# Investigation into the death of a man at HMP Preston in January 2010

**Report by the Prisons and Probation Ombudsman for England and Wales**

**March 2011**

This report considers the circumstances surrounding the death of the man at HMP Preston on 1 January 2010. The man was found collapsed in his cell at 9.40am. He was 48 years old. A post-mortem examination found that he died from bronchopneumonia (inflammation of the walls of the airways) caused by chronic obstruction pulmonary disease (COPD). This is a chronic respiratory condition that results in the narrowing of the airways.

I offer my sincere condolences to all those who knew the man.

The investigation was conducted by one of my investigators on my behalf. I would like to thank the governing Governor for his co-operation. I also extend thanks to the liaison for the Ombudsman's office. In addition, I thank the clinical reviewer who conducted a review of the man's clinical care. I apologise for the delay in issuing my report.

The man was remanded into custody in 1995, and sentenced to life imprisonment in 1997. He spent time at HMP Holme House, HMP Durham and HMP Wormwood Scrubs, before transferring to HMP Garth in April 2003. He remained at Garth until 24 December 2009, eight days before his death, when he moved to Preston.

This is the fourth death from natural causes at Preston since 2004, when the Ombudsman's office began investigating all deaths in custody. I have looked into various aspects of the man's clinical care, and I endorse four recommendations made by the clinical reviewer.

The 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

**Jane Webb**
**Acting Prisons and Probation Ombudsman** **March 2011**

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## SUMMARY

The man was remanded to HMP Holme House in July 1995. He transferred to HMP Durham, and then to St Nicholas Hospital in Newcastle for psychiatric assessment, in 1996. After being sentenced to life imprisonment for murder, he returned to Holme House, and in January 1997 he transferred to HMP Wormwood Scrubs. In May 1999, the mental health team at Wormwood Scrubs noted that he displayed odd, psychotic behaviour. One year later, in May 2000, he transferred to the prison's mental health observation unit. He moved to St Nicholas Hospital under the Mental Health Act in January 2001, but returned to Wormwood Scrubs in April 2002.

The man suffered an asthma attack in September 2002. This was his first recorded asthma attack in a prison setting. In April 2003, he transferred to HMP Garth. Two years later, he suffered his first serious episode of breathing difficulties. Over the next six months, he became short of breath on numerous occasions. He spent time in the prison's healthcare unit as well as in outside hospital, and was treated for asthma.

During 2006, he continued to experience shortness of breath, and was eventually diagnosed with chronic obstructive pulmonary disease (COPD), a chronic respiratory condition that results in narrowing of the airways. It is not easily reversible, often becomes progressively worse over time, and most commonly results from smoking. He was advised to stop smoking but refused to do so.

Episodes of shortness of breath continued in 2007. In June and July he spent time in hospital, and was prescribed antibiotics for an infection which was exacerbating his asthma and COPD. There was little of note in his clinical record between July 2007 and January 2009. It is possible that during this period his health was more stable and he was less prone to attacks. In April 2009, he was found to be very breathless in his cell. The nurse who attended noticed that the cell was very smoky. He was advised about smoking and the effects that it was having on his health, but when the nurse returned a few minutes later, he was found to be smoking again. The man also saw a respiratory consultant in April.

In August, the man again saw a respiratory consultant. He told the consultant that he had stopped smoking three months earlier and that his breathing was well controlled. A doctor from the prison raised concerns that the consultant had not fully understood the true clinical picture. The man saw the consultant again in October; he was advised to stop smoking and referred to a smoking cessation service. He also had a chest X-ray and was referred to a chest physiotherapist.

The man was seen by a doctor at Garth on 3 November, when he presented with shortness of breath. On 18 November, he was admitted to hospital and stayed there for five days before being discharged. He spent six nights in hospital after being admitted on 5 December. After his return to Garth on 12 December, the man was reviewed and assessed as stable. Ten days later, he was seen by a physiotherapist. On 24 December, he transferred to HMP Preston under a regional protocol for prisoners requiring more comprehensive medical care. He was accommodated in the healthcare unit and appeared to settle well. Medical staff noted no concerns

between 24 and 30 December. He was reviewed by the first prison doctor on 31 December, when he reported no concerns and said he was feeling well.

In January 2010, he was found collapsed in his cell. Members of healthcare staff checked for signs of life and began cardio-pulmonary resuscitation (CPR). This continued when paramedics arrived, but the efforts were unsuccessful, and he was pronounced dead at 10.28am.

