Investigation into the circumstances surrounding the death of a man in hospital, in May 2008, whilst in the custody of HMP Highpoint

Report by the Prisons and Probation Ombudsman for England and Wales

April 2009

This is a report into the death of a man. He was a prisoner at HMP Highpoint, and died of natural causes in hospital. He had only spent one day in Highpoint after transferring from HMP Wormwood Scrubs.

The investigation was led by my one of my investigators. I must thank both Suffolk and Hammersmith & Fulham Primary Care Trusts (PCTs) for the appointment of two reviewers to conduct independent clinical reviews. I am also grateful to the Governor and staff of HMP Highpoint for their assistance.

I offer my sincere condolences to the man's family for their loss. One of my family liaison officers made contact with the man's family to offer them the opportunity to be involved in the investigation process. Unfortunately, a delay in receiving the clinical reviews has held up the issuing of this report, and I apologise for any distress this has caused.

The clinical reviews note that the man had some significant health problems, and show that he received broadly appropriate care whilst in prison. Indeed, one of the reviewers commends the care he received in his short time at Highpoint. There are some issues over the management of information in healthcare at Wormwood Scrubs. The clinical reviewer's report makes a number of recommendations that would improve the way records are maintained and the consequent provision of service. Wormwood Scrubs have already carried out an internal review of the care the man received and are aware of some of the failings identified in the clinical review. I hope that the Governor has implemented plans to address these shortcomings, but I nevertheless draw the clinical reviewer's recommendations to his attention.

I make three further recommendations to the head of healthcare at Wormwood Scrubs. I am pleased to note that the Prison Service have accepted these recommendations. I also draw attention to the long period during which the man was subject to physical restraints in hospital, despite the very poor state of his health. I note the Prison Service's comments in relation to this.

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Prisons and Probation Ombudsman **April 2009**

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SUMMARY

The man was serving a sentence of two and a half years imprisonment. He had a number of health problems, including a long history of ulcers (and associated stomach issues such as constipation) and diabetes. He had previously undergone a partial amputation of his left foot. At the time of his imprisonment he had been under the care of an outside hospital.

When first taken into custody, the man was held at HMP Brixton. His health problems were noted in reception and he remained in contact with the healthcare centre there until he transferred to HMP Wormwood Scrubs in November 2007. He complained on reception of chest pains and was taken straight to healthcare, where he was assessed and kept under observation. He remained in Wormwood Scrubs' healthcare centre for a week.

The man's time at Wormwood Scrubs lasted until 1 April 2008, and he was in continuous contact with healthcare. His treatment was kept under review, although at one point he was found not to be receiving his second daily dose of medication for diabetes. He was given responsibility for his own drugs as a result, despite some concern at his previous compliance with his medication. On more than one occasion he complained of stomach pains, and on 6 March 2008 he was taken to hospital for tests.

On 1 April, the man was transferred to HMP Highpoint. He was sick during the journey, and unwell at reception, and so was taken straight to healthcare. The prison doctor carried out an examination, and referred him to the local hospital. He was taken there in an emergency ambulance. He was diagnosed with a peptic ulcer, given medication, and returned to prison.

The man's condition had not improved by the following morning. He was assessed throughout the day, and in the afternoon the decision was taken to refer him back to hospital. A taxi was ordered, but before it arrived he was found lying on the floor of his cell. Once again, an emergency ambulance was summoned and he was taken to hospital.

The man thereafter remained in hospital. Healthcare staff at Highpoint maintained daily contact with hospital staff, but his condition did not improve sufficiently for him to return to prison. By early May, he was on a life support machine. The prison had begun the process to apply for compassionate release to allow the man to go to a hospice. However, on 6 May before this process was complete, doctors decided that there was no further treatment they could provide. The man's family gathered at his bedside and his life support machine was switched off. He died that evening.

THE INVESTIGATION PROCESS

1. My investigator visited Highpoint and spoke to the staff who had cared for the man. He interviewed three members of staff. The interviews were recorded and the transcripts are attached to this report. Notices were posted to staff and prisoners about the investigation inviting their contributions, but none was received.

