Investigation into the circumstances surrounding the death of a man while in the custody of HMP Wymott.

Report by the Prisons and Probation Ombudsman for England and Wales

January 2010

This is an investigation into the circumstances surrounding the death of man at HMP Wymott in December 2008. The man was aged 66 when he died. I would like to extend my condolences to his family and friends for their loss.

An independent review of the man's clinical care was conducted on behalf of Central Lancashire PCT. I have written to Central Lancashire PCT outlining the clinical reviewer's recommendations.

The man suffered from insulin dependent diabetes. He did not comply properly with his treatment, which often made him very unwell. On the day of his death he was rushed to hospital because of his unstable diabetic condition.

I must apologise for the delay in issuing this report, although this has not delayed the giving of feedback to the prison itself.

I would also like to thank the Governor and staff at Wymott for their full and ready cooperation during the course of my investigation. I am particularly grateful to staff from the Business Development Unit at Wymott for their assistance as liaison officers. I make one recommendation. I am pleased to see that the recommendation has been accepted.

Jane Webb
Deputy Prisons and Probation Ombudsman **March 2010**

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SUMMARY

The man was sentenced to three years imprisonment on 8 February 2008. This was his first time in prison but he quickly settled into prison life and developed positive relationships with staff and prisoners.

The man was received at HMP Preston on 8 February and remained there until early November 2008 when he transferred to Wymott. First reception healthscreen identified that the man was diabetic and epileptic. Healthcare staff identified that the man had a history of poor compliance with his medical treatment and care plan.

During those nine months at Preston, attempts by the healthcare team were focused to stabilise his diabetic condition through improved compliance and self management. There were numerous episodes of care specifically to help the man improve control of his condition.

On several occasions during February, the man was found to have collapsed. Healthcare staff attended and treated him accordingly. They would reassure him and continue to support him to improve his management of diabetes, albeit with little success.

The man was received at Wymott on 7 November. Healthcare staff assessed him on reception and considered he was capable of administering his insulin though they noted the history of poor compliance with his medical regime.

Healthcare staff were called to see the man on 1 December. He was confused and very poorly. He was taken to the Accident and Emergency Department at Chorley Hospital by ambulance and admitted to the intensive care unit (ICU). He was diagnosed as suffering from ketoacidosis (most common in untreated type 1 diabetes mellitus, when the liver breaks down fat and proteins in response to the body's need for oxygen and which tends to occur when blood glucose is too high).

Later that day, the man was transferred from ICU to a ward where he was treated for both diabetic ketoacidosis and pneumonia. He started to improve but remained at Chorley Hospital for the next two weeks. He was discharged back to Wymott on 15 December.

I wing staff were soon concerned about the man again and, on 17 December, they found he was short of breath and very ashen in colour. Healthcare staff were asked to visit and give treatment.

On the morning of 27 December 2008, prison staff alerted healthcare staff that they were concerned about the man. Healthcare staff went to see him on I wing. They took emergency medical equipment with them from the treatment room.

The man was lying on his bed and was unconscious. Healthcare staff immediately requested an emergency ambulance. They examined him and

administered treatment. The prison doctor inserted a cannula (for the delivery of fluids into the vein) and set up sodium chloride solution (salt based fluid) to be administered intravenously. They administered oxygen to help the man breathe.

When the paramedics arrived they tested the man's blood sugar and found it was high. He was taken by emergency ambulance to the Accident and Emergency Department at Chorley Hospital. Prison bedwatch staff were instructed not to apply mechanical restraints because of the man's poor condition. Later, hospital nurses told the officers that the man "had arrested (heart momentarily stops) three times and that if he arrested again they would leave him".

At around 4.30pm the hospital nurses told bedwatch staff that the man had "passed away at 4.20pm". The coroner's officer was called and attended the hospital. The duty governor contacted the man's brother, as his listed next of kin, to inform him of the news.

I make one recommendation which asks the Governor of Wymott to consider providing prison staff working within the elderly and disabled community with training to raise awareness of how they should respond to the health problems experienced by prisoners in that community,

THE INVESTIGATION PROCESS

1. The investigation was opened on 28 December 2008. The investigator issued notices announcing the investigation to the staff and prisoners of HMP Wymott. The notices included an invitation to those who wished to contribute to the investigation to make themselves known. No prisoners or staff came forward although the investigator spoke to a number of prisoners and staff within the elderly and disabled community and healthcare department.