A post-mortem examination found that the man died from bronchopneumonia (inflammation of the walls of the airways) caused by COPD.

In conjunction with the clinical reviewer, I have investigated various aspects of his medical care, including chronic disease management, smoking cessation, care planning, clinical records, the transfer to Preston and the use of a defibrillator (a piece of medical equipment that monitors a patient's heart rhythm and administers a shock if necessary). I endorse four recommendations made by the clinical reviewer.

## THE INVESTIGATION PROCESS

1. One of my senior investigators opened the investigation on 4 January 2010. Upon visiting HMP Preston, he met the liaison officer for the Ombudsman, who facilitated access to all of the records regarding the man's period in custody, including his clinical record. My investigator also met the deputy governor, the acting head of healthcare, Chair of the Independent Monitoring Board (IMB) and a member of the Prison Officers' Association (POA).

2. One of my family liaison officers (FLOs) wrote to the man's mother to explain the purpose of the investigation and offer the family the opportunity to raise any questions or concerns. The man's family raised no issues of concern at the outset of my investigation. They were also offered the opportunity to receive and comment on the draft version of this report. However, to date they have chosen not to do so. I hope that the findings of my investigation answer any questions they may have had, should they review the report in the future.

3. Central Lancashire Primary Care Trust (PCT) appointed a clinical reviewer to conduct a review of the man's clinical care whilst in custody. (The purpose of a clinical review is to examine the medical care that a prisoner received whilst in custody, which should be of an equivalent standard to what might have been expected in the community.) His findings are summarised in this report and the full clinical review is included as an annex.

4. During the course of the investigation, my investigator conducted recorded interviews with six members of Preston's staff. Transcripts of these interviews were produced.

5. My office disclosed the clinical reviewer's clinical review to the healthcare manager at HMP Garth. The head of Prison Health for NHS Central Lancashire, wished to make representations about the content of the clinical review. The clinical reviewer was unavailable to liaise with her and so she provided her comments directly to my investigator. These have been incorporated into this report. She also supplied her own root cause analysis into the man's death, which is included as an annex.

## HMP PRESTON

6. HMP Preston has a maximum operational capacity of 800. It serves courts from north-west England and holds remanded, unsentenced and convicted adult male prisoners. In addition to standard residential location, the prison has units for induction, drug dependency, vulnerable prisoners, segregation and reintegration.

7. Healthcare at Preston is provided by Central Lancashire Primary Care Trust (PCT). The healthcare unit has inpatient facilities for prisoners with mental health needs and those with physical health problems. The inpatient beds are a regional facility that can be used by prisoners from other north-west prisons, should they require comprehensive healthcare support. The other prisons involved in the regional programme are Garth, Wymott, Haverigg, Lancaster, Kirkham, Buckley Hall and Risley. Referrals are made by clinical staff from these prisons, after which staff from Preston visit prisoners and decide whether to accept them. Decisions are reached based on clinical need.

### Performance

8. The Ministry of Justice produces quarterly performance figures for all prisons in England and Wales. Every establishment is given a rating between 1 and 4 based on 34 agreed performance indicators (a rating of 1 indicates serious concerns about performance, whereas a rating of 4 means exceptional performance). For quarter 3 of 2009-2010 (October, November and December 2009) Preston received a rating of 3, indicating good performance. The most recent figures available at the time of writing are for quarter 4 of 2009-2010 (January, February and March 2010), at which time Preston maintained its rating of 3.

9. HM Chief Inspector of Prisons inspected Preston in August 2009. Her report found that the prison was performing reasonably well despite managing “a wide range of transient, needy and sometimes difficult prisoners in conditions largely designed and built in the 19th century”.

### Previous deaths at Preston

10. The Ombudsman’s office has been responsible for investigating deaths in custody since April 2004. Prior to the man’s death, three prisoners have died from natural causes whilst in the care of Preston. Two of these deaths were from peritonitis and one was from pneumonia. There are no similarities between the previous deaths and that of the man.

## KEY FINDINGS

### July 1995 – April 2002

11. The man was remanded to HMP Holme House on 1 July 1995. In early 1996, he was transferred to HMP Durham and then to St Nicholas Hospital in Newcastle for psychiatric assessment. He was assessed as suffering from a paranoid psychotic illness, but denied that he was mentally ill. Having been sentenced to life imprisonment for murder, he man returned to Holme House. On 15 January 1997, he was transferred to HMP Wormwood Scrubs.

