PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into death of a man at Doncaster Royal Infirmary, while a prisoner at HMP Hatfield in January 2012

Report by the Prisons and Probation Ombudsman for England and Wales

January 2013

This is a report into the death of the man, who died at Doncaster Royal Infirmary (DRI) in January 2012, while a prisoner at HMP Hatfield. A post-mortem concluded that the man appeared to have suffered a heart attack. I would like to offer my condolences to his family for their loss.

The investigation was carried out by one of my senior investigators. A clinical reviewer was commissioned to undertake a review of the man's clinical care. The clinical was assisted with a colleague. HMP Hatfield co-operated fully with the investigation.

The clinical reviewers conclude that the standard of healthcare the man received was generally good and particularly commend the actions taken by the prison on the day that he died. However, a number of aspects of healthcare were identified as requiring improvement. For example, the man had a history of deep vein thrombosis, and following a consultation at hospital where he was prescribed "life long" warfarin, this medication was stopped after six months. This decision was not challenged by healthcare staff at Lindholme or Hatfield, although this did not appear to contribute to his death. There was also poor communication between Hatfield and DRI and the standard of clinical record keeping regarding the man at each of the prisons in which he was held was poor. Finally, it is disappointing that Hatfield delayed appointing a family liaison officer and were slow in notifying the man's family of his death.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2013**

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SUMMARY

1. The man was remanded into Hull prison in August 2009. On arrival, he told healthcare staff that he was an alcoholic, receiving methadone for an addiction to heroin and suffering from depression. After consultation with his community doctor, a prison doctor initially prescribed methadone, an anti-depressant, an anti-psychotic drug, an anxiety reducing drug and vitamins. The man was also prescribed drugs for alcohol withdrawal.

2. During his time at Hull prison he attended healthcare frequently for both physical and mental health assessments. He experienced severe ankle pain and was prescribed painkillers. He also had dental problems and was seen by the dentist regularly for treatment.

3. The man transferred to Doncaster prison in January 2010. Healthcare staff at the prison were made aware of his physical and mental health conditions and he was medicated accordingly.

4. The man was transferred to Lindholme prison in April 2010. It was not until December of that year that, during an appointment with a doctor, the man spoke about his history of Deep Vein Thrombosis (DVT). He said he had suffered multiple DVTs, the last one on 2008.

5. From then on, the man received anti-coagulation medication[1] at the prison's anti-coagulant clinic. He had regular blood tests to ascertain the effectiveness of the warfarin medication[2] he had been prescribed.

6. In July 2011, the prison received a letter from Doncaster Royal Infirmary (DRI) saying that the man's treatment had concluded. The prison rang to query this as they believed he was on "lifelong" medication. They were told that this was not the case and confirmed the warfarin should stop. The man was unhappy about this and queried the decision three times, but no other action was taken.

7. The man transferred to Hatfield Open prison in August 2011. He visited healthcare there and again asked why his medication had been stopped. He was given the same reason as before.

8. On 13 January 2012, the man felt unwell and visited healthcare. He was examined by a nurse and then a doctor and they were sufficiently concerned about him to telephone for an ambulance. The man was taken to Doncaster Royal Infirmary (DRI) where and echo cardiogram and blood tests were carried out. The man discharged himself from hospital later that day and returned to the prison, against hospital advice. They wanted to run additional tests. Although he told healthcare staff that the hospital tests had returned 'normal' there was no accompanying paperwork from the hospital

[1] prevents clotting of the blood
[2] medication for reducing blood clotting

9. On the morning of the man's death, he again felt unwell and returned to healthcare. He was experiencing a pain in his shoulder and shortness of breath. While being examined he became agitated and left to return to his unit. Before he got there he deteriorated and returned to healthcare. This time he was experiencing a pain in his chest as well as between his shoulders and appeared to be clammy and sweating. An ambulance was called immediately. The man was en-route to a hospital in Sheffield when he experienced a heart attack and was diverted to DRI. Staff at the hospital were unable to revive him.

10. A post mortem carried out on 31 January gave the cause of the man's death as a sudden cardiac arrest.

11. This report makes five recommendations. These concern the discontinuation of the man's warfarin, medical record keeping, establishing a protocol with Doncaster Royal Infirmary to share patient information, keeping an ECG machine on site and the prompt appointment of a family liaison officer.

