PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a woman at hospital, while a resident at Edith Rigby House Approved Premises, August 2012

Our Vision

‘To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision’

This is the report of an investigation into the death of a woman, who died of a spontaneous bleed on the brain while a resident at Edith Rigby House Approved Premises, Preston. She was 54 years old. I offer my condolences to her family and friends.

A review of the clinical care the woman received at HMP Holloway before her release was conducted.

The woman had high blood pressure at Holloway. Although nurses checked her blood pressure several times, there was no recorded plan to monitor her blood pressure and she was not reviewed by a doctor until shortly before her release, when she was prescribed medication for hypertension. She was released from Holloway on 27 July, and went to Edith Rigby House Approved Premises in Preston.

Although the clinical reviewer concludes that the woman's symptoms did not suggest that she was at risk of an acute event, there were aspects of the management of her high blood pressure which were not well managed at Holloway, and the standard of medical record keeping there was poor.

While staff at Edith Rigby House were generally attentive to the woman's healthcare needs, she was not checked for 16 hours before she was found unresponsive in bed. I consider this was too long for someone who was known to be unwell, but I am aware that earlier checks would have been unlikely to make a difference in her case, as there was little to indicate that she was other than asleep.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **March 2014**

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SUMMARY

1. On 28 January 2011, the woman was sentenced to three years imprisonment and was taken to HMP Holloway. Her blood pressure was taken in reception and was in the "pre-high" blood pressure range. The secondary health screen was conducted on the same day.

2. On 21 September 2011, the woman's blood pressure was checked by a healthcare assistant as part of the over 50s clinic. Her blood pressure reading was high at 160/102. On 27 September, the healthcare assistant checked again and her blood pressure had gone up to 168/108. The healthcare assistant took her blood pressure again on 19 October and it was still high at 152/99. Despite this, an entry in her on-going clinical record of that day said "blood pressure report, normal, no further action". There is no evidence that she was reviewed by a doctor or nurse. There was no plan to manage her blood pressure after the three high readings.

3. At a GP appointment on 23 July, the woman complained of a headache and was given a single dose of medication to reduce her blood pressure, but it did not work so she was taken to hospital. She was discharged the next day, after being diagnosed with a urine infection and prescribed antibiotics. The next day, the GP prescribed her blood pressure medication to be taken daily.

4. The woman was released from Holloway on 27 July. As she was leaving, she collapsed outside the gate and officers called a prison nurse. Her blood pressure, temperature and blood sugar were all within normal range and she was advised to see her GP or go to the local hospital if she continued to feel unwell.

5. The woman travelled by train to Preston and arrived at Edith Rigby House at 3.00pm. She had a full induction and was given a bedroom on the first floor. As she was unsteady on her feet she was advised to use the stair lift.

6. On 3 August, the woman's key worker at Edith Rigby House went to a doctor's appointment with her, because she had sickness, headaches and pain in her left shoulder. Her blood pressure was 140/90 and the doctor said that if her symptoms persisted then she would be referred for a CT scan. She was told to stop taking the antibiotics and blood pressure medication because they were making her feel sick. The doctor said that she would review her on 9 August, and referred her for a blood test.

7. On 4 August, the woman felt unwell and went to bed after dinner. She was seen in bed at 9.00pm during the evening resident check. She was not checked again until 1.15pm on 5 August. She appeared to be snoring loudly so was left to sleep. At 1.45pm, two members of staff checked on her again and she was still snoring very loudly. At 2.05pm she was checked again, and her breathing had changed. She was unresponsive, an ambulance was called to take her to hospital and her next of kin was contacted.

8. After several tests at hospital, the woman was diagnosed with a bleed on the brain. She did not regain consciousness and died with her family present.

THE INVESTIGATION PROCESS

9. The Ombudsman's office was informed of the woman's death on 8 August 2012. The investigator issued notices to staff and residents at Edith Rigby House to inform them of the investigation process and asking anyone with relevant information to contact her. No responses were received. Although she was no longer in prison custody, we also examined the clinical care she received at Holloway, as she had been in their care just before her death.

10. HM Coroner for Preston and West Lancashire District was informed of the investigation. A copy of the post-mortem report was received on 14 November. A copy of the investigation report will be sent to the Coroner to assist his enquiries.