12. In May 1999, the mental health team at Wormwood Scrubs noted that the man displayed odd, psychotic behaviour, and by April 2000 mental health professionals thought there was evidence that he was suffering from an untreated mental illness. On 20 May 2000, he was transferred to the mental health observation unit in Wormwood Scrubs.

13. On 31 January 2001, the man was transferred to the St Nicholas Hospital in Newcastle under Section 47 of the Mental Health Act. Section 47 provides for sentenced prisoners to be transferred to a hospital for treatment. He was thought to be suffering from schizophrenia and psychosis. In addition to the mental health concerns, he was also diagnosed with asthma during his time at the hospital. In April 2002, he returned to Wormwood Scrubs after being deemed well enough to return to a prison setting.

### September 2002 – January 2009

14. On 23 September 2002, a note was made in the man's clinical record that he had suffered an asthma attack. Although he had been diagnosed with asthma whilst in the St Nicholas Hospital, this was his first recorded asthma attack whilst in a prison setting.

15. In April 2003, the man was transferred to HMP Garth. Two years later, on 3 May 2005, he suffered his first serious episode of breathing difficulties. An entry in his clinical record notes that he was short of breath, cold and clammy, and had low blood pressure. He was admitted to Chorley District Hospital where he remained for two days, before returning to Garth on 5 May.

16. The man suffered shortness of breath on 24 October. A note in his clinical record stated that although he had been prescribed an inhaler by this point, he had not used it for several days prior to him feeling unwell. In December, The man again felt unwell and struggled to breathe. He was transferred to the healthcare unit within the prison for overnight observation, and treated with a nebuliser (a piece of medical equipment used to administer medication in the form of a mist inhaled into the lungs). He was prescribed a five-day course of Prednisolone, a corticosteroid medication often used in the treatment of asthma.

17. On 10 January 2006, the man again suffered shortness of breath. On 24 January, he commenced nicotine replacement therapy using patches.

18. Between February and August, the man suffered from six separate episodes involving the familiar symptoms of him struggling to breathe. In July, the first prison doctor noted in the clinical record that the man's "asthma [is] uncontrolled, patient refuses to stop smoking". On 17 August, Prednisolone was prescribed on a long-term maintenance basis rather than as a short course, and a referral was made to a respiratory physician.

19. Following the referral, the man suffered three further incidents involving shortness of breath. He saw a respiratory physician at Chorley District Hospital on 21 September, but suffered three more episodes by November.

20. On 10 December, following tests at the hospital, he was diagnosed with chronic obstructive pulmonary disease (COPD). This is a chronic respiratory condition which results in narrowing of the airways, limiting the flow of air to and from the lungs. It is not easily reversible, often becomes progressively worse over time, and most commonly results from smoking. Despite being advised to stop smoking, he refused to do so.

21. The man was again admitted to Chorley District Hospital on 5 January 2007, and was discharged two days later after a diagnosis of and treatment for acute exacerbation of asthma with COPD. He suffered four further episodes between February and June, though none of these resulted in hospitalisation.

22. On 16 June, the man experienced severe shortness of breath and was taken to hospital by emergency ambulance. He was initially admitted to the medical assessment unit and then transferred to the intensive care unit (ICU), where he spent the next 24 hours. He was then moved to a general ward and, five days later, on 22 June, discharged from hospital to the healthcare unit at Garth. The man was admitted to hospital again on 10 July, and returned to the prison on 13 July. During his time in hospital he was prescribed antibiotics as a result of an infection exacerbating his asthma and COPD.

23. Little of note was recorded in the man's clinical record between July 2007 and August 2008. Between August 2008 and January 2009, there is no information at all about his physical health. It is possible that he was more stable and less prone to attacks during this time.

**April 2009 – January 2010**

24. On 7 April 2009, the man was found to be very breathless in his cell. The nurse who attended noticed that the cell was very smoky. The man was advised about smoking and the effects it was having on his health. However, when the nurse returned to his cell with a nebuliser, he was found to be smoking again.

25. A note was made in the man's clinical record on 22 June that he had seen a respiratory consultant in April, but a follow-up letter had not been received. There was also concern about the man's prescription medication, in particular the high dose of Prednisolone that he had been using for a prolonged period.

