Investigation into the circumstances surrounding the death of a man at HMP Hewell in October 2011

Report by the Prisons and Probation Ombudsman for England and Wales

June 2012

Final Report

The man died at HMP Hewell in October 2011. He had entered custody in October. In the last week of his life, he developed a cough and was prescribed an antibiotic for a chest infection. On the morning in October, he suddenly became very unwell. He was found on the floor of his cell, bleeding from the nose and struggling to breathe. He then became unresponsive and, despite the best efforts of the healthcare staff and paramedics, did not recover.

The post mortem report found that the man's death was caused by a massive pulmonary embolism (a blood clot on the lung) resulting from deep vein thrombosis (DVT) in his left leg. DVT had caused a clot to form in his leg, which then travelled to his lung, resulting in his death.

The investigation was completed by two of my investigators. They visited Hewell to interview a prisoner, three doctors and a prison officer.

One of our family liaison officers (FLO) contacted the man's next of kin to discuss the investigation. I would like to extend my condolences to his relatives. I hope that the report provides them with a better understanding of what happened to him in prison.

A clinical review of the medical treatment which the man received in prison was undertaken by a Doctor, who was appointed by Worcestershire Primary Care Trust. He assessed whether the care he received in custody was comparable to that he could have expected in the community. I am grateful to the Clinical Reviewer for his assistance.

The investigation concludes that healthcare staff could not have foreseen or prevented the man's death and that the care he received was equal to, or even exceeded, that which he could have expected to receive in the community. We do, however, make two recommendations regarding the need for HMP Risley to ensure the improvement of communication between prison healthcare providers and community GP surgeries, and the need for HMP Hewell to ensure that healthcare staff are fully aware of emergency response procedures.

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Prisons and Probation Ombudsman **June 2012**

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SUMMARY

1. The man had previously been held in custody between February 2010 and January 2011 . He stayed at HMP Hewell and HMP Risley. Whilst at Risley, he was admitted to hospital and underwent tests for heart problems. However, a consultant cardiologist found no evidence that he was suffering from significant heart disease. He was prescribed ongoing medications to treat raised cholesterol and high blood pressure.

2. On 6 October 2011, the man appeared in court and was taken to Hewell. He described a number of symptoms to a doctor. The doctor consulted his previous clinical record under a different name and requested his community GP records. The doctor allowed him to bring into prison several of his existing medications for heart problems and keep them in his cell. The doctor planned to review his symptoms two weeks later.

3. The man spoke to a nurse on 17 October and reported a chesty cough. He was seen by a different doctor the next day, who diagnosed a chest infection and prescribed an antibiotic. On 21 October, he moved into cell 3 on the first landing of B spur on Houseblock 6. His cellmate later told the investigator that he continued to cough during the next couple of days.

4. On the morning of Sunday 23 October, the man stayed in cell after it was unlocked. His cell mate went to speak to a friend on another landing. At about 9.25am, a prisoner from a neighbouring cell found him collapsed in his cell. He was bleeding from the nose. The prisoner went and fetched prison officers from an upstairs landing.

5. The officers put out a call on the radio network and a doctor and two nurses who were about to start a surgery on B spur came downstairs to the cell. The man was pale, clammy and sweating. He was struggling to breathe and soon lost consciousness. The doctor asked officers to call an ambulance and the staff began attempts to resuscitate him. An ambulance arrived at 9.46am and he was taken to hospital, but he did not recover and died at 10.32am. The post mortem report indicated that his death was caused by a pulmonary embolism after a clot travelled to his lungs from his legs. The clot was caused by a condition known as deep vein thrombosis.

6. The Clinical Reviewer found in his clinical review that the healthcare staff at Hewell could not have predicted or prevented the man's death. His collapse was sudden and unexpected. The Clinical Reviewer commented that the healthcare he received was equal to that which he would have received in the community. We make two recommendations. These concern communication between prison healthcare providers and community GP surgeries, and ensuring healthcare staff are fully aware of emergency response procedures.

THE INVESTIGATION PROCESS

1. One of the investigators was told about the man's death in October 2011. Notices were issued to staff and prisoners at HMP Hewell telling them about the investigation process and inviting them to contact the investigator.