2. In addition, my investigator studied all relevant prison records relating to the man. They included his main prison record, medical records and statements made by staff. He visited the healthcare centre, including the areas where he spent his brief time in Highpoint.

3. Suffolk Primary Care Trust (PCT) identified an independent healthcare consultant to carry out a review of the man's clinical care. I am grateful to her for undertaking this review. In addition, Hammersmith and Fulham PCT commissioned a review of the man's medical care in Wormwood Scrubs. This review was conducted by another clinical reviewer, to whom I am equally grateful. My investigator discussed aspects of the man's care with healthcare staff at Highpoint and with both clinical reviewers.

4. I wrote to HM Coroner for Suffolk to inform him of the nature and scope of my investigation. A copy of the post mortem report was made available to me. Upon completion, my report will be sent to the Coroner to assist in his enquiries into the man's death.

5. One of my family liaison officers contacted the man's daughter at the beginning of the investigation and offered the opportunity to raise questions and concerns for us to consider. His wife had asked whether he received medical attention in good time. When his family had visited him in Wormwood Scrubs, he had complained of being in pain but said that no action was taken despite his reporting it to staff. I hope that the quality and level of his contact with healthcare staff is reflected in my report, and help address the family's concerns. A copy of my report will be made available to the man's family on completion, and it will be translated into his wife's first language.

HMP HIGHPOINT

6. HMP Highpoint is located at Stradishall, about 13 miles from Bury St Edmunds in Suffolk. Originally split into north and south sites, the north site is now a separate prison called HMP Edmunds Hill. Highpoint holds sentenced adult male prisoners with a security category of C or below.

7. The healthcare centre is staffed between 7.30am and 8.00pm Monday to Friday and 8.00am and 5.00pm at weekends. There are between three and five members of staff on duty. A doctor covers both Highpoint and Edmunds Hill and attends each prison on a surgery basis between the hours of 9.00am and 5.00pm. If a doctor is required outside those hours, the local on-call service is used.

Previous deaths at Highpoint

8. This is the fourth death at Highpoint I have investigated since I took over responsibility for all such investigations. None of the circumstances of the previous three deaths is relevant to the death of the man who is the subject of this report.

HM Chief Inspector of Prisons' reports

9. The most recent report published by HM Chief Inspector of Prisons on Highpoint is that on an announced inspection in May 2007. None of the issues raised in the report touches upon this investigation.

10. The most recent inspection report on Wormwood Scrubs followed an unannounced inspection in June 2008. It does not contain any issues which are of relevance here.

Independent Monitoring Board (IMB) reports

11. Each prison in England and Wales has an Independent Monitoring Board responsible for monitoring day-to-day life in the prison and to ensure that proper standards of care and decency are maintained. The most recent annual reports published by the IMBs for Highpoint and Wormwood Scrubs do not raise any issues relevant to this investigation.

Prisoner transfers

12. Regulations for prisoner transfers are contained in Prison Service Order (PSO) 1025. This PSO introduces the Prisoner Escort Record (PER) and is designed to ensure that, when a prisoner is moved between prisons (or other external destinations), those responsible for him/her are made aware of any risks or vulnerabilities. A PER form must be completed for every external movement, highlighting the known risks: medical, security and other. PSO 1025 says that healthcare staff at the dispatching prison must sign the PER form to show that they have considered medical risks. The form contains a “First Aid Given” box

which must be ticked to indicate if the prisoner has been given first aid for any reason before leaving the prison.

13. Once the prisoner is being moved, escorting staff must maintain a record of events on the PER form. If incidents occur, they must be highlighted so prison staff at the receiving jail are aware of any risks and vulnerabilities.

14. Regulations for continuity of healthcare for prisoners are contained in PSO 3050. This PSO notes that, when prisoners are being transferred, current healthcare needs should be assessed to ensure continuity of care. Written guidelines should include the identification of physical problems. The PSO goes on to say that “local policies should ensure that there are systems in place to ensure appropriate and continuing clinical care in any transfer or release”.