26. The man was seen at Chorley District Hospital on 13 August by a respiratory consultant. The man told the respiratory consultant that he had stopped smoking three months previously and that his breathing was well controlled under his medication. On 9 September, a second prison doctor from Garth raised concerns about the man's medication and whether the respiratory consultant had fully understood the true clinical picture. Five days later, the doctor referred the man back to the respiratory consultant with particular concerns about his medication.

27. The man attended the respiratory consultant's chest clinic on 12 October. He was advised to stop smoking and referred to a smoking cessation service. His Prednisolone medication was also changed to a reducing course. The dosage was halved for three days, halved again for another three days, and then would cease completely. A chest X-ray was undertaken, and the man was referred to a chest physiotherapist.

28. The man was again seen by the second prison doctor on 5 November due to shortness of breath. He was prescribed a 30mg daily dose of Prednisolone for five days. This was a higher dosage than he had been prescribed before the reducing course 18 days earlier, though it was for a short period rather than on a long-term basis.

29. On 18 November, the man was referred to Chorley District Hospital and transferred by emergency ambulance after being very short of breath. A note was made in his clinical record that he continued to smoke despite claiming otherwise. He was admitted to the ICU, and moved to a general ward two days later. The man returned to the healthcare unit at Garth on 23 November.

30. The man was again admitted to hospital on 5 December, and stayed on a general ward for six nights. He was given antibiotics and diagnosed with acute infective exacerbation of COPD. On 12 December, he was reviewed at Garth by a third prison doctor and found to be in a stable condition.

31. A respiratory physiotherapist saw the man on 22 December at the request of his consultant. Two days later, the man was transferred to HMP Preston's healthcare unit under a regional bed protocol. This is an arrangement whereby prisons in the Central Lancashire area are able to transfer prisoners with chronic and/or difficult to manage conditions to Preston, which has more comprehensive healthcare facilities. When the man arrived, he seemed to settle well. He was located on H2 unit, which is the part of the healthcare unit used for people with physical health problems. A nursing care plan was opened.

32. Members of staff noted no medical concerns in the man's clinical record between 24 and 30 December. On 31 December, he saw the second prison doctor (who covers both Garth and Preston) who completed a routine review, stating that the man had no concerns and felt well.

33. On the morning of the man's death, a healthcare support worker began her shift on H2 unit at 7.30am. During interview with my investigator, she said that upon starting work, she checked all of the prisoners on the unit by looking through the observation panels in the cell doors. She saw that the man was asleep in his bed and did not have any cause for concern.

34. In her original statement to the police following the man's death, the healthcare support worker said she had last seen him alive just before 9.30am, when she had taken his breakfast to his cell. However, she later changed her statement to say that she did not see the man at this time. During interview, she clarified that a prisoner with responsibility for serving breakfast to the other prisoners had arrived on the unit, and that he had been the one to offer the man his breakfast. This was between 9.00am and 9.25am. She recalled that the man had declined his breakfast but was observed to be alive and responsive by the prisoner who had offered it to him.

35. The deputy healthcare manager was also working on the morning. She said during interview with my investigator that she left the healthcare unit at around 8.20am to undertake duties dispensing medication to prisoners in other areas of the prison. She returned to H2 at 9.40am and agreed with the healthcare support worker that they would immediately undertake routine observations of the prisoners on the unit. The deputy healthcare manager explained that checks such as temperature, blood pressure and respiratory function were done at least once per day and recorded in the prisoners' clinical records. She asked the healthcare support worker to start opening the cells and said she would follow with the necessary medical equipment.

36. The man was located in the cell at the end of H2 landing. The healthcare support worker went to this cell before any others. She recalled during interview looking through the observation panel and seeing the man on the floor of the cell. She said that his back was against the wall and his legs were straight out on the floor. His head was to one side and his eyes appeared to be rolled back. She said she immediately thought this was a serious situation, and shouted to the deputy healthcare manager for help whilst opening the cell door.

37. The deputy healthcare manager said she heard the healthcare support worker shout for help only seconds after she had left to begin unlocking cells. She immediately went to the man's cell, which took only a few seconds. Upon arrival, the deputy healthcare manager said she saw that the man was lying in the cell, and was partially propped up against either a chair or the wall. He appeared to have been incontinent of urine, and had some saliva and food on his face. His eyes were wide open. The deputy healthcare manager said the man did not respond to a slight shake, and that she was not able to find a pulse in his wrist or neck.