2. The investigator made a preliminary visit to the prison on 23 February 2009. He met the Governor, the chair of the local branch of the Prison Officers' Association, and the chair of the Independent Monitoring Board. A member of staff from the Business Development Unit acted as the investigation liaison officer.

3. The investigator made a tour of the prison and visited I wing annexe of the elderly and disabled unit to see the man's room. He talked to a number of staff and prisoners who had known the man. The unit accommodates around 75 prisoners within a small contained unit.

4. The investigator had access to the man's prison and clinical records. He reviewed all relevant documents, which included the man's core record, clinical record, wing documentation, care plans and other custodial and clinical documents. The investigator constructed a chronology of significant events from his review of the man's case files and identified any emerging issues.

5. The investigator made arrangements to interview staff at the prison. He interviewed the man's personal officer, his prison doctor and a senior nurse, the key people who were involved in the man's care.

6. The investigator asked Central Lancashire Primary Care Trust (PCT) to organise a clinical review of the healthcare the man had received whilst in custody. The PCT commissioned the review. I am grateful to the clinical reviewer for completing her work expeditiously.

7. One of the Ombudsman's Family Liaison Officers (FLOs) telephoned the man's brother who lives in the south of England. He was not available so the FLO talked to his wife. The man's sister-in-law told the FLO she did not think her husband would have any specific concerns or questions about his brother's time in custody. She explained that the man had always been prone to neglecting himself and both she and her husband felt the prison had done all they could to care for him. She also spoke very highly about the help and support they had received from prison staff following the man's death.

8. The FLO followed up her telephone call with a letter to the man's brother suggesting he get in touch should he wish to add to his wife's comments. The FLO did not receive any further correspondence. I

hope this report provides the man’s family with a better understanding of his time in prison and the events leading to his death.

THE MAN

9. The man was born on 3 April 1942 in London and was 66 years old when he died. He lived in Lancashire before he was sent to prison. His next of kin was his brother, who lives in the south of England.

10. The man was convicted on 19 December 2007 at Preston Crown Court and sentenced to three years imprisonment on 8 February 2008. He had not been in prison before but prison staff said "[He] is a chirpy, polite elderly man who is just getting to grips with wing regimes. Do not foresee any problems with him settling in."

11. The man suffered from diabetes, high blood pressure and epilepsy. His home GP confirmed that he had not cooperated with treatment and attendance at the surgery for years and his attendance for hospital appointments was poor. Prison staff noted that the man "was a slightly built man who looked much older than his years".

12. The man was quiet and introvert by nature. His personal officer said "he kept himself to himself. He just tended to sit in his cell smoking all day. He was no problem at all, but he got quite confused sometimes". His doctor described how "he liked some attention but not over-the-top attention. He was very good".

13. Staff said they were shocked when the man died because he seemed to be "generally coping". They were concerned at times because he did not always take his medication and administer his insulin properly. The investigator found that staff and prisoners spoke about the man with compassion.

HMP WYMOTT

14. HMP Wymott is a large category C closed training prison (category C prisoners cannot be trusted in open conditions, but do not have the resources and will to make a determined escape attempt), which holds both vulnerable prisoners and prisoners on ordinary location.

15. Mainstream prisoners and vulnerable prisoners are held in separate accommodation and so Wymott is effectively two separate prisons with their own range of workshops, education and training facilities. The prison opened in 1979 and new accommodation was added in 1996. Vulnerable prisoners mainly live in the original house blocks.

16. A new residential block of two wings was opened in 2004 and this is used as the induction wing. Wymott can hold an Operational Capacity of 1144 prisoners with a Certified Normal Accommodation 1081 prisoners. There are two specialist units: a drug therapeutic community and an elderly and disabled community. Healthcare services are commissioned and provided by Central Lancashire Primary Care Trust.

17. Healthcare services at Wymott are commissioned and provided by Central Lancashire Primary Care Trust. Services are classified as Type 3 healthcare which provides 24 hour nursing care, 7 days per week but with no inpatient facility. This does not include inpatient beds so prisoners often go to HMP Preston, which has an inpatients unit.