2. The investigator liaised with the acting staff officer during the investigation. He visited Hewell on 26 October to collect paperwork relating to the man's time in custody. He also spoke to the Governor and the Deputy Head of Healthcare and visited Houseblock to look at his cell and talk to his cellmate.

3. The investigator asked Worcestershire Primary Care Trust to commission a clinical review of the medical treatment the man received while in custody. The purpose of the review is to establish whether the care which he was offered in prison was comparable with that he could have expected in the community. The Clinical Reviewer completed the review

4. On 24 November, the investigator and the Deputy Ombudsman visited Hewell to interview two doctors and a prison officer. They spoke to, the Governor, and the investigator also provided written feedback about the progress of the investigation. On 19 December, the other investigator interviewed another doctor during a visit to Hewell.

5. The investigator who was told about the man's death wrote to the local Coroner at the start of this investigation to inform them of its nature and scope. HM Coroner will be provided with a copy of the report.

The man's family

6. On 23 November, our family liaison officers, contacted the man's daughter, his named next of kin.

7. The man's daughter said that she had visited her father whilst he was held at Hewell. He seemed to be in a lot of pain and discomfort during the visit but said that he thought that he had a chest infection and that he was waiting to see a doctor. His daughter asked whether her father saw a prison doctor at this time and whether he was assessed and treated appropriately.

8. The man's daughter explained that her father had had stents fitted after experiencing heart problems during a previous period in prison custody. She said that he had suffered problems with painful swelling in his legs. She remembered that her father had visited his GP and, on one occasion, when the swelling was particularly bad, had sought out of hours emergency assistance. His daughter said that her father had been diagnosed with circulatory problems. She questioned whether prison healthcare staff were aware of her father's circulatory problems and, if so, whether this knowledge could have helped to prevent his death. She asked whether anything more could have reasonably been done to detect and treat the blood clot before it caused her father's death.

9. The man's daughter spoke positively about the help and support she had received from the prison. She said her father's property was returned promptly and her family were appreciative of the financial assistance provided towards the funeral. She mentioned that her family were touched to receive a wreath from prisoners. She said that she also appreciated the fact that the prison had organised everything so quickly.

10. The man's daughter received a copy of the draft report as part of the consultation process. In her response, she explained that it had proved too distressing to read the detail of what had happened to her father and as such she was not able to raise any further issues. Her mother also read the report but had no further questions for the investigator. We would like to thank the man's family for their consideration of the report.

HMP HEWELL

11. HMP Hewell is a grouping of three pre-existing prisons located on the same site (HMP Blakenhurst, HMP Brockhill and HMP Hewell Grange). The prison cluster was renamed in June 2008. Hewell primarily accepts prisoners from courts in the West Midlands, Worcestershire, and Warwickshire. Houseblocks 1 to 6 hold 1074 men in Category B conditions. Houseblock 7 has been decommissioned and The Grange Resettlement Unit holds 187 men in Category D conditions. HMP Hewell in total holds 1261 men.

12. Healthcare at Hewell is commissioned by Worcestershire Primary Care Trust. Houseblocks 1 to 6 have 24 hour nursing staff, with in-patient care comprised of 21 single cells.

Independent Monitoring Board (IMB)

13. Each prison has an Independent Monitoring Board (IMB), whose members are appointed by the Secretary of State for Justice from the local community. Their role is to satisfy themselves that the prisoners are treated humanely and justly and that there are adequate programmes for preparing prisoners for release. The IMB report directly to the Secretary of State if they have any concerns. They also submit annual reports on how the prison has performed. Members of the IMB have access to every prisoner and every part of the prison.

14. The most recent annual report published by the IMB at Hewell covers the period from 1 December 2009 to 30 November 2010. The board commented:

> 'At the end of the last reporting year, the Board expressed concerns that further reductions in the prison's budget could have an adverse effect on any future consolidation or improvements. Reductions in budgets have continued. The prison has repeatedly met these demands with diligence. There is little indication that budget reductions are having a direct effect on offenders. However, as cuts continue, it is hard to see how they will not have an adverse impact.'