11. A clinical reviewer was appointed by NHS North Central London to review the clinical care the woman received before she was released from HMP Holloway. She was given a copy of the woman's prison medical records. The clinical review was received on 4 December 2012.

12. The investigator received the woman's prison records. She liaised with the manager of Edith Rigby House throughout the course of the investigation. On 28 August, she and her colleague interviewed five members of staff at Edith Rigby House. She later interviewed another member of staff by telephone. On 6, 8 and 22 November, the investigator and the clinical reviewer interviewed five members of healthcare staff at HMP Holloway.

13. One of the Ombudsman's family liaison officers (FLO) contacted the woman's brother and cousin shortly after her death and explained the purpose and scope of the investigation. They had the following concerns which they asked the investigator to consider:

    - The appropriateness of the clinical care she received at HMP Holloway.
    - The timeliness of the response when she collapsed outside HMP Holloway on 27 July.
    - Whether it was appropriate for her to have travelled to Edith Rigby House on 27 July, rather than being taken to hospital.

14. The family received a copy of the draft report. They raised a number of concerns that do not impact on the factual accuracy of this report and have been addressed by way of separate correspondence.

15. The report was also issued for consultation with the Prison Service and the Probation Trust. The Prison Service response is reflected at the end of the report. The Probation Trust partially accepted recommendation 4, stating that recall would have been an appropriate response to the woman not reporting to Edith Rigby House, but accepted that it should have been communicated better that it would not mean an automatic return to prison, if she was able to verify she was receiving medical treatment. Recommendation 5 was accepted and extra checks have been implemented.

EDITH RIGBY HOUSE APPROVED PREMISES

16. The purpose of an approved premises is to provide an advanced level of residential supervision for offenders in the community, within a supportive and structured environment. Residents have to comply with their individual licence or bail conditions, curfews and the premises' house rules, but otherwise are free to come and go. Edith Rigby House, in Preston, run by Lancashire Probation Trust, is just one of six approved premises for women in the country. It opened in March 2012, and has 12 single bedrooms. Residents are responsible for their own healthcare, but staff help them to register with the local GP surgery and book appointments, if needed. All medications are kept in locked cabinets in a designated room, given out by staff, and recorded in a medication book.

17. Licence conditions can include attending offending behaviour courses, exclusion zones and curfews. As well as the curfew in the licence, Edith Rigby House requires that residents must be present between the hours of 11.00pm and 6.00am. There is a book at reception which residents must sign as they leave and enter the building so that staff know where they are.

18. Staff carry out daily resident checks to ensure that residents who have not signed out of the building are accounted for, and residents are adhering to the approved premise rules. On weekdays, residents are woken up at 7.30am so that they can attend the morning residents' meeting. A check is done during the morning and another during the afternoon. Residents are then checked again at around 9.00pm and are encouraged to be in their own rooms by this time. During the night, the landings are checked every hour. At weekends, residents are not woken in the morning. By around midday a check will be done to account for the residents that have not signed out. Checks are done again in the afternoon and evening.

19. There have been no previous deaths at Edith Rigby House.

HMP Holloway

20. Holloway is one of 13 female prisons in England and Wales. It occupies a site in North London and can hold up to 501 women, in single or dormitory rooms. Healthcare services are commissioned by NHS North Central London and delivered by a range of different agencies.

KEY EVENTS

HMP Holloway

21. On 28 January 2011, the woman was sentenced to three years imprisonment and went to HMP Holloway. During her first reception health screen she said she was a light smoker, but did not have any particular health concerns. Her blood pressure was recorded as 131/94. The ideal blood pressure range is 120/80, so the reading fell within what is classed as pre-high. Blood pressure is often raised when someone first arrives in prison, so a secondary health screen should take place a few days later and blood pressure is checked again. Unfortunately the secondary health screen took place on the same day. There were no significant entries in her clinical record over the next few months.

22. On 21 September 2011, a doctor asked for the woman's blood pressure to be monitored as part of the over 50s clinic. A Healthcare Assistant (HCA) recorded her blood pressure as high at 160/102. She said she spoke to one of her colleagues about the woman's high blood pressure, but could not remember who and she did not record the conversation in the clinical record. There was no recorded review or plan to monitor her blood pressure.