HM Chief Inspector of Prisons' inspection in 2008

18. HM Chief Inspector of Prisons, Dame Anne Owers, last inspected Wymott in October 2008. She commented in her report:

> "Wymott is a large category C training prison, holding over a thousand men. It has expanded 25% since its last inspection in 2003. Unlike many training prisons which have undergone similar expansion, Wymott has managed to sustain its performance and the quality and quantity of activity available to its prisoners."

19. Dame Anne also wrote:

> "The needs of older prisoners and those with disabilities were not met. The disability policy did not reflect current practice and, although a high proportion of prisoners reported some form of disability, support was ad hoc, with no formal care plans and only limited adjustments, even on I wing, which was supposed to be a specialist unit. Staff on I wing were caring and supportive but there was insufficient input and training to make it an effective unit for older prisoners and those with disabilities. Social care workers were due to be appointed. There were few

links to health services and limited activities for those unable to leave the wing."

Diversity

20. Dame Anne recommended:

> "A diversity policy should be developed and implemented, covering all distinct minority groups, including gay prisoners, those with disabilities and older prisoners, and based on an analysis of their needs."

I wing

21. Dame Anne reported:

> "A policy for the management of older prisoners had just been developed but had not been fully implemented. Over 10% of the population were regarded as older prisoners (over 55) and a separate unit had been established on I wing to cater for some of them, as well as those with disabilities, but the criteria for the wing were unclear. This included an annexe in the healthcare centre of six cells more appropriate for use by prisoners with physical disabilities. None of these prisoners had care plans and little had been done to make reasonable adjustments to living conditions; for example, prisoners using a wheelchair were accommodated in ordinary cells. However, prisoners on this unit were generally unlocked all day, limited low level work was available on the unit, and a communal dining and television facility had been provided. Interactions between staff and prisoners on this wing were positive.
>
> "I wing held up to 75 prisoners and was the only wing where prisoners could eat out of their cell. A stair lift allowed prisoners to access the association facilities on the upper landings. I wing also had a separate annexe in the nearby healthcare centre, with cells more suitable for use by prisoners with disabilities, but they were too isolated for such prisoners to be held there."

22. Dame Anne recommended:

> "Individual care plans should be developed for older prisoners with special needs and those with disabilities. Activities for older prisoners and those with limited mobility should be improved to provide more stimulating and purposeful occupation.
>
> "Cells for prisoners with a disability or limited mobility should be adapted to meet their needs."

Older prisoners in England and Wales: a follow-up to the 2004 thematic review by HM Chief Inspector of Prisons June 2008

23. In 2004, Dame Anne published a report on the treatment and conditions of the growing number of older prisoners in England and Wales. A short follow-up report revisited the issue, four years on, to detect whether there had been any changes. Dame Anne comments in the follow-up report:

> "The population of men over 60 in prison has risen slightly over that period, reaching nearly 3% of the population; at the same time, the population of women over 50 has increased significantly, reaching nearly 7% by mid-2007. It is well-known that prisoners are likely to have earlier onset of chronic health and social care needs than the general population.
>
> "There have clearly been some positive developments over the last four years. Survey responses from older prisoners are more positive than they were; healthcare arrangements have in general improved; some individual prisons, or prison staff, are carrying out good and innovative work to meet the specific needs of these prisoners.
>
> "Older prisoners are a relatively compliant population – hence the title of our previous report, *No problems – old and quiet*, taken from a prisoner's wing file. In an increasingly pressurised prison system, their needs are therefore likely to be overlooked unless there is specific provision – yet the issues they pose are likely to become more acute, as an increasing number of long-sentenced prisoners grow old and frail in prison.
>
> "The voluntary and healthcare sectors have done a great deal of important and useful work in this area. It now falls to the National Offender Management Service to make full use of that work and of the recommendations in our last report, and ensure that prisons properly reflect, and can provide for, the needs of their ageing population.
>
> "There were some good examples of provision for older prisoners organised and managed by health services staff, but this was largely done in isolation with little evidence of multidisciplinary working. It was disappointing that the social care needs of older and disabled prisoners were still considered the responsibility of health services. A lead nurse for older prisoners was not evident in all inspections, despite the requirements of the National Service Framework for Older Prisoners. However, there were some good examples of care for this older age group. But there was a complete lack of staff training in identifying the signs of mental health problems among the elderly."

