the dose and requested that various blood tests be taken. Neither his community GP nor cardiologist (heart specialist) were contacted to confirm the prescription.

23. On the same day, the man was visited in healthcare by a prison chaplain. It is usual for a chaplain to see all new prisoners within 24 hours of their arrival at the prison. The chaplain told the investigator that he had also received a telephone call from the man’s son, who explained that his father was a very religious man and had arrived at Norwich on 4 October. The chaplain recalled that he talked with him about faith and helped him to use the telephone to call his family. The man also requested a Bible and the religious book ‘Daily Bread’, which were provided by the chaplaincy. In addition to this meeting, the chaplain recalled that he saw him regularly during his time in the prison and would usually stop and talk with him.

24. The results of the requested blood tests were available on 7 October, and revealed some abnormalities. An appointment was made with the doctor to review the findings. On the same day, consideration was given to allocating the man a cell on a standard residential unit. However, as he sometimes appeared confused about his medication there were concerns that he would find it difficult to cope with managing his own medication and that he was too frail to live on a standard wing. Healthcare staff therefore recommended that he remain living on the inpatient unit. Four days later, on 11 October, he moved to a cell on the older prisoners’ unit.

25. The man’s next review with the doctor took place on 13 October. The doctor recorded that he “looks well”. His blood pressure was checked and recorded as 116/75, within the normal range. They discussed the results of the previous week’s blood test, and the doctor noted that the test should be repeated to “establish renal [kidney] status”. There is no indication that the required blood test went ahead.

26. The man’s wife sent some him socks that were specially designed to aid circulation. His property record shows that the socks arrived at the prison on 18 October and he was given them the same day.

27. No concerns were raised about the man over the following week, and he was reported to be in good spirits. During the night of 1 November, he sustained an injury to his left shin after catching it on the edge of his bed. The following day he reported it to a nurse and the wound was cleaned and dressed. His son noticed this injury in hospital and referred to it in his correspondence with our office.

28. On the same day, the man asked that his dose of furosemide be increased to the amount he was prescribed in the community. The doctor requested a blood test,

to check his kidney function, before making this adjustment. This test went ahead two days later.

29. Later on 2 November, the man's international normalised ratio (INR, a blood test used to check the effectiveness of warfarin) was taken, and found to be slightly higher than the normal range. The warfarin prescription was reduced and it was requested that his INR be checked on a weekly basis. All future readings were within the normal range.

30. The doctor saw the man for review on 4 November. He noted that he had some leg oedema (swelling due to fluid retention), and explained that he would review the results of the blood test requested two days previously before deciding on a change to his medication. The result of the blood test was "satisfactory" and the doctor prescribed a course of amiloride (a diuretic similar to furosemide, used to treat water retention caused by heart failure or kidney disease). The following day, his blood pressure was checked and was recorded as 109/72, within the normal range.

31. The man saw the doctor again on 9 November, and said that the injury he had sustained to his leg was still painful. The doctor examined the wound, which was a bruise and cut that was leaking a pale discharge. A nurse cleaned and dressed his wound, and he was prescribed a course of antibiotics. The following day, his dressing was changed when he was found to be allergic to the original material. The wound was examined and redressed over the remainder of his time in prison, and recorded to be healing well.

32. On the morning of 21 November, the man felt faint for around three to four minutes while making his bed. He told the nurse that he had no chest pain but did not feel completely aware of his surroundings. The nurse checked his blood pressure, which was 145/101, an elevated reading. Later that morning, he saw the doctor for assessment. The doctor recorded that he appeared to be breathing normally and had a regular pulse. His blood pressure was 100/56, which is at the lower end of the normal range. The doctor asked that an electrocardiogram (ECG, a test of the electrical activity of the heart in order to detect abnormal heart rhythms) be carried out.

33. The following afternoon, the man saw a nurse. He told the nurse that he had felt dizzy in the morning but that this had resolved quickly. The nurse noted the doctor's request for an ECG the previous afternoon and recorded that she would make an appointment for it to be done the following day (23 November). He saw a nurse the following day to have the dressing changed to his shin injury. There is no indication that the requested ECG was taken.