23. The HCA checked the woman's blood pressure again on 27 September, because a nurse had asked her to. She could not remember which nurse had asked her and the request was not recorded in her clinical record. The woman's blood pressure had gone up to 168/108. There was still no recorded plan to investigate the cause of her blood pressure.

24. The HCA took the woman's blood pressure again on 19 October. Her blood pressure had dropped to 152/99 since the last two recordings, but it was still high and she should have been referred to the doctor. The entry in her on-going clinical record says "blood pressure report, normal, no further action". Although it was attributed to her in the electronic medical record, she told the investigator that she did not enter this comment and was not sure what it meant. The woman's blood pressure was not checked again for the rest of the year.

25. On 13 February 2012, a doctor examined the woman and recorded that her blood pressure was "a little high" at 145/98. The doctor recommended that she be reviewed in a few weeks time, but there is no record of this being done.

26. On 21 July, the woman said that she had fainted and hurt her left arm. A nurse could not see any injuries and gave her paracetamol, advised her to drink water and to make a doctor's appointment. Her blood pressure was recorded as normal at 104/64. The next day she said that she had a headache, so the nurse took her blood pressure and gave her paracetamol. The nurse did not record the reading, but noted that it was raised and suggested the woman go to the nurses' clinic the next day to have it checked again.

27. At 11.44am on 23 July, the woman's blood pressure while lying down was 194/88, but while standing up was 170/96. The healthcare assistant referred her to the doctor. An hour later, a doctor noted her high blood pressure and that she had recently fainted. She said that she had been having headaches since she fainted, which had become worse over the previous two days. She was alert, with no neck stiffness. The doctor took her blood pressure again, which was very high at 205/110 and prescribed amlodipine to treat it.

28. The doctor checked the woman in her cell again at 3.43pm, to see if the amlodipine had reduced her blood pressure. She said that her headache was slightly better. The doctor said she looked better than she had earlier in the afternoon, but when she re-checked her blood pressure it was still very high at 200/115. The doctor tried to check the back of her eyes for intracranial pressure[1], but the lighting was not good enough. The doctor said that her pulse was not as high as she would have expected for someone with a headache and feeling unwell.

29. The doctor sought advice from the lead GP at Holloway and telephoned the on-call registrar at the hospital. The doctor explained that the woman's blood pressure was high and had not come down with medication, but her pulse rate was low. The on-call registrar said that she should be reviewed and the doctor could either do another eye test, or send her to hospital for further tests, such as a computerised tomography (CT) scan. The doctor decided to send her to hospital, with a note about her examination. She was taken to the hospital at 5.10pm on 23 July.

30. The woman was discharged from hospital and returned to Holloway at 1.45am on 24 July. The hospital discharge letter said that she had had a blood test and a chest X-ray. There is no evidence that her blood pressure was investigated or that she had a CT scan, as the doctor had discussed with the on-call registrar. She was diagnosed with a urinary tract infection and prescribed antibiotics, an antihistamine to treat sickness and dizziness, and pain relief. Another doctor reviewed her discharge letter and confirmed her prescription. (The previous doctor reviewed the discharge summary after her death and told the investigator that she was surprised at the diagnosis in light of her symptoms.)

31. A nurse reviewed the woman in her cell the next day, 25 July. She said that she had a headache and was lying in bed, but was able to sit up. She was not nauseous, but was slightly unsteady on her feet and her blood pressure was 153/91. The nurse advised her to have her blood pressure taken again the next day, to check her blood pressure medication was working. There is no record that her blood pressure was checked on 26 July.

[1] Increased pressure inside the skull which can be caused by high blood pressure.

The woman's release from Holloway

32. A nurse saw the woman in her cell at 8.05am on 27 July, before her release to Edith Rigby House. She said she did not feel well, but was not specific in her symptoms. The nurse thought that she was not looking forward to being released as she would have to leave her family in London and travel to Preston. Her blood pressure had gone down to 136/86, which is normal. She had her medication with her and was given paracetamol. The nurse said she reassured her and advised her to see her GP if her symptoms persisted.

33. Later that morning, the woman was released from Holloway and was due to catch a train to Preston to get to Edith Rigby House. At 10.30am, a code blue[2] was called for a medical emergency at the prison gate. The emergency nurse on duty rang the gate and was told that she had collapsed outside the gate after she was released. The nurse took the red emergency bag that contains life support equipment, and went to the gate with agency nurse. They arrived at the gate four minutes later, at around 10.34am.