38. The healthcare support worker was, at this point, carrying the radio for H2 unit. The deputy healthcare manager explained that this unit's radio had the unique call sign Hotel 4. She further explained that nurses based in the main areas of the prison, with call signs of Hotel 2 and Hotel 3, would be

responsible for responding to medical emergencies. After checking the man for signs of life, the deputy healthcare manager took the radio from the healthcare support worker and gave a message to the prison's communications room, making them aware that she required urgent medical assistance. She then asked the healthcare support worker to retrieve an oxygen cylinder and a bag containing emergency medical equipment from a treatment room located close by on the same landing.

39. At around 9.30am, the first nurse on the scene had made her way from H1, where she was based, to H2 to complete some work. She was therefore in an office on H2 landing when she heard the healthcare support worker shout for assistance, and then, a few seconds later, heard the deputy healthcare manager ask for the oxygen and emergency equipment. At this time, she left the office where she was working and went to the man's cell, where she and the deputy healthcare manager commenced cardio-pulmonary resuscitation (CPR). The deputy healthcare manager administered artificial breaths using an ambu-bag. This is a piece of medical equipment which resembles a large face mask and is attached to an oxygen cylinder. The first nurse on the scene commenced chest compressions.

40. The second nurse on the scene and third nurse on the scene, the nurses assigned to radio call signs Hotel 2 and Hotel 3 respectively, were in a medical treatment room in the main prison when they received instructions from the communications room to attend H2 immediately. Both explained during interview that H2 was only a short distance from where they were, and they arrived within one to two minutes. The third nurse on the scene then attached an automated external defibrillator (AED) to the man's chest. This is a piece of medical equipment that monitors heart rhythms and administers a shock if required. In this case, the AED did not detect a viable heart rhythm.

41. After attaching the AED, the third nurse on the scene relieved the first nurse on the scene and began performing chest compressions. A short time later, a fourth nurse also arrived at the cell. He and the third nurse on the scene continued cycles of chest compressions whilst the deputy healthcare manager administered breaths using the ambu-bag. The CPR continued until paramedics arrived at around 10.10am. The paramedics attached their own equipment to the man and continued to attempt CPR for almost a further 20 minutes. However, the attempts were not successful, and the man was pronounced dead at 10.28am.

42. A subsequent post-mortem examination found that the man died from bronchopneumonia (inflammation of the walls of the airways) caused by COPD.

## ISSUES

### Clinical care

#### *Chronic disease management*

43. It was noted in the man's clinical record that he had six nurse-led asthma reviews between July 2005 and December 2006. However, there is no written evidence in his clinical record that he received an asthma review after this time. The clinical reviewer noted that regular and ongoing monitoring of the man's asthma would be expected, and should have been recorded.

44. The National Institute of Clinical Excellence (NICE) states that mild to moderate asthma sufferers must be clinically assessed and monitored at least annually. Severe sufferers should have such assessments twice a year.

45. Whilst the clinical record indicates that healthcare staff at Garth taught the man about inhaler and peak flow techniques, there is evidence to suggest that he had poor skills in these areas. This was noted in a letter from the man's respiratory consultant, to a doctor at Garth, on 16 April 2007. The clinical reviewer felt that this could have been addressed by healthcare staff on an ongoing basis.

46. The clinical reviewer advised the healthcare manager to ensure that systems existed to identify and review prisoners with chronic disease. In response, the head of prison health said that such systems did exist and had done so for a number of years. She went on to say that prisoners are screened upon arrival, and at any time afterwards as a result of self-request or referral. She pointed out that the man had gone through this process for COPD, and had been referred and seen for Nicotine Replacement Therapy (NRT).

47. Although it was encouraging to learn that systems existed for the referral and treatment of patients with chronic disease, there was nevertheless no evidence that the man had regular asthma reviews in line with NICE guidelines. I therefore endorse the following recommendation made by the clinical reviewer.

    **The healthcare manager at Garth should ensure systems exist to make certain that prisoners with clearly identified chronic disease are managed through review and education in accordance with the PCT's chosen national or local guidance.**

48. Incomplete prescription charts were appended to the man's clinical record. However, he was seemingly compliant with his medication and recording of his prescriptions is legible.