KEY FINDINGS

15. The man was remanded into custody at HMP Brixton on 31 August 2007, following an appearance first at the Magistrates Court and then at the Crown Court. The notes of his reception health screening at Brixton refer to his diabetes, an allergy to penicillin, and that he had previously had a partial amputation of his left foot. On 7 September, to assist with any application for bail, his doctor wrote a letter indicating that he was not a well man and detailing his ailments.

16. A charge of robbery was laid against the man on 6 November. On 12 November, following an appearance at the Crown Court, he was transferred to HMP Wormwood Scrubs.

17. On reception, the man was given a medical screening. He complained of chest pain, and pain in his foot. The chest pain was not radiating (had it been so this might have indicated problems with his heart), and he was not thought to be at imminent risk of becoming seriously ill. He was nevertheless taken from reception directly to the healthcare centre for observation. The following day, the prison doctor wrote to an outside hospital urgently referring him for tests. There is no indication in the records as to whether this referral was followed up.

18. Having complained of light-headedness, the man was assessed by healthcare staff on 14 November. He was discharged from healthcare onto normal location five days later but was to attend the healthcare centre each morning, at mid-day and again in the afternoon, to get his medication.

19. The man continued to have contact with the healthcare department for his health issues, including podiatry and diabetes. On 23 November, he told staff that he had not been receiving his second daily dose of medication. At this point he was given the medication to hold in his own possession. He also told staff that he had had four endoscopies (internal examinations using a thin, flexible telescope to view the inside of the stomach) at an outside hospital, and was awaiting a further appointment in connection with his foot. He was asked to obtain a letter from the hospital about this. He saw the diabetes nurse consultant on 6 December. His diabetes had been poorly controlled and the nurse found that, despite having had diabetes for some time, he had no understanding of the condition. (He had, for example, declined medication on 17 November, claiming to be “fed up”.) A further review was planned for the following month. However, the records do not show any note of this review. The clinical reviewer contacted the diabetes nurse consultant who confirmed that the man refused to attend the further review.

20. Solicitors representing the man wrote to the prison doctor on 6 December 2007 expressing concern that their client was not receiving full medication. The healthcare department responded on 18 December to say that they only provided medical reports requested by the courts. They pointed out that the solicitors could arrange for an independent examination of the man if they so wished. The records do not show if the solicitors followed this up.

21. On 13 February 2008, the man appeared at the Crown Court. He was sentenced to two years and six months imprisonment.

22. The prison doctor was called to see the man at 8.30am on 6 March. He had suffered abdominal pain since the previous day, and vomited twice. The doctor referred him to hospital to be assessed for pancreatitis and a gastric ulcer, and he was taken to hospital at 4.00pm. He returned to Wormwood Scrubs later that day. His prisoner medical record does not contain a discharge summary from the hospital.

23. After the man experienced further abdominal pain, healthcare staff were called to see him again on 8 March. The prison doctor examined him and prescribed medication to treat constipation. The medical record asks for blood tests to be carried out the following Monday to exclude pancreatitis. The records do not show whether these tests were carried out.

24. As part of his sentence progression, the man was transferred from Wormwood Scrubs to Highpoint, a category C (lower security) prison, on 1 April 2008. His personal medical record contained an entry declaring him “fit for transfer”. The medical section on the Prisoner Record Escort (PER) form completed before he left Wormwood Scrubs was ticked to show “no known risk”. The box to indicate whether the prisoner has been given any first aid before leaving the prison was left empty.

25. The transfer vehicle left Wormwood Scrubs at mid-day. The PER form shows that at 1.10pm the man complained of feeling sick. Staff gave him some water, and provided sick bags. He was checked at 1.25pm and had been sick. He told escort staff he now felt better. The PER form shows that he was checked again at 1.55pm and at 2.15pm. On both occasions he was noted as being “ok”.