34. The woman was sitting on a bench talking on a mobile telephone, and she had a family member with her. A member of the public had also stopped to help her. She told the nurse that she had not collapsed, but had felt faint. She had been feeling weak, her blood pressure was sometimes high and she had been to hospital earlier in the week. The nurse took her clinical observations, including her temperature and blood sugar reading, which were all normal. Her blood pressure was 140/70. The nurse noted that she was able to talk normally in full sentences and told her that according to her observations, "no immediate medical problem had been observed or detected". The nurse told her and the family members present that if she continued to feel unwell she should see a GP or go to the local hospital. The nurse said that she appeared happy to go to Preston.

Events at Edith Rigby House

35. At around 11.30am, one of the woman's relatives telephoned Edith Rigby House and spoke to an assistant manager. He told her that the woman had collapsed outside Holloway and was waiting for her travel warrant. She sought advice from the woman's offender manager and was told that if she did not arrive at Edith Rigby House then she would be recalled to prison. The relative said that they had wanted to take her to hospital, but did not want her to be recalled. At 12.10pm, the woman called Edith Rigby House and asked for directions. She then boarded a train at London Euston and was due to arrive in Preston at 3.00pm.

36. The assistant manager telephoned the healthcare centre at Holloway and spoke to the Healthcare Administrator. She asked what medication the woman had been released with and if there was any medical information they

[2] A code blue signifies a life threatening emergency, for example, if a patient has collapsed or is not breathing.

should be aware of before she arrived. The Healthcare Administrator said that she would ask the prison doctor to call Edith Rigby House.

37. The woman arrived at Edith Rigby House at 3.00pm with only the clothes she was wearing. She said that she had had to leave her bags with a relative as she had been too unwell to carry them. She was unsteady on her feet and said that she had fallen earlier. The disabled room on the ground floor was occupied, but she said she was happy to be in a room on the first floor and use the stair lift. She said that she thought she would feel better after a sleep as she had had a stressful day.

38. The assistant manager gave the woman a full induction, explained her licence conditions, and the hostel rules. She had gone to Edith Rigby House as she had previously lived in the area and knew a housing agency that would be able to provide her with accommodation in the community. Her curfew was between 10.00pm and 6.00am. She was due to stay at Edith Rigby House for four weeks before she was resettled into the community. She handed over her medications, which were recorded and stored securely in the medication room. She was given some toiletries and the manager helped to make her bed.

39. At 3.50pm, the Healthcare Administrator sent an email to Edith Rigby House saying that she had not heard back from the doctor, but had attached to the email a summary of the woman's clinical record from Holloway and prescription chart. She had a settled evening and went to bed.

40. On 28 July, the woman refused to take her amlodipine as she said it made her feel "funny". She ate her breakfast with another resident and then signed out and went into town. She told staff that she felt steadier on her feet. When she returned from town, she ate her dinner and then spent the rest of the evening in her room.

41. The woman spent the next day around Edith Rigby House. She did not take her medication in the morning, but said that she was "okay". Staff told the investigator that she was slightly withdrawn, but they put this down to her being new at Edith Rigby House and possibly being anxious.

42. On 30 July, the woman attended a doctor's appointment that had been made for her by a member of staff at Edith Rigby House. She told staff that she had explained to the doctor that she had previously fainted, was in some pain and had slurred speech following the faint. She told the doctor that she felt okay and was given a repeat prescription. She was described as a bit upset during the evening and staff were advised to keep an eye on her.

43. Every resident in an approved premise has a key worker to help the resident to settle in and assist with resettlement. The woman's keyworker met her for the first time on 31 July, when the woman said she thought she was unwell because of one of her medications. The keyworker told her if she was still feeling unwell she should make an appointment to see the GP, and that she would go with her if she wanted. The keyworker said she was not concerned,

but had not known her long enough to notice a change in her health or behaviour.

44. On 1 August, the woman went for a blood test at the doctors. That evening, she said that she was feeling sick and not herself when she collected her medication. The keyworker again advised her to make another doctor's appointment, and offered to go with her. She agreed and an appointment was made for 3 August.