THE INVESTIGATION PROCESS

12. The investigator was notified of the man's death on the day he died and visited the prison on 3 February. During visit, the investigator met with the Head of Site, Head of Healthcare, a representative of the Independent Monitoring Board and the Prison Officers' Association, and the prison's Family Liaison Officer. The investigator explained the role of the Ombudsman and the investigation process. She read the paperwork and identified which documents were required for the investigation. These were forwarded to her by post.

13. However, the prison did not provide a full set of clinical records. The investigator requested these twice and on both occasions records only up until the end of 2009 were sent to her. Despite asking for a complete set she was assured that she had everything the prison held and there was no further information available. This was clearly not the case. Rather than delay this report, the investigator obtained a complete set of records from the clinical reviewer.

14. The investigator issued notices informing staff and prisoners of the Ombudsman's investigation and invited them to contact her with any relevant information. No witnesses came forward.

15. A clinical reviewer was appointed to undertake a review of the clinical care the man received while at Hatfield. The clinical reviewer was assisted by a colleague. The investigator carried out four joint interviews with the clinical reviewer and his colleague on 13 March. The clinical reviewer's report was due on 6 April, but as he was still awaiting the post mortem report an extension was granted until 4 May. The report was received in this office on 30 April.

16. The investigator wrote to the Governor on 15 March providing feedback on her initial findings. She identified the following issues –

    - The prison's only echo-cardiogram machine had been lent to the prison's other site the day before the man collapsed
    - The discontinuation of the man's warfarin treatment
    - Poor record keeping and poor communication between Doncaster Royal Infirmary hospital (DRI) and healthcare.

17. The Head of Healthcare responded to this letter on 13 April. This is discussed in the issues section of this report.

18. The investigator also wrote to HM Coroner to inform him of the Ombudsman's investigation. A copy of this report will be sent to the Coroner to assist with their enquiries.

19. One of the Ombudsman's family liaison officers contacted the man's family to invite them to be involved in the investigation process. The man's family

responded in writing on 30 July. They commented on each recommendation individually.

Recommendation One

20. The family agreed that warfarin therapy should comply with the National Patient Safety Agency guidance, with the continual use of the 'Yellow Book'. They felt that in this case, inaccurate record keeping and information sharing may have been a factor in the discontinuation of the man's warfarin. The family hoped the Prison Service would follow this recommendation.

Recommendation Two

21. The family felt that it was disappointing that the standard of record keeping remains a problem despite being governed by the GMC, NMC and CQC. It was also disappointing that the discontinuation of the man's warfarin was not challenged and the family would like to think that systems are now in place to ensure healthcare workers are confident and proactive in challenging decisions.

22. The family questioned why the man's methadone dosage was increased, and why the agreed reduction of the drug ceased in December 2010. The family believe this highlights the lack of record keeping, which is unsettling given that a controlled drug is being prescribed.

.Recommendation Three

23. The family were disappointed in the lack of communication between Doncaster Royal Infirmary and the prison. However, they acknowledged and appreciated the actions of the Head of Healthcare in addressing this issue.

Recommendation Four

24. The family feel the prison acted appropriately in notifying them about the man's death, given the difficulties they faced. However, they raised the point that it appeared that other prisoners were informed about his death before the family were and they felt this was inappropriate. The family feel that as prisoners have access to telephones it would have been very upsetting to have been given this information from another prisoner before prison staff broke the sad news to them.

Recommendation Five

25. The family were happy to here that the ECG machine has been returned to the prison.

26. The family made two further comments. They thought that there appeared to be a lack of understanding, knowledge and clarity around the use of SystmOne and thought that staff might benefit from additional training and a review of the system as a whole.

27. The family also noted that healthcare had not carried out a Serious Untoward Incident Review which they believed would be good practice in learning lessons and sharing information.

28. The family expressed their wish to commend the actions of Nurse A on the day the man died. They said she acted professionally and appropriately and hoped she received the necessary support and supervision from her manager.

HMP and YOI HATFIELD

21. HMP and YOI Hatfield is a category D open resettlement prison that accommodates 140 adult prisoners and 120 young offenders who are within two years of the end of their sentence. It was previously called Moorland prison, but this was changed in 2010. The prison is divided between two sites known as Hatfield Open and Hatfield Closed prisons. Hatfield Closed prison is located a few miles away and is a training prison.