26. The transfer vehicle arrived at Highpoint at 2.25pm. All prisoners are given an initial health screening on arrival, and the man was seen by a nurse. The initial health screening nurse was sufficiently concerned at the man’s appearance to contact the healthcare centre. He spoke to his nurse colleague and arranged for him to be taken to healthcare for assessment. He made a note that the man claimed he had not been taking his medication prior to transfer, although he did not give a reason why. His reception papers also noted his diabetes and that he had had a stomach ulcer five years previously.

27. Having spoken to the initial health screening nurse, the nurse colleague was working in one of the offices in the healthcare centre whilst the man was brought across. This was at approximately 4.00pm. When he arrived in the healthcare centre, the nurse colleague could see him along the length of the corridor. She was so concerned at his apparent frailty that she went straight to help him in to see the doctor. She did not think he looked well enough to wait in the waiting room.

28. Once the nurse colleague had helped him onto the examination couch, the man told her that he had been unwell before leaving Wormwood Scrubs. He said that he had told staff he felt sick and that he did not want to get on the vehicle. He

said that they gave him some liquid, told him it would stop him from being sick, and that he should get on the vehicle. He said that the liquid had not worked. He told the nurse colleague this while she was carrying out nursing observations (such as checking his blood pressure and temperature). She had not received any documentation to support his version of events and so had to rely on his word. She told my investigator in interview that, bearing in mind his condition when she saw him, she thought it likely that he would have been unwell before travelling.

29. The doctor on duty that day examined the man. He told her that he had run out of Lansoprazole (a medicine used to treat problems with stomach acids or peptic ulcers), and had not taken any since 48 hours before his transfer. He said that he had told staff that he had run out.

30. The nurse colleague, the doctor on duty and the healthcare manager discussed the man's care. As Highpoint does not have night-time nursing cover, they concluded that he should be in hospital. Although he was stable, the doctor on duty was concerned at the waiting time for a standard transfer to hospital and so called an ambulance. The nurse colleague remained with him until the paramedics arrived, and he was taken to the outside hospital in an emergency ambulance at 5.05pm. In hospital he underwent x-rays and blood tests. He was diagnosed as having a peptic ulcer and was discharged. He returned to Highpoint at 11.15pm. On his return to Highpoint, the man was located in the segregation unit where he could be observed through the night. Although clearly not desirable, I judge this was the best that could be done in the circumstances.

31. The following morning (2 April), the man was still presenting as unwell. He was taken to the healthcare centre for monitoring, and the initial health screening nurse referred him once again to the doctor. He was still vomiting, so the doctor on duty prescribed medication and asked for him to be kept under observation. He remained in the healthcare centre until shortly before mid-day. He was judged to be clinically stable, so was moved to a cell on the induction wing unit with instructions for him to continue to be monitored there by nursing staff. On the way from the healthcare centre to the wing, he collapsed and continued to vomit. He had to finish the journey in a wheelchair.

32. At 2.30pm, the man was seen by a Sister, the Acting Health Services Manager. At 3.00pm, he was reviewed by the Sister and his condition was seen to be worsening. The Sister discussed this with the doctor on duty and they agreed that the man needed to be returned to hospital. The doctor on duty telephoned the outside hospital to re-refer the man and express dissatisfaction that he had been discharged the previous day. A taxi was ordered at 3.50pm, but at 5.20pm it had still not arrived. The records do not show whether he was monitored between these times, but at this point the staff nurse went to the man's cell and found him lying on the floor. An emergency ambulance was summoned and he was taken to hospital. He was admitted to the Intensive Care Unit and underwent emergency surgery for a perforated ulcer.

33. When a prisoner from Highpoint is in hospital, there is daily contact between the hospital and the healthcare centre. The man's family were informed that he was

in hospital on 3 April. They were told where he was and given contact details. They were given authorisation to visit (required as part of the security risk assessment for prisoners in hospital) and arrived at the hospital later that day.