45. During the appointment on 3 August, the woman explained that she had been taken to hospital shortly before coming to Preston, as she had fainted. She said that the hospital doctor had been unhappy to discharge her, but she had to return to Holloway, as the escorting officers had wanted to get back to the prison. (There is no evidence of this and her discharge letter shows she was discharged after being diagnosed with a urinary tract infection.) She said that since the hospital admission she had been feeling sick, had headaches and pain in her left shoulder.

46. During the appointment, the woman's blood pressure was taken, which was 140/90. The doctor told her that if her symptoms persisted then she would be referred for a CT scan, and she should stop taking her antibiotic and blood pressure medication because they were making her feel sick. The doctor said that she would review her on 9 August, when she was more settled at Edith Rigby House as anxiety could have been contributing to her symptoms. She was referred for another blood test as her liver test mark[3] was said to have been slightly high (the normal level is 40, hers was 70). While the keyworker and the woman were walking back to Edith Rigby House, she said that she was happy that she was being reviewed again on 9 August and that further blood tests were being done.

47. On 4 August, the woman spent the day at Edith Rigby House. The investigator spoke to a resident who had spent time with her that week. The resident told the investigator that they ate dinner together and she asked her to watch television with her. She said that she did not feel well and went to bed. The resident said that this was the last time she saw her. When the evening checks were done at 9.00pm, she was said to have been in bed. There were no recorded concerns for her that evening or overnight.

[3] Used to determine liver function. There are many reasons why results might show as high, such as infection or disease.

Events leading up to the incident

48. On 5 August, as it was a Sunday, residents were left to have a lie-in because it was a weekend. Staff check the residents at about lunchtime if they have not signed themselves out of the building before that. At 1.15pm, the assistant manager that day completed the checks. She said that the woman was snoring loudly and she asked if she was alright, but there was no response. When she looked in her room, she saw she was not wearing any clothes and she did not want to embarrass her, so left her to sleep. She was not worried and assumed she was fast asleep.

49. At 1.45pm, two members of staff agreed with the assistant manager that they should check the woman again. They then went to her room, found her still undressed on her bed and snoring very loudly. Again, they did not want to embarrass her, so left her to sleep.

50. The assistant manager was due to finish her shift, but said she did not want to go home without checking that the woman was okay. At 2.05pm, the assistant manager and another member of staff went to check on the woman. They knocked on the door and called her name, but did not get a response. They went into her room and could hear heavy breathing and a “rasping” sound, as opposed to snoring. They noticed that she had vomited and urinated. The staff told the investigator that they did not notice any vomit or urine during the previous two checks.

51. The assistant manager and her colleague pressed their personal alarms to let staff know there was an emergency. They covered the woman with a large towel and put her in the recovery position. The assistant manager went to call an ambulance and met a colleague on the stairs. She told her that an ambulance needed to be called and to do it on the wireless telephone and bring the telephone to the room. The colleague brought the telephone up to the room and gave it to the assistant manager, who spoke to the operator and followed their instructions. She was told to try and open the woman’s mouth to check that her airways were clear. She was unable to open her airway, but said that she was breathing throughout.

52. The ambulance staff arrived and took over from staff. They did their own examinations and got the woman ready to take to hospital. In the meantime, a member of staff got a copy of the woman’s medical file, medication and next of kin details ready to go with her. The assistant manager accompanied the woman to the hospital. When they got to the hospital, a doctor asked for the woman’s next of kin details, which the assistant manger gave to them. A member of staff at Edith Rigby House had already telephoned her next of kin and informed them that she had been taken to hospital and was unwell.

53. Hospital staff did various tests on the woman, including a chest X-ray and a CT scan, but she remained unconscious. At 4.50pm, hospital staff diagnosed that she had a bleed on the brain and they would monitor her for the next 24 hours. The on-call manager for Edith Rigby House then called the woman’s next of kin to update them and advised them to contact the hospital urgently.

A password was put in place for staff to be able to contact the hospital directly for updates on her. The assistant manager then left the hospital.

54. The next morning on 6 August, a staff member at Edith Rigby House telephoned the intensive care unit at the hospital for an update. They were told that there was no change in the woman's condition and her family were on their way from London to see her.