34. The prison chaplain recalled that he saw the man on or around 23 November. He asked for a new copy of 'Daily Bread', which was given to him. The chaplain told the investigator that he did not mention his health at this meeting and there was nothing to give him any cause for concern about his wellbeing.

35. On the morning of 24 November, the man's INR was taken by a nurse and was found to be within the normal range. Later in the morning, he saw a doctor for a

review of his leg wound. His recent dizzy spells were not discussed. The doctor recalled at interview that he appeared to be his usual self during the assessment and he had no specific concerns at the time.

36. The man was due to attend Crown Court for a confiscation order hearing on 25 November. Before attending court, all prisoners are required to be assessed by a member of healthcare staff to determine whether they are well enough to attend. As prisoners have to leave the establishment early in the morning, the assessment usually takes place the day before. A nurse in another part of the prison completed his assessment on the evening of 24 November. She noted in the medical record that he was "fit to attend Ipswich CC". She was based in another part of the prison and explained at interview that she never met him. Her assessment was based on his medical records and a telephone conversation with a nurse who worked overnight on the older prisoners unit. This telephone conversation was not recorded in his medical record or elsewhere.

37. At around 9.40pm, the nurse on the older prisoners' unit saw the man to give him his medication. She recalled that he appeared to be in good health and he expressed no concerns.

38. The nurse who completed the 'fitness for court' assessment also completed the health risks section of the PER. She recorded that this was completed at 3.00am on 25 November. She ticked the box to indicate that there was no known health risk. No mention was made of the man's various medical conditions.

39. Later in the morning, the nurse on the unit woke the man for his court appearance. She recalled that there were no concerns about his health at the time and he was in good spirits when he left for court.

40. Two PCOs were tasked with collecting the man, and four other prisoners, from Norwich and transporting them to Crown Court. In statements prepared for Serco, they recalled that he walked slowly with his stick and needed their assistance to climb the steps onto the van. They left the prison shortly after 8.00am, arriving at court at around 9.40am. During the journey, one PCO checked on the prisoners around every ten minutes (this is a standard procedure). No concerns were raised about him during this time.

41. On arrival at court, prisoners are usually handcuffed to a PCO while they walk from the van to the court's holding cells. Both PCOs thought that the man's frailty meant that the use of handcuffs was unnecessary, and were granted permission from a Senior Custody Officer (SCO) to proceed without restraints. We consider this to be an appropriate and thoughtful decision.

42. The man said he felt hot and unwell when it came to his turn to leave the van. He was given a short period to rest and then said he felt well enough to leave the vehicle. He left the van with the help of staff and walked slowly into the reception area of the court. At around 9.50am, he collapsed and fell into the arms of several PCOs who were walking with him for support. The PCOs placed him in the recovery position, at which point the SCO telephoned for an emergency ambulance. While she was on the telephone, the man's breathing became

laboured and he lost consciousness. The operator advised that they start cardiopulmonary resuscitation (CPR), which was carried out by two PCOs.

43. Three paramedics arrived separately between 9.58am and 10.03am and took over CPR. At 10.25am, the man was taken by ambulance to hospital, where they arrived at 10.34am. He was accompanied by two members of Serco staff until around 2.00pm, when staff from Norwich arrived to take over the escort. He was on life support and restraints were not applied at any point.

44. The court manager contacted the duty governor at Norwich to tell him that the man had been taken to hospital. At 12.45pm, the duty governor telephoned the man’s son to let him know what had happened. The man’s wife and three adult children visited in the early evening and remained at the hospital overnight.

45. The following morning, the man deteriorated significantly. The life support was disconnected at around 12.10pm and he died at 2.30pm, with his family present. The duty governor visited the hospital later that afternoon and arrived at 4.15pm, shortly after the family had left. He spoke to the officers on duty at the hospital and gave them details of the appropriate support services available.

46. An operational manager at Norwich spoke to the man’s son on the telephone later that evening. She offered condolences and explained what assistance the prison could offer them. A family liaison officer was subsequently appointed to be the family’s point of contact at the prison. The funeral was held on 9 December, and consisted of a church service and burial. The prison contributed to the arrangements and costs.