22. Primary healthcare is provided by Nottingham Trust who supply a doctor and nursing service to prisoners. Any prisoner in need of hospital treatment will be transferred to Doncaster Royal Infirmary. All dental, optical and chiropody treatments are carried out at the Hatfield Closed prison site.

Her Majesty's Inspectorate of Prisons report (HMCIP)

23. The last published report for Hatfield followed an announced inspection in November-December 2010. The report noted that the health services provided were functional but the health centre required modernisation. Clinical governance arrangements were sound. Prisoners generally received good pharmacy and dentistry services, although there was poor access to the dentist. There were gaps in psychological services and group therapies.

24. Lone working in healthcare was standard practice for portions of the day and, at the time of the inspection, the nurse on duty was working alone. The geography of the prison and layout of healthcare meant that lone workers were isolated.

Independent Monitoring Board (IMB) report

25. Each prison in England and Wales has an Independent Monitoring Board made up of unpaid volunteers from the local community, responsible for monitoring the prison and ensuring that proper standards of decency and care are maintained. The latest IMB report covers the period 1 March 2010 to 28 February 2011. With regard to healthcare at Hatfield, the IMB noted that it provided a limited clinical service for 260 prisoners with other treatment facilities available from the Closed site.

Previous deaths at Hatfield Open prison

26. Since this office took over responsibility for investigating deaths in prison custody in 2004, there have been no deaths at Hatfield Open prison.

KEY EVENTS

August 2009 – December 2011

27. The man was remanded into Hull prison in August 2009. He was identified as having a history of substance misuse, and had been taking methadone[3] for 20 years. He was also a heavy drinker, and sometimes experienced paranoia. After checking with his doctor in the community, he was prescribed citalopram[4] ,trifloperazine,[5]methadone, diazepam[6] trifluoperazine and thiamine[7].

28. The man moved from Hull to HMP Doncaster in January 2010, then to HMP Lindholme in April the same year. He did not always engage well with healthcare and missed a number of appointments. During this time the man's never complained of chest pain, but had an on going ankle problem, that was treated as arthritis with pain relief medication. The man also took anti depressants throughout his time in custody.

29. The man's medical records are often difficult to follow and decipher and it is difficult to obtain an accurate picture of the management of the man's substance misuse treatment. After an initial dose of 10mls of methadone when he first came into prison, it was quickly increased to a stabilisation dose of 20mls. It appears that this was increased to 40mls at a review in October 2009. In November 2010 he said he would like start a reduction programme. However, this did not happen and at the time of his transfer to Lindholme he remained on 40mls a day. In August 2010, he started a reduction plan and by December he was on 24ml per day. He was still taking this dose at the time he died, some 17 months later.

30. The man has also been prescribed an alcohol detoxification when he arrived at Hull. In August 2011, when at Lindholme, he was prescribed another alcohol detoxification although the reasons are not recorded.

31. The man was often on strong pain relief medication. There was also an incident in September 2010 where another prisoner was seen giving medication to the man. It appears there is some suggestion that he relied on medication and perhaps alcohol while in prison, although any meaningful conclusion is difficult to draw from the records.

December 2010 to July 2011

32. On 21 December, the man saw prison Dr A. He told the doctor he had a pain in his thigh that was getting worse. He said he had a history of DVT[8],

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[3] Used in the treatment of heroin addiction
[4] an anti-depressant
[5] an anti-psychotic drug
[6]an anxiety reducing drug
[7] vitamin B1
[8] Deep vein thrombosis. A clot in a deep vein.

something that the man had not raised previously, and was not mentioned by his community doctor. The man said that he had suffered multiple DVTs, the last in 2008. The doctor made an immediate referral for the man to be seen at hospital.

33. The next day, the man had an ultrasound at Doncaster Royal Infirmary (DRI) and he was examined. The result showed he had DVT and would require long term anti-coagulation[9]. The discharge letter from the hospital gave a prescription of co-codomol tablets, an injection of enoxaparin[10] each evening for ten days and a dose of oral warfarin[11] to be taken each evening. The medical notes said that the man had a swollen leg and thigh, had previous episodes of DVT. A scan showed that he had occlusive thrombus in the left femoral vein[12].