The Independent Monitoring Board (IMB) Annual Report 2008/09

24. The Prisons Act 1952 requires every prison to be monitored by an independent board appointed by the Secretary of State for Justice from members of the community in which the prison is situated. The Board must satisfy itself as to the humane and just treatment of those held in the prison it monitors.

25. Wymott IMB's most recent annual report was published in May 2009. The executive summary contains the following remarks:

> "The Board considers that the Prison is providing a safe environment in which prisoners are treated with decency and respect and have access to an extensive programme of education and skills. The Senior Management of the Prison have set out to address those areas where prisoners are not treated decently within the limitations of what the Prison can do given its national resource allocation."

Healthcare and Mental Health

26. The section of the IMB's report dealing with Statutory Reporting Areas: Healthcare and Mental Health reports:

> "Generally Healthcare in the Prison has improved since its takeover by the PCT and the appointment of a new Healthcare Manager in 2008. However the Board considers that the Unit still has some way to go before it achieves the NHS aim of treating prisoners to the same standard as patients in the community. Given the high concentrations of poor physical and mental health, drug addiction, general low self-esteem and lack of access to private medicine and retail pharmacies, the Board considers the PCT should be offering a service that exceeds what it provides for the general population.
>
> "A lead nurse for elderly prisoners has been designated. Care plans for elderly prisoners are now being developed and the prison has produced an Elderly Prisoner Action Plan as a response to the HMCIP Thematic Review. However due to staffing shortages and pressure of work, the lead nurse has been delayed in producing an individual healthcare plan for each elderly prisoner. A revised induction document has been designed to more fully assess elderly prisoners' medical and social needs and is implemented."

Elderly and disabled community (I wing)

> "Consider the introduction of specialist training for I Wing officers to enhance the quality of care for elderly and disabled prisoners. Although I Wing is identified as the elderly and disabled community it does not appear to have attracted significant additional funding to reflect the specific requirements of that role. In the course of the year, however, the Governor was able to find sufficient funds to appoint two care workers, to install a stairlift on I Wing and to set up a daycare activity centre, all of which enhance significantly the facilities on the wing. The appointment of the care workers, in particular, provides much-needed assistance with daily living. Although the activity centre had been completed by the end of the reporting year it had not yet been commissioned.
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> "The layout of I Wing creates difficulties for wheelchair users. However, the installation of the stairlift is a welcome addition, and the social environment of the wing and the good staff-prisoner relationships provide further benefits."

27. The section of the IMB's report dealing with Reports on Other Areas of the Prison: Elderly and Disabled, reports:

> "The Prison now employs two Care Workers located on the elderly and disabled wing and the Board welcomes this. The Careworkers provide the assistance that some disabled and elderly prisoners require on a daily basis. The Board also recognises the important role that prisoners play in the care of their fellow inmates. Careworkers are developing their own day-to-day care plans under the supervision of the named nurse for elderly or disabled prisoners. However medical care plans for each prisoner have not yet been constructed. There is a growing collaboration between Careworkers and Healthcare, which may lead to opportunities for improved care. At the time of writing there does not appear to be arrangements for the development of the careworker role.
>
> "Whilst the Board considers that the care provided by discipline staff for elderly and disabled prisoners on I Wing is good and that the careworkers will provide vital support it is concerned that there is no specialist training for officers; for example recognising early geriatric mental health deterioration. However the introduction of the careworkers may help to bridge this gap. The Board welcomes the development of a day care centre for the elderly and disabled, which promises an improvement on the previously poor arrangements for association, education and work."

Previous deaths in custody at Wymott

28. Since 2004, the Ombudsman's office has investigated 25 deaths at Wymott, which include 22 deaths by natural causes and three apparent self-inflicted deaths. I am satisfied that there is no link between the circumstances surrounding this investigation and the other deaths, although a number of the deaths by natural causes were also associated with chronic disease and long term medical conditions.

29. Four of the deaths were elderly men who were, or had been, located on I wing within the elderly and disabled community. These were all deaths by natural causes and associated with long term conditions such as coronary heart disease.