ISSUES

Continuity of healthcare

47. Prison Service Order 3050 (PSO, a policy document applicable to all prisons in England and Wales), regarding continuity of healthcare for prisoners, instructs that:

    > "When a prisoner enters reception … efforts should be made to retrieve any information required from the prisoner's GP or other relevant service he/she has recently been in contact with."

48. The man's community GP was not contacted for details of his medical history. Healthcare staff had received some information about his health from his solicitor and his wife but his GP would have been able to provide more detailed information about his conditions and ongoing treatment, and formally confirm the medication that he was prescribed. This would have been particularly useful as the dose of furosemide prescribed in the community was higher than the usual dose, and was changed by the doctor without discussion with his GP or cardiologist.

    The Head of Healthcare should ensure that staff request community GP records for all new arrivals in prison, with particular priority for those who report a chronic disease or other significant condition in their medical history.

49. In addition, the man had a total of nine outstanding hospital appointments when he arrived at Norwich. Some of these were for regular clinics, including a heart failure clinic. The appointments were all for hospitals in his home area in the north east of England.

50. It is standard practice when a new prisoner arrives into any prison that all outstanding hospital appointments are rebooked. This is because, for reasons of security, prisoners are not permitted to know in advance of any time outside of the establishment. In addition to this, it would not be practical for the man to attend hospital appointments in the north east so all of his clinics would have to be rebooked locally. We note that one of his appointments was for warfarin monitoring, which was carried out internally at the prison. However, none of his other appointments were rebooked, and he subsequently missed the clinics.

    The Head of Healthcare should ensure that all outstanding hospital appointments are rebooked for all new arrivals into the prison.

Medicines management

51. The man's dose of furosemide was reduced on his arrival at Norwich. In the community he took a 160mg dose twice daily (totalling 320mg per day), whereas this was reduced to 80mg twice daily in prison (totalling 160mg per day). We have noted above that the original dose was higher than usually prescribed but was not checked with his GP or cardiologist.

52. When he saw the man on 2 November, the doctor noted that he had asked that his furosemide prescription return to the previous dose. He requested blood tests and, when these were completed, prescribed amiloride, a medication similar to furosemide. He indicated in another entry that the man's leg oedema had increased, which prompted the addition of amiloride.

53. In the memo she sent to Norwich, the man's wife explained that he was weighed each morning. If his weight fluctuated, his dose of furosemide was adjusted following consultation with his local heart clinic. The clinical reviewer comments that this practice did not continue following his imprisonment. She goes on to say that requested changes to or reviews of his medication were not always followed up and there was no record of the pharmacy being involved in reviewing his complex medication regime. She comments

> "The possible aggravation of [the man's] congestive cardiac failure via the change in his diuretic medication may have been a contributing factor precipitating his [heart attack] and collapse."

The Head of Healthcare should ensure that medication reviews and changes are fully documented.

The Head of Healthcare should ensure that the medicines management team are consulted where a patient has complex or multiple prescriptions.

Care planning and monitoring of clinical observations

54. The man's son asked whether his father's blood pressure, cholesterol and weight were monitored and his diet assessed during his time in Norwich. On his first day at the prison, his blood pressure was checked and was found to be within the normal range. During the following month, it was checked on a further three occasions, and each time was within the normal range. When he experienced a dizzy spell on 21 November, his blood pressure was slightly elevated, but soon returned to the normal range. It was not checked again after this date. The clinical reviewer considers that it should have been checked more regularly. His cholesterol was not checked during his time in Norwich.

55. As we have noted in the previous section, there is no record that the man was weighed at any time at Norwich. There was also no assessment of his dietary requirements which, as the clinical reviewer comments, should be considered in respect of his heart disease and diabetes.

56. There are several care plans on the man's electronic medical record. These could be used to set out to staff how often his blood pressure and weight, or any other necessary observations, should be taken and what action they should take if the results are outside of the normal range. However, the care plans on his record were standard templates that had not been tailored to his individual needs and appear to have been added as part of a 'tick box' exercise rather than with the intention of being implemented.