34. On 26 December 2010, the man attended an anticoagulant clinic[13]. The anticoagulant treatment record showed that he took warfarin medication every day between 26 December and 4 January 2011, except for 31 December. On that day, he refused to take the warfarin and despite being told of the risks to his health, could not be persuaded otherwise. This was his only record of non-compliance with his medication and the clinical reviewer theorises that this might be because he was planning to drink alcohol but this is purely an opinion. The man remained on methadone, but this had been reduced to 24 ml.

35. The man annotated on the warfarin record card that he was unhappy that he was still suffering pains in his leg, but had not been seen by healthcare.

36. On 3 January 2011, the man was seen in healthcare by Nurse B, a staff nurse. He complained that his left calf felt very sore and he had difficulty walking. It was agreed that his calf size would be measured and monitored and noted that he was able to walk.

37. The next day, the man was admitted to hospital suffering shortness of breath. The discharge summary from the hospital stated that the man was on "life long" warfarin and referred him for an echocardiogram[14] (ECG) to exclude pulmonary hypertension[15]. (The result of the ECG was normal, excluded pulmonary hypertension and showed "good bi-ventricular systolic" function).[16]

38. On 14 March a note in the man's medical record noted that he had cellulitis [17]in his foot and was prescribed antibiotics. It is also noted that healthcare sought advice from DRI's Tissue Viability Nurse[18]. They were advised to use

[9] prevents clotting of the blood
[10] an anti-coagulant medication
[11] medication for reducing blood clotting
[12] the blood flow to the artery in his leg was obstructed
[13] a clinic were medication is administered
[14] measures the activity of the heart
[15] high blood pressure
[16] affects both ventricles. Pressure on heart
[17] a skin condition
[18] prevents ulcers and infection

soft bandaging and crepe. However, the man was not happy that he had been prescribed a penicillin based antibiotic as he knew this should not be taken while on anti-coagulation medication, showing a good knowledge of the medication. He told healthcare of his concerns and on 17 March was told to stop taking the medication immediately. The plan was for him to see a doctor as a matter of urgency to discuss this. There is no record of what he was prescribed, if anything, instead.

39. A hospital letter, dated 28 March (following his appointment on 4 January), was recorded in the man's medical record. It said that "This gentleman's recent echocardiogram showed good biventricular systolic function with no evidence to suggest pulmonary hypertension and this is re-assuring". The man was due to attend the hospital the next day for a CT scan[19], however his medical record notes this was cancelled. It is clear that he did attend the hospital for a scan, although the date is not recorded. (on 5 May the results of the CT scan were received and recorded. It read "Just to let you know that the recent CT scan showed no evidence of any mass within your abdomen, which is obviously re-assuring. No further tests are therefore required.")

40. The following month, on 6 April, the man was seen by (noted in the records as "other community health service"). He was complaining of pains in his groin area, similar to pains he had experienced when he had DVT. Dr B asked them to take the man's temperature and blood pressure, but "was comfortable" that this was not a recurrence of DVT and did not need to see the man.

41. On 3 May, it was noted in the medical records that the man's cellulitus had cleared up. He no longer needed to be seen for dressing of the ankle, but was told to return if the condition appeared again.

42. On 5 July, an entry was made in the man's medical record. It said that a telephone call had been received from the coagulation clinic at the hospital and he had completed his course of warfarin and needed to stop taking it. A letter from the doctor at the hospital, written to healthcare, confirms this. He said that the man had been on anti-coagulant therapy for recurrent DVT since 24 December and the six month therapy has been completed. Therefore treatment was stopped from 4 July 2011.

43. On 18 July, it is noted that the man queried this. He was told by a healthcare worker A, that she telephoned the anti-coagulation clinic for the man's latest warfarin results and was told that he had completed the course. The hospital explained that the reason they referred to the warfarin as "life long treatment" was because there is no limit to the length of time a patient can be on the medication. This depends on how they respond to treatment and what their test levels indicate. The healthcare worker confirmed that the hospital had said the warfarin should be stopped.

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[19] a computerised tomography scan which uses x-rays and a computer to obtain detailed images of the body

HMP and YOI Hatfield - from August 2011

44. On 2 August 2011 the man transferred to Hatfield Open prison. He was seen in reception by a member of healthcare, B. The First Reception Health Screen does not mention anything about the man's history of DVT. However they discussed the man's medication and he continued to be prescribed methadone (24ml) and mirtazapine.