34. Prison security measures also meant that two prison officers were always with the man in hospital. This is known as bedwatch. My investigator spoke to two of the officers who spent time on bedwatch with him while he was in hospital. They both said that, while he was in hospital, staff had little interaction with him owing to his condition and to the breathing and other medical equipment around him. He was not able to move other than occasionally getting from his bed to a chair next to it. On 20 April, after he had been in hospital for over two weeks, it was agreed that physical security restraints (handcuffs or other chains) should not be routinely applied whilst he was in the Intensive Care Unit.

35. Records indicate that the man's condition initially seemed to slowly improve whilst in hospital. From 15 April he was to be weaned off the ventilator, but problems with his blood pressure meant that he had to continue to use it. By 25 April, his condition was noted to be deteriorating. His wound had re-opened and at one stage he had had to be taken back to the operating theatre.

36. As the man was seriously ill, prison staff at Highpoint began the process to apply for him to be released on compassionate grounds. They thought that it might be possible for him to be transferred to a hospice, and began to compile the necessary documentation.

37. The bedwatch officers with the man on 6 May 2008 arrived at the hospital at approximately 7.45am. The officers who had been on duty overnight gave them a handover briefing. It was in this briefing that they learned that medical staff had agreed to turn off the life support machine that day. One of the bedwatch officers informed the duty governor at Highpoint.

38. The man's wife was at the hospital, and asked the doctor if they would leave the machines on until the rest of his family could make their way to the hospital. The doctor agreed and the rest of the family arrived in the early afternoon. I am pleased to note that, during this difficult time for the family, the prison officers stood to one side and made themselves as unobtrusive as possible. This displayed a degree of sensitivity that reflects well on the Prison Service and which I hope the family found appropriate.

39. The life support machines were switched off at 4.21pm. At this point the officers withdrew from the room and waited nearby. At 7.05pm, the man was pronounced dead. At approximately 7.30pm, a nurse came and told the bedwatch officers that he had died.

40. One of the bedwatch officers telephoned the duty governor and informed him of the man's death. The duty governor asked the bedwatch officer if any support was needed, then said that the officers could leave the hospital. The second bedwatch officer went straight home, and the bedwatch officer who made the call, went back to Highpoint to return the prison equipment before she too went home.

41. After a death in custody, a debrief is usually held on the same day to ensure that staff involved have an opportunity to discuss any issues arising. In addition, a critical incident debrief may be carried out within five to ten days in order to give staff an opportunity to understand the circumstances in greater detail, review their thoughts and feelings, and to help with the reactions some people may experience after being involved in a traumatic incident. No debriefs were held following the man's death. However, both bedwatch officers were offered support at the time and subsequently.

42. The prison appointed a family liaison officer, who remained in contact with the family to offer ongoing support. The prison assisted the family with the funeral costs.

Post mortem report

43. The post mortem examination was carried out on 6 May 2008. The conclusion was that the man had died from natural causes. The cause of death was given as:

1 (a) multi-organ failure
(b) intra-abdominal sepsis
(c) perforated gastric ulcer

2. type II diabetes mellitus
peripheral vascular disease.

ISSUES

Clinical care

44. The man undoubtedly suffered from serious health problems. He had previously had a partial amputation of his left foot. He had a history of duodenal and gastric ulcers going back several years, and had suffered badly from constipation. He was in constant contact with the healthcare departments of the three prisons where he was held.

Wormwood Scrubs' report into the man's care while in custody there

45. An undated care plan in the man's record shows that, following his admittance to hospital, Wormwood Scrubs were notified "re treatment at discharge". The head of safer prisons at Wormwood Scrubs, instigated a review of the man's care until he transferred to Highpoint. Between 23 and 28 April, the head of safer prisons was in correspondence with staff at Highpoint to obtain the necessary documentation to carry out the review (which was conducted by one of the healthcare managers).

46. The review notes that although the man told staff at Highpoint that he had complained of abdominal pain on a number of occasions, his medical records do not include any complaints after 8 March. There is no indication from the file that he complained of pain on the day of his transfer to Highpoint. He had been seen by a doctor in healthcare for abdominal pain on two occasions.