57. The clinical reviewer considers that there were omissions in the ongoing assessment and management of the man's health. She goes on to say that it is unclear whether these omissions would have had any impact on his death. However, we make the following recommendation:

    The Head of Healthcare should ensure that care plans are tailored to a patient's individual care needs, including provision for ongoing assessment of needs and levels of monitoring, in line with nationally defined best practice.

Follow up to dizzy spell on 21 November

58. When he assessed the man following his dizzy spell on the morning of 21 November, the doctor asked that his blood pressure be monitored and that an ECG be taken. As we have noted above, his blood pressure was not checked following this assessment. The requested ECG was also not taken.

59. At interview, the doctor explained that there can sometimes be delays in carrying out an ECG at Norwich. This can either be because there is not a machine in the inpatient or older prisoner units, or because there are not staff on duty who are trained to use the machine.

60. On 22 November, the man saw a nurse for a review. The nurse noted that his ECG was outstanding and recorded that she would book an appointment for him to have it done the following day. There is no record of the appointment and, although he had recorded contact with nurses on the following two days, an ECG was not taken.

61. As previously, the clinical reviewer concludes that it is not clear whether these omissions would have had an impact on the man's death. However, we make the following recommendation:

    The Head of Healthcare should ensure that there is sufficient equipment and trained staff to allow tests requested by the GP to be carried out promptly.

'Fitness for court' assessment

62. Before attending court, all prisoners are required to be assessed by a member of healthcare staff to determine whether they are well enough to attend. The man was passed fit by a nurse on the evening of 24 November. She noted in his medical record that he was "fit to attend Ipswich CC". She did not assess him in person and told the investigator and clinical reviewer that she had never met him. The nurse based her assessment on the information contained in his medical record and on a telephone conversation with a nurse who was on duty on the older prisoners unit. She explained at interview that it is standard practice to base a 'fitness for court' assessment on a prisoner's electronic medical record only, and that she spoke to the unit nurse because of the man's status as a resident of the older prisoners unit. We note that the conversation between the two nurses was not entered on his record. We take the view that, for residents of

the inpatient or older prisoner units or those with a significant medical history, an examination in person, preferably by a nurse who knows the man, is essential ahead of an event, such as a court appearance, that is likely to result in additional stress.

The Head of Healthcare should develop a local policy to guide staff in assessing a prisoner's fitness for court, including an instruction that residents of the inpatient or older prisoner units, or those with a significant medical history, are assessed in person with the findings and recommendations fully documented.

63. The nurse noted on the man's PER that he had no known health risks. In contrast to the PER completed when he came to Norwich from court on 4 October, she made no mention of his numerous medical conditions. This section of the PER is an important tool in highlighting to escort staff any risks or special assistance that someone might require.

The Head of Healthcare should ensure that any significant medical conditions are highlighted in the 'health risks' section of the person escort record.

Access to chaplaincy services

64. The man's son asked whether his father was able to attend chaplaincy services at Norwich. On his first day at Norwich, he was visited by a prison chaplain. The chaplain spoke to him about his faith and gave him a Bible and other religious material. In addition to this, a member of the duty chaplaincy team visits the healthcare inpatient and older prisoner units every day. The chaplain saw him on a number of occasions and told the investigator that he did not raise any concerns about practising his faith or any problems with access to services.

65. A service is held in the inpatient unit every Sunday. It is open to residents of the inpatient unit and those of the older prisoner unit, which is on the floor below (a lift is available for those with limited mobility). The chaplain recalled that the man attended some of these services. We are satisfied that he had reasonable access to chaplaincy services.

Visits

66. The man's son said that the family were only able to visit him on three occasions in prison, due to the rate that visiting orders were sent out by the prison. Records show that these visits took place on 20 October, 13 November and 17 November, with another visit scheduled for 1 December. He was on the 'standard' level of the prison's incentives and earned privileges scheme. (IEP, a scheme to encourage and reward good behaviour in prisons. The scheme usually operates on three levels, 'basic', 'standard', and 'enhanced', with privileges such as more time out of cell, access to in-cell television, and higher rates of pay available.) This meant that he was allowed two visits each 28 days, one of which could be at the weekend.