45. A week later, on 8 August, the man visited healthcare and spoke to a healthcare assistant. He was not satisfied and wanted to know why the warfarin medication had been stopped. The man was still not satisfied with the explanation he was given and asked to see a doctor. Dr A (the doctor the man saw at Lindholme who worked at both prisons) explained again what the letter from the hospital had said regarding the warfarin medication. The man seemed satisfied with the explanation this time. The man then complained of a pain in his ankle. The doctor examined it and found no tenderness or swelling.

46. The man said he sometimes felt a niggling pain in his thigh. He was told that, although the examination showed nothing abnormal, an appointment would be made to investigate the pains. On 19 August, the man was diagnosed with ankle arthritis. The prison were awaiting X-rays they had requested from Lindholme prison six weeks earlier, so agreed to request these again from the prison.

47. On 21 September, healthcare received the man's ankle X-rays. After consideration of these he was referred for a hospital appointment.

48. On 23 November, the man complained of lower back pain. He was examined by Dr C. The man said he had been given an additional mattress by another prisoner which had helped him slightly, but wing staff said they would remove it as it was not prescribed for medical reasons. The doctor gave permission for the man to keep the mattress and diagnosed chronic lower back pain.

49. Three weeks later on 12 December, the man became concerned about an increase in his Body Mass Index [20](BMI). He saw Dr D and requested a referral for the remedial gym[21]. He discussed diet and exercise and was told that he could use the normal gym as the same results could be achieved. However, on 9 January 2012, he was granted his request to attend the remedial gym, as he had suffered from DVT. It is not recorded whether the man attended the gym.

13 January 2012

50. On the morning of 13 January, the man attended healthcare and was examined by Nurse C. He complained of a pain in his chest, which appeared to be centralised but radiating to his left shoulder. He also said he felt as if he

[20] measure of body fat based on weight and heart

[21] a gym programme adapted for prisoners with health problems

had been punched in the chest and although this did not hurt, he felt "pressure" there. He was not sweating or clammy and did not feel sick. He told the nurse that he had a history of DVTs. The nurse took a blood pressure reading and referred him to be seen by the doctor. There was no ECG available at the prison to carry out a test as this had been lent to the Closed site the day before and not returned.

51. Shortly afterwards, the man was seen by Dr E. He told her that pain had come on while he was sitting in his cell that morning, and although the pain had subsided he was still aware of it. Bearing in mind the man's history of DVT and that he was also displaying shortness of breath, the doctor arranged for an ambulance to take him to hospital. This arrived within a few minutes as an ambulance is stationed in the prison's car park at all times and was there at the time (it is a place from where the ambulance responds to all emergency calls). The doctor wrote a letter to accompany the man to the hospital. She said she had concerns about the man's DVT and queried a pulmonary embolus[22] and a "release on temporary licence" (ROTL) was prepared for the man to leave the prison unescorted by prison staff.

52. The man returned to the prison later that day. He had no information about what had happened at the hospital. The hospital did not contact healthcare with any information about the man, and neither did healthcare request it. The man saw Nurse C and told her that the hospital had carried out an ECG and a blood test and that they wanted him to stay at the hospital for another 12 hours, so they could carry out another blood test. However, the man did not want to wait any longer as he said he felt fine and the pain had gone, so he discharged himself. The man said the ECG and blood test had shown as being normal. The man did not attend healthcare again until 26 January, except to receive a daily dose of methadone.

The day the man died

53. On the morning the man died, he told a member of his unit staff that he felt unwell and would go to healthcare. He arrived there at approximately 8.40am and joined a queue of other prisoners. Nurse C saw the man and noted that he looked unwell. Given what had happened on 13 January she called him into the consulting room straight away.

54. The man complained of a pain between his shoulders he experienced while he was sweeping with a broom that morning. He was also short of breath. The man did not appear clammy or nauseous and had not been vomiting. Nurse C attempted to take the man's observations (blood pressure and pulse) but he became increasingly agitated stating he felt unwell and needed to lie down. He left healthcare at 8.55am. The nurse was in the process of contacting the man's unit to ask him to return, when he did so of his own accord. The man was still complaining about the pain between his shoulders, but now had chest pain and was clammy and sweating. An ambulance was called immediately and the nurse gave the man aspirin and administered

[22] blockage of main arteries

oxygen. There was no doctor on duty to see the man at that time, as they are only at the prison on Monday, Wednesday and Friday mornings.