30. I investigated the death of a man at Wymott in November 2007 and made a recommendation that the Head of Healthcare should ensure tighter monitoring and follow-up of delays and missed appointments, particularly those of chronically ill patients. The investigator found no evidence from the circumstances surrounding the man's death that he missed any scheduled appointments because of a lack of monitoring by the prison. This was confirmed by the clinical review.

KEY EVENTS

31. The man was convicted on 19 December 2007 at Preston Crown Court and sentenced to three years imprisonment on 8 February 2008. It was his first experience of imprisonment.

32. A first reception healthscreen identified that the man had type 1 diabetes (insulin dependent diabetes which required a daily injection of insulin), and epilepsy, although healthcare staff could not find a definitive diagnosis of epilepsy recorded in his medical record. The reception nurse made a note to send for his GP records and also made a referral to the diabetic specialist nurse.

33. The man was admitted to the healthcare centre and located on H2. Staff reported that he was "orientated and conversing with other prisoners and staff. He quickly settled into prison life and ate his meals and accepted his medication". Healthcare staff contacted the man's home GP, and requested full details of his medical history, prescribed medication and any pending hospital appointments.

34. The man was found collapsed on the floor on 19 February. Healthcare staff attended and administered glucose (which aids recovery when a diabetic patient has collapsed because of low blood sugars). He had not injured himself and his diabetes quickly stabilised after he was given glucose. Later, the man asked the staff what had happened. He was seen by the doctor the following day and a plan put in place to ensure "close monitoring".

35. Two days later, the man was found unconscious. He was suffering from hypoglycaemia (a medical condition where blood sugar level has fallen causing collapse). Healthcare staff attended and administered glucose and oxygen (to help breathing). The man regained consciousness and staff provided reassurance. A prison doctor, reviewed the man and agreed a plan to observe him, supervise his insulin dosage, and take blood tests.

36. Over the next few months, healthcare staff continued to monitor the man's diabetes. He cooperated sporadically and blood sugar tests indicated that his diabetes was often unstable.

37. On 4 June, the man was reviewed by the specialist diabetes nurse who recommended a change in his insulin. She advised the healthcare team of the suggested changes.

38. The man complained of hip pain on 5 November. He was reviewed by the doctor and prescribed co-codamol (pain relief medication).

39. During those nine months at Preston, healthcare delivery was focused on attempts by the healthcare team to stabilise the man's diabetic condition through improved compliance with care and self

management. There were numerous attempts to improve the man's control of his diabetes, as evidenced by the written entries in his medical record.

40. Preston provides type 4 healthcare services over the 24 hour period for prisoners who need acute care and comprehensive clinical assessment and this includes inpatient beds. The man remained at Preston until 7 November when he was transferred to the elderly and disabled community at Wymott. The care team at Preston considered that the elderly and disabled community would be preferable for the man because he would be located with other prisoners with similar needs.

41. On 7 November, healthcare staff at Wymott assessed the man on reception and considered he was capable of administering his own insulin, though they noted his history of poor compliance.

42. Reception staff completed the first night check and the man signed the relevant custodial behaviour agreements. Because of his limited mobility and disabilities he was located in the elderly and disabled community on I wing.

43. Prison staff visited the man in the elderly and disabled community to interview him and agree his custodial plan. He was of retirement age and did not want to work, nor did he wish to attend education. However, the man said that he was willing to participate in any appropriate offending behaviour programmes.

44. The man was happy to be located on I wing and was introduced to his personal officer who wrote in his F2052A (inmate personal record system):

> "[The man] is a bit of a loner. [He] has never been married and looked after his mother until she died. His hobby is watching TV. He has no friends on the outside and did not go out of his flat to socialise.
>
> "He is very happy here at Wymott on I wing and has no issues. He does not seem to have any contact with friends or family and does not work. He is 65 years old. He is polite and I have explained the need for him to keep his medication and needles safe and out of sight at all times which he assures me he will."

45. The Security Department advised healthcare staff on 17 November that the man should not be allowed insulin syringes and a sharps box (container for disposal of syringes) in his possession. The investigator, could not ascertain the rationale for this decision. Healthcare staff reviewed his insulin administration regime accordingly to change to a 'Novorapid flexi pen' (a functional 'pen' to self administer insulin), which was considered both easier and safer to use.