47. The review says that it is uncertain whether the referral to hospital was followed up. There is no clear policy for following up referrals. The review also points out that the records do not make apparent what issues were considered when the man was certified as fit to transfer to another prison. Because there is no clear policy on what should be considered in these circumstances, it is not certain what checks were made on him. In relation to his having told staff at Highpoint that he had not received his medication for 48 hours prior to his transfer, the review notes that he was issued with a 28 day supply to hold in his own possession on 19 March.

Clinical review into the man's care in Wormwood Scrubs

48. The clinical review addresses the man's time in Wormwood Scrubs. The man had complained of chest pain on reception, and was housed in the healthcare centre for observation. He further complained of chest and epigastric (stomach) pain on 6 March and on 8 March. This pain was found to be caused by constipation. He had been taken to hospital on one of these occasions.

49. The review notes that the man's blood sugar control had been problematic for some time. Medications were adjusted on several occasions to improve the levels. At one point he had not been receiving the correct dosage, and he was subsequently given control of his own medication (known as in-possession medication). However, the review also notes some evidence that he did not always comply with his medication, having refused medication in November 2007

and refused to attend a review with the diabetic nurse consultant in January 2008.

50. When the man was taken to hospital on 6 March, no discharge information was obtained by the prison. Discharge summaries contain valuable information, and should be obtained from external healthcare providers.

51. The clinical reviewer makes a number of recommendations which would improve the management of healthcare in Wormwood Scrubs. The recommendations cover assessment screening, management of medications, assessments prior to transfer, medical information from external agencies, and record-keeping. The review does conclude, though, that none of the deficiencies identified directly related to the man's death.

52. Having told healthcare staff in Wormwood Scrubs that he had been attending an outside hospital in relation to his stomach problems, the man was asked to obtain a letter from the hospital. This was in relation to his foot, and did not play a part in his death. Nevertheless, whilst prisoners are in custody they have far less autonomy to do such things than ordinary patients. Their health is in the hands of the prison's medical system, and in this case staff in the healthcare centre should have made efforts to obtain the necessary information from the hospital themselves.

53. Staff in Wormwood Scrubs did have concerns about the man's compliance with his medication. Despite this, he was at one point given responsibility for maintaining his own medication. He received a good level of observation from healthcare staff, but the papers do not make it clear whether a risk assessment was carried out as to whether it was safe to let him hold his own medication.

54. The man's solicitors raised concerns with the prison doctor that he was not receiving his full medication. This may have referred to the period in November when he had not been receiving his second daily dose of medication for his diabetes. The prison's response simply stated that the prison was only obliged to provide medical reports requested by the courts. His records do not show whether there was a good reason to respond in such stark terms, but this reply seems inadequate and unnecessary in view of the fairly simple point made. The records do not show if the solicitors followed it up. I understand that there are sensitivities about the release of medical information, but in my view it would have been reasonable for the prison to have supplied some information relating to the man's care. I do not make a formal recommendation, but healthcare at Wormwood Scrubs may wish to consider whether such a response was appropriate and to learn the lessons therefrom.

55. The day after the man arrived at Wormwood Scrubs, the prison doctor wrote to another outside hospital urgently referring him for tests. This referral does not seem to have been followed up. In this case it does not seem likely that this had an effect on the man's prognosis. However, in other cases it might make a considerable difference to the treatment and ongoing care of a prisoner.

Recommendation: The head of healthcare at Wormwood Scrubs should consider putting in place a system of monitoring referrals to outside health agencies to ensure that all referrals are acted upon.

56. When the man was taken to hospital on 6 March, no discharge information was obtained by the prison. Once again, this does not seem likely to have made a great difference in this case but could do so in others.

Recommendation: The head of healthcare at Wormwood Scrubs should consider putting in place a system to ensure that discharge information is obtained whenever prisoners are referred to outside health agencies.