55. Nurse C telephoned , a senior officer (SO) to request an ambulance. The SO immediately made the call and while he was still on the telephone the first responder vehicle arrived from the ambulance station in the prison car park.

56. The paramedic arrived in healthcare at 9.05am, examined the man and took an ECG reading. It showed abnormalities. Approximately seven to ten minutes later the ambulance arrived and was also directed to healthcare. After assessing the man, the paramedics decided he should be taken to Sheffield Northern General hospital for thrombolysing[23]. The SO prepared a ROTL for the man to be taken to hospital and the ambulance left the prison at 9.35am. Again the man was unescorted by prison staff.

57. Nurse C was contacted by a nurse in Accident and Emergency at DRI and asked for the man's next of kin details. The nurse said she thought the man had been taken to Sheffield Northern hospital, but was told that while en-route to the hospital he had suffered a cardiac arrest [24] in the ambulance and it was diverted to DRI which was closer.

58. Nurse C contacted the SO for the man's next of kin details and told him that the man was in a very serious condition. The SO accessed the man's prison records and found that his partner was noted as his next of kin, but there was no telephone number for her.

59. The SO was aware that the man and his partner had been involved with Social Services and telephoned a duty worker there. He explained the seriousness of the situation and the duty worker gave him a mobile telephone number for the man partner. He tried to call the number three times, but it appeared to be disconnected. The SO rang the duty worker again and explained the problem. The duty worker agreed to call at the partner's home address as it was close by and telephone him back with an update.

60. At approximately 10.30am, the SO rang DRI. He spoke with a staff nurse there and explained the difficulty he was having contacting the next of kin. The staff nurse said that the man was in a critical condition and staff were continuing to work on him.

61. At 11.20am, after speaking to a member of staff at the hospital, Nurse C telephoned the SO and told him that the man had died. She gave him the contact details of a member of staff at DRI. The SO passed this information to the duty governor.

62. Ten minutes later the duty worker from Social Services rang the SO back. She said that she had been to the man's partner's house, and while there was clearly somebody there, nobody answered the door. The SO told her that the

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[23] a procedure to dissolve a blood clot in the heart
[24] heart failure

man had died, but that she was not to pass this information on to anybody as it was the prison's responsibility to do so.

63. Half an hour later the Deputy Governor arrived from the prison's Closed site and took charge. The acting Head of Site at Hatfield asked the Governor's Secretary to contact the Independent Monitoring Board (IMB) to inform them of what had happened. He then held a full staff meeting (at approximately 12.30pm) where he informed staff of the news. He accompanied members of the Chaplaincy and the Care Team[25] to notify prisoners. The prisoners were reminded about the services of Listeners[26] and the Care Team who were made available to them.

64. A debrief was held for staff at 2.00pm. It was agreed that a memorial service would be held in the prison on the day of the funeral. A senior manager issued a notice to staff and prisoners setting out where help was available.

65. All prisoners at Hatfield have a contact sheet which lists family and friends. Having tried but not been able to contact the man partner, staff found his mothers contact details on the contact sheet. The acting Head of Site at Hatfield and another member of staff were appointed as the prison's family liaison officers and agreed to contact the man's mother that afternoon.

66. That afternoon the acting Head of the Site at Hatfield and the other member of staff (who was due to go on leave and handed over to another member of staff after the visit) and the other member of staff visited the man's mother, in the absence of being able to contact the man's partner. They arrived at her house at 3.20pm, four hours after The man had died. The other member of staff explained what they knew of what had happened to the man and what would happen next. Other family members arrived to support the man's mother.

67. A post mortem was carried out on 31 January at DRI. The cause of death was given as left ventricular failure[27], ischaemic heart disease[28] and coronary artery atheroma[29]. A toxicology test was also carried out. Apart from methadone and mirtazapine (which were within the therapeutic range[30]) no other drugs were detected in the man's blood or urine.

68. The man's family visited the prison to see where the man had lived. They met two of his friends and collected his belongings. The prison contributed towards the man's funeral costs and acting Head of Site at Hatfield and the other member of staff attended the funeral.