55. At 12.00pm, hospital staff contacted Edith Rigby House for further information about the woman's medical background. An assistant manager called the Healthcare Administrator at Holloway and asked for further medical information. She said that the woman had vomited and fainted in her cell on 21 July and had subsequently been taken to hospital on 23 July, and was diagnosed with a urinary tract infection. She was then discharged the following day with medication. She said that she would contact the hospital she was taken to, to ask if any details from her previous hospital admission needed to be passed on. She said the discharge summary from the woman's admission had not been scanned into her clinical record and could not be found at that time. (The discharge summary was scanned onto her clinical record on 23 July.)

56. The woman's niece telephoned Edith Rigby House at 2.21pm. She said that her aunt was not responding to medication and remained in a critical condition. She was on her way to the hospital, but the prognosis was not good.

57. The woman's family were with her, but she was still not responding to any tests. Further scans were done later that day to determine if treatment should be withdrawn. At 12.15pm, a nurse at the hospital telephoned Edith Rigby House and said that stem cell test[4] results had been negative and that staff were waiting to speak with the family about withdrawing life support. A hospital nurse rang Edith Rigby House at 3.15pm and confirmed that the woman had died.

58. The funeral was held in Preston on 24 August. The family declined the offer of staff attending the funeral and of a financial contribution to the funeral expenses, which was offered in line with national guidance.

[4] Tests used to determine the level of brain activity and if recovery is likely.

ISSUES

HMP Holloway

Clinical care

59. The woman had been suffering from high blood pressure since September 2011. Despite her blood pressure being checked on various occasions, there was no documented plan to monitor her blood pressure and she was not reviewed or examined by a doctor until July 2012, after she had fainted in her cell. Nevertheless, the clinical reviewer indicates her symptoms did not suggest that she was at risk of an acute event, such as a bleed on the brain. She makes several recommendations in her review that the Head of Healthcare at Holloway will need to consider.

60. In particular, we agree with the clinical reviewer's concerns that the woman did not have a secondary health screen. Such assessments are important and could have led to medical staff more thoroughly investigating her blood pressure and putting a care plan in place.

The Head of Healthcare at Holloway should ensure that a secondary health screen is carried out for all prisoners.

The Head of Healthcare at Holloway should ensure that care plans are implemented for all prisoners with high blood pressure.

Record keeping

61. The Nursing and Midwifery Council (NMC) is a nursing regulatory body for England, Wales, Scotland and Northern Ireland. The NMC has clear guidelines relating to record keeping. Good record keeping is an integral part of nursing, and is essential to the provision of safe and effective care. The General Medical Council has similar standards. A principle of good record keeping outlined by the NMC is that:

> "You should record details of any assessments and reviews undertaken, and provide clear evidence of the arrangements you have made for future and ongoing care. This should also include details of information given about care and treatment."

62. It was not possible to determine exactly what examinations had been done during the woman's consultations with healthcare staff at Holloway. On many occasions, specifically after she had her blood pressure taken by a healthcare assistant, there were no documented conversations with a lead nurse or doctor about her high blood pressure. There was also no documented plan of care or management of her blood pressure. We agree with the clinical reviewer that her clinical record did not support effective care and the standard of record keeping in the clinical record sometimes fell below acceptable standards.

The Head of Healthcare at Holloway should ensure that all healthcare staff follow the General Medical Council and the Nursing and Midwifery Council requirements for accurate record keeping made as close to the actual time as possible and which record clear evidence of future and ongoing care.

Edith Rigby House

Travelling to Edith Rigby House

63. The woman was released from HMP Holloway on 27 July. She had said she felt unwell during the morning and had been seen by a nurse, who could find no medical cause for her symptoms and considered her fit for release. After she had been released she felt faint and, as she was still within the grounds of Holloway, she was examined by a nurse. Again, she was considered fit to be released and was advised if she felt worse to see a GP or go to her local hospital. The clinical reviewer finds this was a reasonable judgement as she did not present with any specific symptoms.

64. Two of the woman's relatives met her from HMP Holloway and were present when she was examined by the nurse after she had been released. Her relatives were still concerned about her, so telephoned Edith Rigby House and told the assistant manager that she had collapsed outside Holloway. They were concerned about her travelling to Preston, and wanted to take her to hospital. The assistant manager sought advice from the woman's offender manager. The offender manager in turn spoke to a senior probation officer who said that if she did not arrive at Edith Rigby House by that evening, she would be recalled to prison.