49. The clinical record makes it clear that the man was short of breath on many occasions. The available prescription charts, however, indicate that only two nebulisers were prescribed for use as required. It is unclear if the man had a nebuliser in his possession. In the respiratory consultant's letter to Garth on

24 April 2009, it is suggested that this was the case, and that the man was using a nebuliser once or twice per day. His prescription charts, though, are not clear about whether this medication was for use in possession, or was simply prescribed in the healthcare unit after episodes of shortness of breath. The clinical reviewer wrote:

> "If nebulisers were used as [when required] medication there should have been a clear prescription of this in the in-possession prescription section on the back sheet. If the man had at any time a nebuliser machine in his possession, one would expect to see clinical reasoning/rationale for this in his notes and, in terms of safe practice, evidence that the patient had been given training in the use of a named medical device, together with a shared risk assessment in terms of security."

50. With reference to the clinical reviewer's comment, I ask the head of healthcare at Garth to ensure that all prescription charts are clearly completed for in-possession medication.

***Smoking cessation***

51. It was well documented that the man was a smoker and continued to smoke throughout his sentence, despite advice from healthcare professionals. There is no evidence of a strategy to support him stopping smoking prior to 2006.

52. There is evidence in the man's clinical record of a stop smoking management plan in January 2006. This involved him being given nicotine replacement therapy. However, this attempt at smoking cessation had failed by the end of February.

53. The clinical reviewer wrote:

> "There is inconsistent evidence regarding the approach to helping The man to stop smoking. It is known that smoking is a major issue with regard to exacerbating asthma/COPD."

54. The man's respiratory consultant, wrote to the doctor at Garth on 1 May 2008, stating:

> "Clearly the key to his future management of his asthma and COPD primarily relates to his smoking cessation and I shall leave this in your hands."

55. Several comments made in the man's clinical record refer to his refusal to stop smoking. Whilst individual choice is a factor, it should be taken into account that his illness was aggravated by smoking. The clinical reviewer could not find any clear plan or strategy by healthcare staff to work proactively with the man to reduce his level of smoking. However, he also noted that this might not have happened due to a lack of understanding of, or training about, stop smoking interventions.

56. The clinical reviewer wrote:

> "The available nursing documentation contains only one formal nursing care plan and this dates from August 2006, wherein a nursing action states 'for staff to discourage [The man] from smoking'. There are no review dates on this piece of documentation."

57. Following an inpatient stay in hospital in November 2009, the man's clinical record indicates that members of staff were supervising and reducing his tobacco consumption. However, in December, it was noted that he had no cigarettes and was looking in bins and asking other prisoners for tobacco. The clinical reviewer commented that "this does not evidence that the man was participating in a controlled programme of smoking management".

58. The clinical reviewer concluded that the head of healthcare at Garth should conduct a training needs analysis with regard to knowledge and skills around smoking cessation. The head of prison health responded by saying that such analyses had been completed on at least two occasions in the five years prior to the man's death. Staff members had undertaken NRT training to facilitate the smoking cessation service, and a local protocol based on the PCT's policy was in place.

59. The clinical reviewer also commented on record keeping with regard to prisoners' smoking status. The head of prison health said that this already occurred and had done for a number of years. However, as the man's smoking status did not seem to be consistently recorded, I endorse the following recommendation made by the clinical reviewer.

**Prisoners' smoking status should be recorded on all medical records and stop smoking advice offered routinely and opportunistically at any healthcare intervention.**

***Care planning and nursing care***

60. The clinical reviewer found one pertinent care plan in the man's clinical record, relating to his asthma and COPD. There was no regular referral in the clinical record to this care plan, which did not appear to have been updated regularly. The clinical reviewer wrote:

> "Given the increasing complexity of his healthcare problems, particularly in the latter half of 2009, the care plan does not demonstrate sound application of the nursing process in managing the man's needs."

61. In particular, the clinical reviewer noted that the care plan should have specifically referred to the man's frequent episodes of shortness of breath, management plans, his smoking status and actions to reduce this, the use of his inhaler and his mental health issues. The clinical reviewer also thought the plan should have referred to members of healthcare staff accompanying the man to outpatients appointments due to his limited social skills.

62. The clinical reviewer found the daily record of the man's clinical care to be legible and compliant with record keeping guidelines. However, healthcare staff did not always note the time of appointments/entries, or their own role in the healthcare unit. The entries under the heading of 'care plan review' were detailed but did not seem to be influenced by the care plan. The head of prison health said care plans were routinely checked by healthcare managers at both Garth and Preston.