57. The clinical reviewer makes several recommendations to improve the management of healthcare in Wormwood Scrubs. Her review concludes that none of the deficiencies directly related to the man's death. As a consequence, I do not repeat all of the recommendations here but bring them to the attention of healthcare manager of Wormwood Scrubs. However, I would fully concur with the recommendation that the decision-making process leading to prisoners being assessed as fit for transfer must be documented in the prisoner's medical record.

Recommendation: The head of healthcare at Wormwood Scrubs should ensure that the decision-making process in assessing prisoners as fit for transfer is documented in the medical records.

Clinical review into the man's care in Highpoint

58. The review addresses the man's care from his arrival at Highpoint until his death. The reviewer has found that prison and healthcare staff showed concern and care of the highest order for the brief period that the man was in Highpoint. He was assessed on reception and taken directly to hospital. When returned from hospital he was kept under observation. The following day, when he was found to be seriously ill, he was immediately referred once again to hospital. When there were delays with the taxi due to take him there, and his condition worsened, an ambulance was summoned urgently.

Other matters

59. I note that the bedwatch officers said that staff had little interaction with the man because of his condition, and that he was not able to move other than occasionally getting from his bed to a chair next to it. So far as I can see, it was over a fortnight before it was agreed that physical security restraints should not be routinely applied. I understand the culture of risk aversion that surrounds decisions about the use of restraints, but question whether he could not safely have been released from restraints earlier. I have chosen not to make a formal recommendation, but invite the Governor to consider this matter with his senior management team in light of this report. (The Prison Service have responded to this and the response is on page 18.)

60. No hot debrief was held for staff in the light of the man's death. The death of a prisoner can be a traumatic experience for staff as well as for fellow prisoners. I

note that both officers who were on bedwatch with him on the day he died were offered support, both at the time and subsequently. As he had spent such a short period of time in Highpoint, and as his death occurred after a significant stay in hospital, I do not feel that the lack of a debrief in this instance was unreasonable.

Conclusion

61. The man came into prison with a number of health problems. Throughout his time in custody he was in contact with prison healthcare, and his medication was kept under regular review. The clinical reviews of his time in Wormwood Scrubs and Highpoint respectively both find that he received the care he required. However, there are some issues around the management of information in the healthcare department in Wormwood Scrubs which were identified in the prison's own review, and in the clinical review. I make three recommendations based on the information contained in the reviews, but I would also draw the attention of the Governor of Wormwood Scrubs to the full list of recommendations in the clinical reviewers report. I also invite the Governor of Highpoint to consider whether restraints were applied for too long to the man given the state of his health.

RECOMMENDATIONS

The head of healthcare at Wormwood Scrubs should consider putting in place a system of monitoring referrals to outside health agencies to ensure that all referrals are acted upon.

The Prison Service have accepted this recommendation. They comment that Healthcare are awaiting the implementation of the clinical information system which will assist with identifying and tracking referrals.

The head of healthcare at Wormwood Scrubs should consider putting in place a system to ensure that discharge information is obtained whenever prisoners are referred to outside health agencies.

The Prison Service have accepted this recommendation. They say that Healthcare are working on a template for the discharge information from hospitals, and have met with at least one of the hospitals where they regularly send patients.

The head of healthcare at Wormwood Scrubs should ensure that the decision-making process in assessing prisoners as fit for transfer is documented in the medical records.

The Prison Service have accepted this recommendation. They say that the “fit for transfer” documentation is currently being reviewed.

The Prison Service have also responded to my comments in paragraph 61. I invited the Governor to consider whether the man was kept in restraints whilst in hospital for longer than he might have been. The Prison Service say that the prison received daily updates saying that his condition was improving. Therefore, on a daily basis a discussion amongst senior managers took place regarding the level of restraint required. Every prisoner is individually risk assessed for the appropriate levels of restraints when they have an external appointment or stay. The man was unknown to the prison, which made undertaking a full risk assessment difficult. Once his condition deteriorated arrangements were made for the removal of restraints.