65. The investigator spoke to the manager of Edith Rigby House and was assured that all staff are aware that some residents can be taken ill when released and it is not unusual for them to be taken to hospital. Residents would not be recalled to prison if they were admitted to hospital. However, that is not the advice that the woman was given and it is a concern that the message she received might have prevented her from getting medical treatment on 27 July, when she felt unwell.

Lancashire Probation Trust should ensure that offender managers and other probation staff understand that attending to legitimate health problems should not be regarded as a breach of licence conditions.

Resident checks

66. The Approved Premises Manual 2011 says that staff must "carry out regular tours of the building, including checks of residents' rooms. Tours should be conducted at all times of the day... Tours should be random, rather than on a fixed schedule, to avoid residents gaining the impression that they are being closely observed only at certain times… Checking around the AP and being

familiar with events also makes it easier to monitor the well-being of all residents, particularly those deemed to be vulnerable for any reason".

67. The woman went to bed early during the evening of 4 August and she was seen in bed when staff were doing resident checks at around 9.00pm. Staff do not make an early morning check at weekends which allows residents to have a lie-in. This meant that she was not checked until after 1.00pm on 6 August – 16 hours after the previous check.

68. When the woman was checked at 1.15pm on 5 August, staff thought she was asleep and snoring, but did not get a response. Staff went to check on her half an hour later and again thought she was asleep, but did not get a response. Staff only tried to wake her at around 2.00pm, nearly an hour after she was first checked. As staff knew that she had been unwell and the assistant manager was clearly concerned enough to check her before she finished her shift, this appears to be a long time for her to have been left. However, we also note that an earlier check would have been unlikely to make a difference to the outcome. On the first two occasions that she was checked, she was considered to have been sleeping deeply and this would undoubtedly have been the case had she been checked earlier in the morning. Nevertheless, in other circumstances staff could be alerted and timely medical assistance could be crucial.

The manager of Edith Rigby House should ensure that residents' wellbeing is checked at appropriate times of day, with particular attention to those for whom there are health concerns.

CONCLUSION

69. While her overall healthcare was satisfactory, the man's high blood pressure was not managed sufficiently well at Holloway. She was referred to hospital for investigation shortly before her release, and there was no indication that that she was seriously unwell or likely to suffer from a serious medical condition. The day she was released she felt unwell but did not seek further medical help as she was warned that she might be recalled to prison if she did not arrive at Edith Rigby House in Preston by the agreed time.

70. At Edith Rigby House the woman received good support for her health appointments. We are concerned that staff waited so long before checking her, despite knowing she had not been feeling well, but in the particular circumstances it does not appear that earlier checks would have resulted in her receiving medical treatment more quickly.

RECOMMENDATIONS

HMP Holloway

1. The Head of Healthcare at Holloway should ensure that a secondary health screen is carried out for all prisoners.

2. The Head of Healthcare at Holloway should ensure that care plans are implemented for all patients with high blood pressure.

3. The Head of Healthcare at Holloway should ensure that all healthcare staff follow the General Medical Council and the Nursing and Midwifery Council requirements for accurate record keeping made as close to the actual time as possible and which record clear evidence of future and ongoing care.

Lancashire Probation Trust and Edith Rigby House

4. Lancashire Probation Trust should ensure that offender managers and other probation staff understand that attending to legitimate health problems should not be regarded as a breach of licence conditions.

5. The manager of Edith Rigby House should ensure that residents' wellbeing is checked at appropriate times of day, with particular attention to those for whom there are health concerns.