67. The man had one visit in his first 28 days at Norwich, and two in the second 28 day period. A further visit was booked for the first week of the third 28 day period. While he was eligible for an additional visit in the first period, it is the responsibility of prisoners to complete and send out visiting orders at Norwich. Prisoners who have difficulty completing a visiting order can ask staff for help. There is no record of him asking staff for help with the visiting order system, or making a complaint about the number of visits allowed.

Contact with the man's family

68. The man's son asked why a governor, who was due to meet the family at hospital following his father's death, was unable to get to the hospital before the family left. Following the man's death at 2.30pm, the duty governor was notified over the telephone by the escort staff at 2.35pm (according to records kept by the escort staff). Shortly afterwards, the duty governor left the prison for Ipswich. He arrived at around 4.15pm.

69. It is around 50 miles from the prison to the hospital. Given this distance, we do not think 4.15pm was an unreasonable delay in the duty governor arriving at the hospital. However, it is completely understandable that the family did not wish to remain at the hospital until that time. We note that the operational manager spoke to the man's son over the telephone at 5.00pm and that the duty governor followed this up the next day ahead of the appointment with the family liaison officer. We consider the prison's efforts to contact the family to be reasonable in the circumstances.

CONCLUSION

70. The man arrived at Norwich with a significant medical history. We have identified several areas of practice that might be improved, including continuity of care, medicines management, care planning and 'fitness for court' assessments. Nevertheless, we cannot say that these omissions contributed to his death. The clinical reviewer concludes that some of these issues might have been contributing factors to his heart attack, but that the stress of his court appearance and underlying heart disease might also have been causal factors.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that staff request community GP records for all new arrivals in prison, with particular priority for those who report a chronic disease or other significant condition in their medical history.

   Accepted

   The reception nurse will request information from new reception prisoners relating to their community GP details. This information will be passed to a designated member of the healthcare admin team who will request all information from the GP relating to the patient.

2. The Head of Healthcare should ensure that all outstanding hospital appointments are rebooked for all new arrivals into the prison.

   Accepted

   The reception nurse will ask whether there are any outstanding hospital appointments when processing newly received prisoners. These will then be rebooked by the healthcare admin team.

3. The Head of Healthcare should ensure that medication reviews and changes are fully documented.

   Accepted

   Medication reviews are currently in place and constitute a current initiative involving more appropriate prescribing. Documentation will be audited to ensure that clinical notes represent this.

4. The Head of Healthcare should ensure that the medicines management team are consulted where a patient has complex or multiple prescriptions.

   Accepted

   Medicines management meetings have recommenced and part of this forum will include discussions around complex cases that require multiple prescriptions.

5. The Head of Healthcare should ensure that care plans are tailored to a patient's individual needs, including provision for ongoing assessment of care needs and levels of monitoring, in line with nationally defined best practice.

   Accepted

   A newly appointed clinical lead has joined the nursing team. Part of the nurse's responsibility will include the management of care plans which will be scrutinised at monthly clinical governance meetings if required.

6. The Head of Healthcare should ensure that there is sufficient equipment and trained staff to allow tests requested by the GP to be carried out promptly.

   Accepted

   There will be a full review of equipment across the prison including ECG machines. New equipment is being purchased to enable both sites to be equipped. Staff will also undergo training to ensure they are able to use the equipment.

7. The Head of Healthcare should develop a local policy to guide staff in assessing a prisoner's fitness for court, including an instruction that residents of the inpatient or older prisoner units, or those with a significant medical history, are assessed in person with the findings and recommendations fully documented.

   Accepted

   The newly appointed operational lead is developing standard operating procedures (SOP) for all healthcare departments and specific undertakings. The assessment of prisoners who are due to attend court will be a specific SOP and will be signed as understood by all staff. It will take into account all healthcare conditions and the possible impact that attending court might have on the individual.

8. The Head of Healthcare should ensure that any significant medical conditions are highlighted in the 'health risks' section of the person escort record.

   Accepted

   All person escort records will come under the above remit and will include specific information where necessary.