HM Inspectorate of Prisons' report

15. The former HM Chief Inspector of Prisons, completed an unannounced inspection of Hewell in November 2009. In the report of the inspection, she wrote:

> '…houseblocks 1-6 (previously HMP Blakenhurst) provided a good local prison function…
>
> 'Health services included a wide range of clinics delivered by in-house and visiting specialists. Primary care services were generally good, but access to all services varied between houseblocks, and prisoners' perception of healthcare was poor. Too many prisoners were failing to

attend healthcare appointments, although work to reduce this was ongoing.

'There was a comprehensive range of primary care service, although prisoners were unhappy with the overall quality of health services. In our survey, only 36 percent of respondents on houseblocks 1 to 7 said that the overall quality of health services was good…

Previous deaths at Hewell

16. Since 2004, the Ombudsman has investigated deaths at Blakenhurst, Hewell Grange and Brockhill. None of the previous investigations raised any issues which are pertinent to the circumstances surrounding the man's death.

KEY EVENTS

12 February 2010 – 11 January 2011

17. The man had previous convictions and had spent time in prison under a different name. Most recently, he had served a custodial sentence..

18. The man was held at HMP Hewell between February and March 2010. When he arrived at Hewell, he told the staff about a family history of heart disease, high blood pressure and strokes. In early March, he reported episodes of nausea, palpitations and chest pains. The doctor ordered an electrocardiogram (ECG), which showed a normal heart rhythm.

19. The man transferred to HMP Risley in March 2010. A few days later, he told a doctor that he felt short of breath and light headed, was experiencing chest pains and had a tingling sensation in his fingers. He explained that he usually had high blood pressure and thought he might have a rapid heart rhythm. The doctor checked his heart sounds, which were normal. The man explained that he had previously been prescribed propranolol (a beta blocker used to treat high blood pressure, chest pains and an irregular heart beat). The doctor began a new prescription for this drug.

20. Staff performed another ECG on the man in April, and the results were once again normal. They also referred him to the chest pain clinic at a nearby hospital. He was prescribed simvastatin (used to control raised cholesterol), ramipril (used to treat high blood pressure with the possible side effect of a dry cough) aspirin (to thin the blood) and glyceryl trinitrate (GTN) spray (for angina pain).

21. The man attended his outpatient appointment at the chest pain clinic on 24 May. Clinic staff recorded left sided chest pain that had been increasing in severity. They advised that he should undergo tests and that his prescription for propranolol be changed to atenolol (another beta blocker used to treat heart problems). He was escorted to another hospital appointment on 18 June.

22. On 25 June, the man was admitted to the accident and emergency department of the local hospital. He had fainted and was escorted in an emergency ambulance after prison healthcare staff had performed another ECG. His heart rate had slowed (a condition known as brachycardia). He stayed in hospital and eventually returned to Risley on 1 July.

23. During the summer, a consultant cardiologist wrote to healthcare staff, indicating that his test results were normal and confirming that there was no evidence that he was suffering from significant heart disease. The cardiologist discharged him and advised that his prescriptions for ramipril, simvastatin and aspirin should continue. The man did not return to hospital for outpatient appointments whilst he was held at Risley and did not report any further related symptoms. He was released from custody on 11 January 2011.

October 2011

24. On 4 October, just before he was remanded into custody again, the man went to see his local GP at Balliol Road Surgery in Coventry. He reported symptoms including tingling in his arms and feet, blurred vision, headaches, itching and slurred speech. His blood pressure was elevated so the doctor prescribed appropriate medication to treat this condition. The doctor told him to return in four weeks for a further review.

25. On 6 October, the man appeared at a local Magistrates' Court and was remanded into custody for two new offences of threatening words and behaviour. He was taken to Hewell. On the Person Escort Record (PER, a form which is used when a prisoner transfers to record any risks), escort staff recorded that he suffered from heart arrhythmia and epilepsy.