46. On 27 November, the man was seen for diabetic review. Healthcare staff noted:

> "[The man] has been a diabetic patient for years. His blood glucose has been unstable for some time. He claims to be compliant with diet and insulin regime. Blood sugar this morning with BM machine = 28 (excessively high). Has had diabetic foot screening earlier this year. States has not had recent eyesight test.
>
> "Plan: Ensure listed for diabetes specialist nurse clinic. List for eye sight test and diabetic retinopathy (non-inflammatory damage to the retina of the eye) screening. Relist for diabetic blood tests next month."

47. Healthcare staff were called to see the man on 1 December. He was confused and could not tell staff his age or where he was. Blood sugar testing recorded a very high reading. Staff recorded his vital signs (pulse, blood pressure and oxygen saturation level), administered oxygen and called an emergency ambulance. His oxygen saturation levels did not improve. The man was taken to the Accident and Emergency Department at Chorley Hospital. The investigator could not find any evidence to indicate that attempts had been made by the prison to inform the man's family of his admission to hospital despite the seriousness of his condition.

48. The next day, the Head of Healthcare, telephoned Chorley Hospital, where the man had been admitted to the intensive care unit (ICU), for an update on his condition. He had been diagnosed with ketoacidosis. Hospital staff said he was currently stable and could be transferred to a ward later that day. Later that day, the man was duly transferred from ICU to a ward where his condition started to improve.

49. The man remained at Chorley Hospital for the next two weeks and was discharged back to Wymott on 15 December. Prison healthcare staff reviewed the man's hospital discharge plan on his return. (It is common practice that when a prisoner is discharged from hospital he returns to prison with a discharge letter and plan.)

50. On the morning of 27 December, prison staff alerted healthcare staff that they were concerned about the man. Two nurses and the doctor went to see him on I wing. They took emergency medical equipment with them from the treatment room.

51. The man was lying on his bed and was not conscious. The healthcare staff found that he did not respond to "voice and painful stimulus" (such as pinching the skin of the patient). They immediately requested the control room to call an emergency ambulance.

52. The nurses took the man's vital signs observations: his blood pressure was very low at 67/45 (abnormally low), the pulse oxymeter could not record his oxygen saturation levels at all, and they tried to test his blood sugar but again could not get a reading. Their equipment simply recorded a reading 'Err' (error).

53. The doctor inserted a cannula (for the delivery of fluids into the vein) and set up sodium chloride solution (salt based fluid) to be administered intravenously. They then administered oxygen to help the man breathe.

54. When the paramedics arrived they tested the man's blood sugar on their machine which tested 'high'. The man was taken by emergency ambulance to the Accident and Emergency Department at Chorley Hospital.

55. At the hospital, the prison officers escorting the man were instructed not to apply mechanical restraints in view of the gravity of his condition. Hospital staff attended and later told the officers that the man's heart had momentarily stopped three times and that if it stopped again they would not administer any more treatment.

56. The duty governor tried to contact the man's brother and after a number of attempts, she managed to speak to him on the telephone at 4.00pm. She informed him that his brother was seriously ill in hospital.

57. At around 4.30pm, hospital nurses told the prison officers that the man had "passed away at 4.20pm". His family spoke positively about their interaction with the prison following his death.

58. At 5.00pm, the duty governor telephoned the man's brother again and informed him that his brother had died. Later that evening the man's sister-in-law contacted the prison and asked that the family be advised of the funeral date. She explained that they did not want to make the funeral arrangements. Another governor acted as the prison family liaison officer to support the family and kept them informed of all follow-up arrangements.

ISSUES

Clinical care

59. The clinical reviewer concluded that the man received "an appropriate level of general healthcare, and had the opportunity to see a health professional on a regular basis".

60. She continues:

> "[The man] had access to emergency care from professionals throughout the 24 hour period and also had access to a paramedic service in the same way as any other resident of Central Lancashire. He was also treated in Chorley Hospital." She makes reference in her report to both healthcare services at Wymott and Preston.