[25] team of staff trained to speak and listen to staff and prisoners who are distressed
[26] prisoners trained to listen and talk to others who are distressed or need to talk
[27] unable to pump blood
[28] lining of the walls of the coronary artery
[29] sudden cardiac death
[30] these medications had been prescribed for The man and therefore traces of the drugs were to be expected

69. A critical incident debrief (or cold debrief) was held on 9 February. It was run by a chaplain and a member of the Care Team alongside members from the Prison Service's Staff Care and Welfare Team and staff who had worked closely with the man were invited to attend.

ISSUES

Clinical Care

70. The clinical review concludes that the overall access to regular healthcare both in terms of physical and mental health appears good. The clinical reviewers particularly commend the actions taken by the prison on the day that the man died. However, there are a number of important issues which need to be examined as a result of the man's death.

Anti-coagulation

71. A key issue for the clinical reviewers was the man's treatment for DVT. They question why the man's anti-coagulation was discontinued, as he had suffered DVTs previously and was therefore at risk from a future pulmonary embolism.

72. The clinical reviewers interviewed the Consultant Haematologist [31] at DRI. It is noted in their review that the discontinuation of the warfarin medication was not appropriate protocol for a patient who had suffered multiple previous DVTs and the Consultant agreed with this. Despite the man questioning why the medication had been stopped, it appears that the hospital's decision was not challenged by either Lindholme or Hatfield, merely clarified and confirmed.

73. The clinical reviewers note that in the community a "Yellow Book" is used to record anti-coagulation treatment. This is recommended by the National Patient Safety Agency and assists communication between all parties. It is usually kept by the patient and during an interview with a doctor at the prison, it was confirmed that this booklet was used for the man. In the man's case the book clearly states that he has "recurrent DVT" and the anti-coagulation should be "lifelong". This book usually accompanies a patient's blood samples to the laboratory at DRI. In this case it was issued by the hospital and used correctly initially. It appears to the clinical reviewers that the prison stopped sending this booklet with the man's blood samples at the end of February 2011, as there was no recording after this date.

74. The clinical reviewers also find that the hospital did not appear to have a system to identify that the man should been a lifelong anti-coagulation patient once the booklet was no longer being used, although the letter from the hospital advising the discontinuation of the treatment states that the man had "recurrent DVT". In the event, the clinical reviewers conclude that the man heart attack was not attributable to his history of DVT and warfarin treatment. However, this was a serious error.

75. The clinical reviewers make the following recommendation which we endorse.

    The Heads of Healthcare at Lindhome and Hatfield should ensure that warfarin therapy complies with the National Patient Safety Agency

[31] a doctor specialising in blood conditions

guidance, including the continual use of the "Yellow Book", which would have ensured the continuation of warfarin in this case.

Patient records at Hull, Doncaster, Lindholme and Hatfield

76. The clinical reviewers note that, aside from seeking clarification, healthcare staff at the prison did not challenge the discontinuation of the man's warfarin, despite his own enquiries about this. They were additionally hindered by poor record keeping systems within healthcare.

77. There is no patient summary in the medical notes which allows a doctor to easily ascertain that the man had recurrent DVTs at a glance. There were also no full and accurate records they could rely on.

78. The investigator had difficulty obtaining a full set of medical records from the prison, despite requesting these twice. She was told that she had been sent everything the prison healthcare held on the man when this clearly was not the case. The investigator obtained the required information from the clinical reviewers who were able to access the records themselves.

79. A particular concern relates to the man's substance misuse. There is no record of the reasons a second alcohol detoxification was prescribed in August 2011. Similarly, although the man methadone prescription was amended, there is little evidence of a coordinated approach to his substance misuse problem, and after a reduction in his methadone from 40mls to 24 mls, the records are silent about any further action. The lack of clarity in the records on this issue is particularly worrying and the clinical reviewers make the following recommendation which we endorse:

The Heads of Healthcare at Hull, Doncaster, Lindholme and Hatfield should ensure that all healthcare staff follow the requirements for accurate and contemporaneous record keeping in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.

Lack of communication between Doncaster Royal Infirmary and Hatfield

80. When the man attended hospital on 13 January he had an ECG and blood tests, and was awaiting further blood tests. However, against medical advice he discharged himself and returned to the prison. There was no evidence that the man had been given a discharge letter or recommendations for further management of his condition. The clinical reviewers view this as a lost opportunity to further explore the man's complaint and to exclude coronary heart disease.

81. Once the man had returned to the prison without any information, other than what he told Nurse C, no member of healthcare contacted the hospital to enquire about the outcome of the man's tests and any conclusion they may have reached. In essence, both the hospital and the prison neglected to pass or seek further information about the man.