26. During his first night reception health screening, the man told Staff Nurse that he was prescribed simvastatin, ramipril, aspirin and felodipine (used to control high blood pressure). He had brought supplies of these drugs into prison with him. The Staff Nurse recorded that staff would need to contact his community GP for more information about his heart problems and possible early onset multiple sclerosis. (There are no other references to a possible MS diagnosis in the clinical record.) She recorded that the man had no outstanding hospital outpatient appointments but had apparently been referred to a neurologist (a doctor specialising in disorders of the nervous system).

27. A doctor assessed the man the same evening in the reception clinic on Houseblock 6. He said that he had changed his name since he was last in custody. The doctor recorded his previous name and prison number. His previous name was on his medication labels because he had not yet informed his community GP about the change in his personal details.

28. The doctor assessed and read the man's clinical record from 2010 to confirm which medication he had previously been prescribed and to verify his identity. The doctor agreed that he could be given his own supply of the four medications that he had brought with him to prison. The doctor allowed him to keep the sealed blister packs of medication with him in his cell. He authorised a repeat prescription when he exhausted his current supplies. (In the event, the prison never actually prescribed any repeat doses because He had not yet exhausted his own 28 day supply when he died.)

29. The man also told the doctor that he would fidget at night because he had been experiencing pains in his legs for the last four months. He also described occasional loss of sight associated with headaches during the previous three months. He said that, at night, he sometimes experienced weakness in his hands and started to slur his speech. The doctor planned to review him in two weeks time to consider further investigation of his symptoms.

30. The doctor requested the man's records from his community GP. At the time of his death, the prison had still not received any documents from the community surgery. Although doctors request these records routinely during the reception process, they do not subsequently check if they have arrived in each individual case due to the volume of new prisoners received on a daily basis. A further request could be made to the GP surgery if the prisoner reported worsening symptoms.

31. The next day, 7 October, a nurse assessed the man. The nurse recorded that his multiple sclerosis symptoms were under investigation and also wrote:

> 'Fluctuating tachycardia [the heart is beating too fast], bradycardia [the heart is beating too slowly] and palpitation?'

32. The man appeared at court again on 14 October. His next court appearance was set for 4 November. His daughter visited him on Saturday 15 October.

33. On 17 October, the man told another Nurse that he was feeling 'very chesty and coughing up phlegm'. The next day, 18 October, a different doctor assessed him. He told the doctor that he had been coughing for a few days, felt short of breath and was experiencing pain in the wall of his chest when he coughed. He said that he felt feverish and had already taken paracetamol and ibuprofen.

34. The doctor examined the man. The doctor found that his chest was clear, he was not having undue difficulty breathing and he did not have a fever. The doctor diagnosed a possible chest infection and prescribed amoxicillin (an antibiotic) for seven days. He collected the prescription the same day.

35. When the investigator spoke to the doctor, he confirmed that the man had not been particularly short of breath, was not coughing up either phlegm or blood and did not report any pain or swelling in his legs during the consultation. He confirmed that he did not consult his clinical record under his different name.. However, he told the investigator that he would make the same diagnosis of a chest infection in the future if anybody else presented with the man's symptoms.

36. On Wednesday 19 October, the man's daughter visited him again. She told the family liaison officer that her father seemed to be in a lot of pain and discomfort, but told her that he thought that he had a chest infection.

37. The man moved into a different cell on the first landing of B spur on Houseblock on Friday 21 October. He shared a cell. The man's cell mate told the investigator that he had mentioned that he had a heart problem and also said that he had a chest infection. He had told his cell mate that he had experienced similar symptoms in prison before.

38. The man's cell mate recalled during interview that the man kept coughing on Friday 21 and Saturday 22 October. However, he remained chatty and did not seem otherwise particularly unwell. He said that the medication he'd been

given for his chest infection was not helping. He did not seem to have any other symptoms and did not cough up any blood. His cell mate suggested that the man ask to see the nurse during rounds at 4.00pm on Saturday afternoon but he replied that he would go the next day.

Sunday 23 October

39. The man's cell mate told the investigator that the man woke up coughing at about 4.00am, 5.00am and 6.00am on Sunday morning. He eventually woke himself up coughing at about 8.00am but stayed in bed. The cells were unlocked at about 8.45am. He made a cup of tea for the man and then went to chat to a friend on the third landing.