63. Given that healthcare staff did not consistently record their dealings with the man in his care plan, I endorse the following recommendation made by the clinical reviewer.

**The head of healthcare is advised to ensure a regular care plan audit is undertaken for patients and that plans are used to lead and influence the individual care of each patient.**

### *Clinical records*

64. The role of the clinical record is to provide a list of occurrences. The man's record was detailed and informative about his interventions with healthcare staff and frequent hospital admissions. However, the clinical reviewer noted that this record did not demonstrate a plan of care in the absence of a comprehensive care plan in the nursing record. He wrote:

> "The man suffered from chronic respiratory illness with frequent exacerbations. Management of his condition may have benefited from a definitive 'pathways' approach to assessment, planned care delivery and case review."

65. There were no medical notes relating to the man's respiratory problems between August 2008 and January 2009. Whilst he may not have experienced any physical health problems during this period, this seems unlikely considering the frequency of issues over the remainder of the clinical record, as well as his asthma and COPD.

66. I endorse the following recommendation made by the clinical reviewer.

**The head of healthcare should consider adopting a 'pathways' approach to the management of chronic disease.**

### *Transfer to Preston*

67. The man was transferred to Preston on 24 December 2009 due to deterioration in his health. Preston has a regional inpatients unit for chronic medical conditions, and covers all prisons within Central Lancashire PCT. This means that prisoners from a number of establishments, including Garth, can transfer to Preston if they require regular nursing care in a healthcare setting. Decisions are made based on clinical need, outside the normal arrangements covering the transfer of prisoners.

68. The clinical reviewer noted that the man should have been consulted over his move to Preston and, if any consultation had taken place, it should have been noted in his clinical record. He also notes that, whilst there are written guidelines about the transfer of prisoners within the Central Lancashire PCT to Preston, the reasons for the man's move were not recorded in his clinical record. The clinical reviewer said there was "no evidence of discussion or assessment either between the two establishments or with the patient".

69. A specific form exists for prisoners transferred to Preston under the regional protocol. However, it seems that this was not completed in the man's case. I note the recommendation by the clinical reviewer in this area, and ask that the heads of healthcare at Garth and Preston ensure that all transfers between healthcare facilities under the regional protocol are fully documented in prisoners' medical records.

***Use of the defibrillator***

70. During the immediate response to the man's collapse a defibrillator was brought to the cell and attached to his chest. This piece of equipment monitors the patient and advises whether or not to administer an electric shock based on the heart rhythm. On this occasion, no shock was advised, but this was not noted in the man's clinical record.

71. The clinical reviewer wrote:

> "The patient was attached to a defibrillator and, although not specifically recorded in the notes, defibrillation does not appear to have been required. The man was attended by paramedics who confirmed death at 10.28am."

72. The use of the defibrillator was noted in the clinical record. However, the advice given by the defibrillator was not recorded. In this case, it appears that there was no shockable heart rhythm and so an electrical shock was not advised. The clinical reviewer felt that for reasons of clarity and thoroughness, this should be fully documented in the clinical record. The head of prison health pointed out that the defibrillators used at Preston electronically recorded the incident in the device's memory, and that this information could be downloaded from the machine to evidence the steps taken during the resuscitation attempt, and the corresponding heart rhythm of the patient.

## RECOMMENDATIONS

1. The healthcare manager at Garth should ensure systems exist to make certain that prisoners with clearly identified chronic disease are managed through review and education in accordance with the PCT's chosen national or local guidance.

   *The recommendation was accepted. Garth reported that chronic disease clinics were in place and that patients were routinely monitored.*

2. Prisoners' smoking status should be recorded on all medical records and stop smoking advice offered routinely and opportunistically at any healthcare intervention.

   *The recommendation was accepted. Smoking status was routinely recorded as part of the reception screening process, and smoking cessation advice was offered by GP and nurse-led services. A lead nurse was appointed for smoking cessation services.*

3. The head of healthcare is advised to ensure a regular care plan audit is undertaken for patients and that plans are used to lead and influence the individual care of each patient.

   *The recommendation was accepted. Care plans were recorded on the electronic patient record and were accessible for audit purposes.*

4. The head of healthcare should consider adopting a 'pathways' approach to the management of chronic disease.

   *The recommendation was accepted. Chronic disease pathways and registers were being established on the electronic patient record and will be available for audit purposes.*