82. The Head of Healthcare writes in her letter of 13 April,

> " The protocol has recently been ratified to ensure all staff contact DRI in the event that a patient self discharges and no discharge letter has been sent back in order to complete comprehensive records".

83. The Head of Healthcare adds;

> "We are in the process of arranging a meeting with the A and E manager to ensure appropriate discharge information is received by the prisons in a timely manner."

84. A recommendation is considered appropriate to ensure implementation of a system to strengthen communication between the prison and DRI:

    The Head of Healthcare at Hatfield should ensure that an agreement is reached with the hospital regarding the process for sharing patient information. This should be achieved by the end of June 2012.

Delay in informing the man's family

85. The man died at 11.20am, but his family were not informed until 3.20pm that afternoon. While acknowledging that the prison made efforts to contact the man's partner straight away, there still seems to have been a delay between that and visiting the man's mother. Importantly, the family liaison officers were not appointed until after the debrief, which was held at 2.00pm.

    In the event of a death, a family liaison officer should be appointed without delay. In the absence of the recorded next of kin information, other close relatives should be informed promptly.

No ECG machine on site

86. Hatfield's only ECG machine was lent to the Closed site on the 12 January, so there was no machine to test the man when he presented as unwell on 13 January. In her letter of 13 April, the Head of Healthcare confirmed that the machine had since been returned to the prison. However, a recommendation remains appropriate here.

    The Head of Healthcare at Hatfield should ensure that staff have access to an ECG machine that is kept on site.

CONCLUSION

87. The man had a number of health problems which, in the main, were managed well by each prison he spent time in. Throughout his time in custody his drug dependency was managed using methadone and was also treated for anxiety and depression. The man also complained on a number of occasions of pain in his legs or ankles. This was attributed to arthritis.

88. It was not until December 2010 that the man appeared to have informed staff that he had experienced recurrent DVT episodes, the last one in 2008. He was given warfarin but towards the end of the treatment, processes appear to have broken down and the appropriate documentation (the Yellow Book) was no longer sent to the hospital with the readings of the man's blood tests. It seems that for this reason the hospital did not realise the man was being treated for multiple DVTs and, after six months of treatment, advised the medication should be discontinued. Despite the man questioning the decision healthcare staff at both Lindholme and Hatfield did not challenge this decision. This was a serious failing, although it does not appear to have contributed to his death.

89. The investigation also identifies weaknesses in communication between Hatfield and DRI, as well as a need to ensure that the Hatfield Open prison has appropriate access to an ECG machine. The man's medical records were poorly maintained at all four prisons at which he was held. Finally, there were delays at Hatfield in notifying the man's family of his death.

RECOMMENDATIONS

To the Heads of Healthcare at Lindholme and Hatfield:

1. The Heads of Healthcare at Lindholme and Hatfield should ensure that warfarin therapy complies with the National Patient Safety Agency guidance, including the continual use of the "Yellow Book", which would have ensured the continuation of warfarin in this case.

   This recommendation was accepted by the prisons.

To the Heads of Healthcare at Hull, Doncaster, Lindholme and Hatfield

2. The Heads of Healthcare at Hull, Doncaster, Lindholme and Hatfield should ensure that all healthcare staff follow the requirements for accurate and contemporaneous record keeping in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council

   This recommendation was accepted by the prisons.

To the Head of Healthcare at Hatfield

3. The Head of Healthcare at Hatfield should ensure that an agreement is reached with the hospital regarding the process for sharing patient information. This should be achieved by the end of June 2012.

   This recommendation was accepted by the prison

4. The Head of Healthcare at Hatfield should ensure that staff have access to an ECG machine that is kept on site.

This recommendation was accepted by the prison

To the Governor of Hatfield

5. In the event of a death, a family liaison officer should be appointed without delay. In the absence of the recorded next of kin information, other close relatives should be informed promptly.

This recommendation was partially accepted by the prison. They responded as follows:

"It is agreed that FLO should be appointed without delay. However, we would like it to be noted that the FLO was contacted at 12.15pm. HMP/YOI Hatfield were notified of the man's death at 11.20am; the FLO was based at HMP/YOI Moorland, although an immediate contact would have been ideal, we feel the circumstances around the location of the FLO should be considered."