40. A little while later, another prisoner, who lived in the neighbouring cell to the man and his cell mate, found him in his cell. He had collapsed on the floor and was bleeding from his nose. The other prisoner went upstairs from the first to the third landing and alerted an Officer at about 9.25am. (The journey upstairs takes a matter of seconds.) The Officer was working at the medical hatch on the third landing. He asked the officer to check the man.

41. The Officer went down to the first landing. The journey from the medical hatch to the cell took about thirty seconds. He recalled during interview that the door was pulled to. The Officer looked through the observation hatch before he entered. He then opened the door, shot the bolt so he could not be locked inside and discovered the man lying on the cell floor on his back with his feet towards the door, breathing very heavily. His nose was bleeding and he kept saying that he could not breathe.

42. Another Officer followed the Officer down the stairs and into the cell. He initially used his radio to notify control room staff of a 'code red' emergency ('code red' was used because the man was bleeding), but then within seconds updated his message to a 'code blue' emergency because he was having difficulty breathing.

43. The Officer who was first alerted asked the man what medication he was taking, and did not get a proper answer, but he did say the word 'heart'. The Officer then tried to help him by placing him in the recovery position until the nurses arrived, but this proved difficult because the man was drenched in sweat. The officer was in the process of using a towel to assist the manoeuvre when healthcare staff arrived. He told the investigator that he thought it took a couple of minutes for the healthcare staff to reach the cell.

44. A Sunday surgery, for new reception prisoners received from court the previous day, was about to begin on the third landing of B spur, so a doctor and two nurses were very close by. The nurse who recorded that the man's multiple sclerosis symptoms were under investigation and another nurse were in the medical room on the third floor when they heard the emergency call on their radios. They asked a doctor to accompany them. (The doctor does not carry a radio or keys.) The healthcare staff brought two emergency response

bags and a defibrillator. Their journey again took thirty seconds and they reached the cell at 9.28am.

45. The man looked pale and clammy and was sweating profusely. He was bleeding from the nose and complained of intense central chest pain. The doctor who accompanied the nurses told the investigator that the first thing he did after he observed the man was to ask Senior Officer (SO) in charge of Houseblock 6 that day to request an ambulance. The doctor remembered that the man was screaming with central chest pain. The SO went to the wing office and told a colleague to inform the control room.

46. The man told the nurses and doctor that he was struggling to breathe. The nurse who recorded that the man's multiple sclerosis symptoms were under investigation took his blood pressure, which was so low as to be unrecordable. His pulse was also very low. Staff took an ECG reading. The reading suggested that he might be having a heart attack. His oxygen saturation was low, so the other nurse gave him oxygen through a mask. However, he could not tolerate this and resisted. The nurse tried to reassure him and held the mask just away from his face, which the man seemed to find slightly easier, although he still tried to push the mask away. The nurses gave him 300mg of aspirin, which he managed to chew. The doctor inserted an intravenous drip in his right arm to administer fluids.

47. SO in charge of Houseblock 6 that day ordered staff to lock all of the other prisoners in their cells during the emergency. Staff also manned the route from the ambulance to the cell to ensure that doors could be unlocked as swiftly as possible for the paramedics. Another Nurse joined her colleagues in the cell.

48. At 9.40am, the man suddenly became unresponsive and went into cardiac arrest. He had no pulse so the medical staff began performing cardiopulmonary resuscitation (CPR). The nurse who recorded that the man's multiple sclerosis symptoms were under investigation performed chest compressions (which the doctor who accompanied the nurses later took over). The other Nurse inserted an airway and gave him oxygen using a bag and mask. The doctor attached a defibrillator (a machine which can deliver an electric shock to reset a heart rhythm if one is detected). However, the machine indicated that the staff should not administer an electric shock but should rather carry on giving CPR. Staff repeated this procedure several times but the defibrillator continued to advise that he did not have a heart rhythm which could be shocked.