61. The clinical reviewer found:

> "Concerns that, in some cases, information was not documented as fully as it could have been or was missing altogether. There was no consistent record of communication between departments and there is no record of a discharge plan from Chorley Hospital.
>
> "The recording of information, particularly around hospital transfers and subsequent management plans is limited. There should be clear pathways of communication between the healthcare team at Wymott and outside hospital departments. This communication should be documented in the patient's record. All staff should have access to a patient's management plan. This plan should include the most recent reviews, evaluation and recommendations.
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> "In a small number of instances, records had been stored without a date or a name attached.
>
> "There is a clear national and local protocol for record keeping. In order to improve communication systems the medical/nursing documentation could be audited. This will demonstrate compliance with the guidelines for records and record keeping as defined by the Nursing and Midwifery Council. From this, managers will be able to identify any training needs for staff and instigate policies and recommendations to achieve compliance.
>
> "The care and treatment offered by consultants and out-patients clinics was maintained and monitored by the healthcare team at Wymott. As far as can be determined from the medical record, all scheduled appointments went ahead. Again, some records of activity are limited.

"In terms of health services for older people, a Band 6 (a senior nurse grade) nursing sister had recently been appointed within the prison healthcare to specifically look at the needs of the older population. She has commenced work based on the National Service Frameworks for older people to review the policies for working with this client group to ensure that the services offered are equal to those offered in the wider NHS. The policies for older people form part of the wider older person's strategy within the prison.

"The development of policies for delivering care to elderly prisoners will improve the way care is delivered at Wymott. [The clinical reviewer] considered that any lack of current policy development would not have negatively affected the overall care package [the man] received. The urgency of the clinical situation often dictated the way that [the man's] care was provided by healthcare staff.

"From what is reported and recorded [the man] appeared to be content with the care he received. There are no recorded complaints or concerns.

"Although there are no records available of a debriefing session following the incident all staff commented that one did occur and it served to relieve anxieties that staff may have felt by sharing their experiences. It also provided the manager with a profile for 'lessons learned' in terms of emergency procedures."

62. The clinical reviewer makes five recommendations with the objective of improving healthcare practice and standards at Wymott. I have written to Central Lancashire PCT outlining these recommendations and attach my letter as an appendix to this report.

63. The clinical reviewer also identifies a number of areas of good practice which include:

"[The man] had a number of long term health conditions which were all treated by professionals who specialised in that particular area. He had access to a specialist diabetic nurse who saw him on a regular basis and ensured that all care was offered in accordance with NICE guidelines and PCT policy.

64. The clinical reviewer finds that the level of service provision the man experienced at Wymott:

> " … arguably exceeded the provision offered in the general community as [the man] was able to access health professionals as he needed to within minutes."

CONCLUSIONS

65. The man was a quiet and perhaps rather lonely person, but he did settle in the elderly and disabled community at Wymott. He had never married and had few friends at home. The investigator found that earlier on in his sentence whilst at Preston, the man did not properly comply with his insulin regime despite staff support and encouragement.

66. He had a number of health conditions, but his main problem was diabetes, which remained unstable throughout his time in custody, despite the considerable efforts of healthcare staff and the intervention of a specialist diabetic nurse. Staff found that the man often did not administer his insulin correctly and would also consume sugar and other unsuitable foodstuffs, which had the potential to destabilise his diabetic condition.

67. The man was transferred from Preston to Wymott on 7 November 2008 and was located in the elderly and disabled community. The investigator found this decision to be appropriate because the man was able to live and associate with other prisoners of similar needs and circumstances. The man was a quiet and introverted individual and location in the community helped him develop positive relationships with other people. It also aimed to encourage him to greater self-reliance, particularly with regards to his diabetes.

68. The clinical reviewer, judged that the man received comprehensive healthcare of a standard equivalent to what could be expected in the community in terms of access and quality. My investigation of the circumstances surrounding the man's death concurs with the clinical reviewer's judgement.

69. The investigator found that prison staff working in the elderly and disabled community care for prisoners with a variety of chronic health problems, such as diabetes. This group of staff would benefit from additional training as they are often the first people approached by prisoners to help them with their health needs and problems. The IMB has previously identified staff training as a gap that needs to be addressed.

RECOMMENDATION

To the Governor

1. The Governor should consider providing prison staff working within the elderly and disabled community with training to raise awareness of how they should respond to the health problems experienced by prisoners in that community.

   Locally training for prison staff working with elderly and disabled prisoners to raise awareness of how they should respond to health problems will be scheduled between February and June 2010. Target date for completion is June 2010.