ACTION PLAN: The Woman

No	Recommendation	Accepted/Partially accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
	Head of Healthcare				
1	The Head of Healthcare at Holloway should ensure that a secondary health screen is carried out for all prisoners.	Accepted	In March 2011 HMP Holloway Healthcare changed for the EMIS electronic medical record system to SystmOne electronic medical record system. After examining the woman's EMIS records it should be noted that she did received a second (Gruben) screen. However at that time both the first and second screen were performed on the same day (unlike now where they are done 48 hours apart). A doctor performed the first screen at 19:38 and a nurse performed the second screen at 19:31 on 28th January. Our reception process changed on 14th May 2012 and the second screen is performed within 48 hours of arrival into the prison. This is monitored and reported to the 'Contract Monitoring' meeting where we are obliged to report on exceptions. Any exceptions are sent to the Primary Care, Mental Health and Substance Misuse leads to investigate and correct. SystmOne has been set up so there is a clear system of identifying patients for a second healthcare screen when they arrive in the prison (they are immediately put on a waiting list on arrival and their name appears "RED" if they are not seen within 48 hours. Healthcare managers review the waiting list daily to ensure they are being reviewed appropriately and clinical staffs are taking appropriate actions.	Completed	
2	The Head of Healthcare at Holloway should ensure that care plans are implemented for all patients with high blood pressure.	Accepted	We have developed a care plan for patients with hypertension that is now available on SystmOne. Since the incident with the woman, our main focus has been on ensuring the care pathways for patients identified with a high 'BP reading' during first	March 2013	

			reception are clear. The Band 3 healthcare assistants (HCA) take basic observations of all new prisoners including BP. These results are documented on a band 3 nurse reception template on SystmOne. The template prompts the HCA to immediately inform the GP in reception if there are abnormal results for any basic observations or urine. We have also added in a text prompt that patients with abnormal BP should be followed up the following day with a repeat BP. This is done by sending a SystmOne task to the B3 nurses (HCA) group who will arrange for the patient to have a BP the following day. A second high reading would prompt them to send another task to the Band 3 HCA group for a third BP. Three consistently high BP's (over 140/90) will lead to automatic appointment with GP for review of the most appropriate clinical intervention. If this is lifestyle advice to manage the hypertension a follow up will be arranged at a suitable time to check BP and re-enforce appropriate behaviours (a care plan will be used for this). If medication is required a follow up appointment will be organised by the GP to monitor treatment effectiveness. The GP sessions will be reinforced with nurse led interventions (lifestyle advice, development of care plan, setting of recalls for repeat BPs). There is now also a service provided by the pharmacy team for medication review that focuses on patients with newly initiated medication that needs a review, patients on multiple prescriptions and patients in need of this service are put onto a specific waiting list. Referral to the clinical pharmacist is an option on the hypertension care plan.		

			The Hypertension Care Plan also provide links to the QoF Hypertension template to ensure appropriate read codes are entered when clinical interventions are made and this template also serves as a prompt to ensure appropriate investigations and healthcare advice are provided. We have also set up a 'Hypertension' waiting list that will be reviewed weekly by the nursing team, this will ensure anyone who appears on the 'Hypertension' QoF register will be easily identified and will be offered a care plan appointment. • Train staff to use Care Plan, hypertension waiting list, • Communication - Healthcare staff Intranet, team meetings, Hypertension Clinical pathway, • Update of clinical templates on S1 to prompt staff.		
3	The Head of Healthcare at Holloway should ensure that all healthcare staff follow the General Medical Council and the Nursing and Midwifery Council requirements for accurate record keeping made as close to the actual time as possible and which record clear evidence of future and ongoing care.	Accepted	Annual record keeping audits are done on an annual basis in all areas. Record keeping training was delivered in March 2012 to a number of healthcare staff at HMP Holloway. We encourage the use of templates and auto-consultations on S1 to ensure consistency of data entry and to make record keeping more auditable. We have a record keeping policy that all staff need to sign that they have read and understood. On the S1 consultation section there is a 'plan section' when clinical staff document the plan for their patients. The hypertension care plans we are developing have a section that reads "Refer to GP for management plan - including commencement of drug therapy, using NICE guidance" which will prompt GP's	March 2013	

			to provide details of treatment plans and reviews. Requirements around record keeping and documenting clinical management plans will be re-enforced with all clinical staff via staff notices (HC Intranet), team meetings, record keeping audits, • Amend Record Keeping Audit Tool (review documentation of abnormal results) • Complete Record keeping Audit by March 2013 • Ensure all staff have signed compliance statement for record keeping policy. • Local record keeping training event – delivered to individual teams so focus on specific needs.		
	Lancashire Probation Trust and Edith Rigby House				
4	Lancashire Probation Trust should ensure that offender managers and other probation staff understand that attending to legitimate health problems should not be regarded as a breach of licence conditions.		Lancashire Probation Trust have responded directly to the PPO		
5	The manager of Edith Rigby House should ensure that residents' wellbeing is checked at appropriate times of day, with particular attention to those for whom there are health concerns.				