49. An ambulance arrived at 9.46am. The paramedics were quickly escorted to the wing and took over CPR from the nursing staff. The doctor estimated during interview that he and the nurses had been performing CPR for about ten minutes at this point. The paramedics gave the man shots of adrenaline but still obtained no response. A second ambulance arrived at 9.55am. He was moved from the cell to an ambulance on a stretcher at 10.15am and left Hewell at 10.20am. However, he did not recover and was pronounced dead at 10.32am, shortly after he arrived at hospital.

50. A member of the care team spoke to the man's cell mate the officer who was alerted of the man's condition, and three other officers. Staff moved the man's cell mate into a cell with a friend to provide him with support.

51. The man had named his daughter as his next of kin. He had provided two addresses for her. (One was his own residence, the other his daughter's.) Because the duty governor in charge of the prison that day was uncertain of the age of the man's daughter or which address she was using, he telephoned the police for advice.

52. The duty governor then telephoned the man's daughter before leaving the prison to meet her face to face. He confirmed her identity, established her age and that she was currently residing at her father's address and told her that he needed to visit her in person because he had some significant news about her father. The man's daughter was travelling in a car at the time and agreed to return to her own address to wait for the duty governor.

53. By the time the duty governor and the Anglican chaplain arrived, the man's daughter's mother had arrived at the address as well as other family members. The duty governor then broke the news of the man's death to his daughter in person.

54. Prison staff held a hot debrief meeting at 12.30pm that afternoon. (This meeting is intended to allow staff to learn any immediate lessons from the emergency and to check on the officers' and nurses' welfare.)

55. The prison's family liaison officer visited the man's next of kin on Tuesday 25 October. The prison managers offered the family financial assistance to pay for the funeral in accordance with the policy of the National Offender Management Service (NOMS). His funeral service was held in November.

56. The post mortem report found that the man's death was caused by a massive pulmonary embolism (a large blood clot which had obstructed the main artery of the lung after travelling up his body from his left leg, which was affected by deep vein thrombosis).

ISSUES

Clinical care

57. The Clinical Reviewer completed a review of the man's clinical care in prison. His findings are worth including in full:

> 'He suffered an acute catastrophic event causing his sudden death. On review of his medical records I can find nothing to suggest that this could have been anticipated or predicted and therefore could not have been prevented. In general I found that the quality of care that he received at both HMP Hewell and HMP Risley was of a standard that was equitable to and in some areas exceeded the care that he would have expected to have received in the community.
>
> 'His reception screenings were robust with appropriate assessments and examinations with clearly recorded and appropriate information including past medical history, current and past treatments and current symptoms.
>
> 'There is no evidence from the records of the reception screens including the doctor's assessment that his subsequent collapse and death from a pulmonary embolis could have been predicted or diagnosed.
>
> 'His medication was continued on admission to HMP Hewell and requests for information from his previous GP regarding his recent consultations were made in a timely manner.
>
> 'His recent symptoms and the suggested diagnosis of multiple sclerosis were noted and an appropriate timescale was made to review his symptoms hopefully with receipt of community records. This management plan appears appropriate.
>
> 'All his consultations appeared to be timely and with appropriate history-taking, treatment and examination. Appropriate investigations and referrals were ordered when necessary.
>
> 'In particular, I compliment the following:
>
> 'The thorough assessment, treatment, referral and post-hospital appointment review whilst at HMP Risley and the documented involvement of the man in his own care.
>
> 'My only criticism was his discharge letter from HMP Risley to his community GP which, although it contained his medication and immunisations whilst in prison … gave no details of the extensive cardiac investigations that had been performed during outpatient and inpatient attendance at Warrington & Halton Hospital. Although the investigation results were normal, it would have been important for his

GP to be aware of these investigations and of these results… a more detailed discharge letter would have been pertinent.

'A few days prior to his death, the man was seen by a prison GP with chest symptoms. There was an appropriate record of the consultation and clear advice was given to him to return if his health was not improving.

'At interview, the GP could not recall any other significant points from the consultation and examination and he stated that there was nothing to suggest there was any other significant problem. He stated that his conclusions from the consultation would be the same if he were presented with a similar problem again in prison or in the community. I can see nothing from the consultation that could have predicted or prevented his death.

'There was a prompt emergency response to his collapse from all personnel. The prison officer immediately made an emergency call on finding the man collapsed and healthcare staff attended immediately with the appropriate equipment and an ambulance was called. He was given emergency care and CPR was started as soon as he arrested.

'There were some concerns noted that the doctor was not fully aware of the emergency calls but he accompanied the nursing staff at their request and therefore there was no delay in his attendance.

'There were anxieties expressed regarding the time taken for paramedics to attend but the timescales show that they were prompt and I think the comments were more due to the pressure and anxiety during the acute emergency rather than actual delay.

'In fact, the prompt response and the immediate arrival of trained staff with appropriate equipment was likely to be a superior response to what the man would have received had he collapsed at home or in the community.'

58. We make the following recommendation based on the Clinical Reviewers findings:

The Head of Healthcare at HMP Risley should ensure that details of any treatment that a prisoner receives at outside hospital are recorded in a discharge letter to their local GP surgery when they are released.

59. As the Clinical Reviewer suggests, the doctor who accompanied the nurses to the man does not carry keys or a radio during his surgery rounds at Hewell. During interview, he told the investigator that he did not know what was meant by the phrases ‘the 3s’ or ‘code red’ or ‘code blue’. We make the following recommendation:

    The Head of Healthcare at HMP Hewell should ensure that all healthcare staff understand basic prison terminology and emergency response procedures.

CONCLUSION

60. The man had only been back in custody for two and a half weeks when he suddenly collapsed and died. He had recently been seen by two different doctors who, in the Clinical Reviewer's opinion, both made appropriate and reasonable assessments based on the information they had. The reception doctor did check his previous prison clinical record and did request his community GP record. In the Clinical Reviewer's opinion, the healthcare staff could not have foreseen or prevented his death.

RECOMMENDATIONS

HMP Risley

1. The Head of Healthcare at HMP Risley should ensure that details of any treatment that a prisoner receives at outside hospital are recorded in a discharge letter to their local GP surgery when they are released.

   The Head of Healthcare at Risley accepted the recommendation and provided the following response:

   'HMP Risley healthcare centre uses "SystmOne", an electronic health record keeping system. It is understood that this system has now been adopted by all prisons. This system enables health information [about] each prisoner to be shared with other prisons as a patient moves from one establishment to another or is re-admitted following release. This system is not compatible with General Practitioner (GP) surgeries record keeping systems unless, they too, use SystmOne. With this in mind, on release, a letter is provided to the patients GP to provide a summary of care. On the occasion of the man being released a summary of care was provided but it is accepted that not all of the information had been conveyed.

   'Following investigation of this incident the process for discharge planning and conveying information has now been enhanced at HMP Risley. There are clear guidelines for the discharging nurses to follow; outlining which information must be sent to the GP. Additionally, nurses are now instructed to attach copies of consultant letters to the discharge letter where appropriate. The discharge letter has been adjusted to include a reminder of contact details for the GP to use to confirm information or request a full copy of the record if required.

   'It is of significant note however, that some patients do not have a GP on release. Some patients do not recall who their GP is and some refuse to supply that information for varying reasons. In this instance, the letter is provided to the patient to give to their GP at their next appointment. In these circumstances it is not always appropriate to attach consultant letters. To mitigate some of the risk that this carries, there is a note to the GP indicating if letters do exist and how to obtain them.

   'Also of note is that some patients decline to attend for a discharge appointment. In this instance, a letter is sent to the GP based on the information contained in the record.

   'If there is not a GP name and address noted in the record and the patient does not attend the discharge clinic, it is not always possible to convey any information.'

HMP Hewell

2. The Head of Healthcare at HMP Hewell should ensure that all healthcare staff understands basic prison terminology and emergency response procedures.

   The Head of Healthcare at Hewell accepted the recommendation and provided the following response:

   'All staff new to healthcare are subject to both a [Primary Care Trust] and a local induction programme, specifically about HMP Hewell and prison life. This will be extended to ensure [that] agency and locum staff who are employed for an extended period also undertake the local induction programme. This includes the terminology when codes are called across the [radio network].'