



**Investigation into the circumstances surrounding the
death of a man in January 2012
at HMP Nottingham**

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

August 2012

This is the report of the investigation into the death of a man in January 2012 at HMP Nottingham. He was 70 years old when he died of heart disease. I offer my condolences to those affected by his death.

An investigator carried out the investigation. The local PCT appointed a clinical reviewer to review the clinical care the man received in custody. Nottingham prison cooperated fully with this investigation.

The man had complex physical and mental health needs. He moved from HMP Whatton to Nottingham, so that he could have 24 hour nursing care. Once at Nottingham another prisoner was appointed as his carer. Later on the day that the carer transferred to another prison, he was found unresponsive in his cell by two healthcare assistants. Resuscitation was not started immediately and only began once additional staff arrived. Paramedics attended and confirmed his death. Although it seems unlikely to have affected the outcome for him, I am concerned that there appeared to be some confusion among those first on the scene about whether resuscitation should have been attempted.

Overall, the investigation concludes that the man's complex physical and mental health needs were satisfactorily managed. However, cardiopulmonary resuscitation was not initiated in a timely fashion when he was found in an unresponsive state, although this was unlikely to have contributed to his death. Of greater concern were weaknesses in the provision of basic social care. Too much reliance was placed on a fellow prisoner to act as his carer and he was not adequately equipped or trained for the task. More broadly, this case is a reminder of the significant challenges posed to the prison system by an ever increasing elderly population, a challenge that many prisons are still struggling to address.

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.

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Prisons and Probation Ombudsman

August 2012

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SUMMARY

1. The man was sentenced to 12 years imprisonment in August 2007, for serious offences. On his arrival at HMP Bedford, it was noted that he suffered from diabetes, heart disease and schizophrenia. He transferred to HMP Isle of Wight (Albany) for three years, before arriving at HMP Whatton in December 2010.
2. His physical and mental health was deteriorating and he did not comply with his diabetic diet and medication. Despite taking medication for his schizophrenia, he still showed signs of mental illness and was regularly assessed by the mental health team and a psychiatrist. He did not maintain his personal hygiene. Eventually he became incontinent.
3. In October 2011, the man was referred for an assessment for admission to intensive mental health unit. After two months, the assessment concluded he did not meet the criteria for this treatment. Over the next few weeks, he was admitted to hospital on three occasions for diabetes-related illnesses. In November, it was agreed that he would transfer to HMP Nottingham, where there was 24 hour nursing cover.
4. On 19 November, he moved to Nottingham and was allocated a cell for prisoners in need of regular medical treatments and observation for the first two weeks. He moved to the vulnerable prisoners' unit on 1 December and a prisoner took on the role of his carer. His incontinence progressively deteriorated. On 5 December, a care plan was drawn up for twice daily visits by healthcare staff to help with his personal hygiene, and change his clothing and bedding.
5. The carer continued to support him on the wing, but he found the role of carer to be onerous and told the investigator he did not have appropriate equipment or resources. On 19 December, suicide monitoring procedures were started after the man told the carer he wanted to kill himself. Over the next few weeks, healthcare staff visited him on the wing at least twice daily, but often he had showered and his cell had been cleaned already.
6. In early January 2012, the carer transferred to another prison. A review of the man's suicide document was undertaken at 8.00am and he was told that his carer had left the prison. At 3.30pm that afternoon, two healthcare assistants entered his cell to carry out his personal care. He was unresponsive on his bed, and the healthcare assistants asked an officer to radio for emergency assistance. A registered nurse was on the wing and attended the cell with a principal officer. The nurse checked him for signs of life then told the officer that he had died.
7. A few minutes later, a senior healthcare officer, also a registered nurse, attended the cell, then fetched an emergency medical bag and defibrillator from the wing. The nurse started resuscitation until the arrival of the paramedics. The man's death was confirmed at 4.05pm.

8. The man's complex healthcare needs were monitored by the prison, but his daily care needs were met by another prisoner who had been appointed as his carer. We are concerned that the carer's responsibilities were not clearly explained to him, nor was he adequately equipped, supported or trained for this demanding role and we make two related recommendations. It is a matter of concern that resuscitation was not started as soon as the man was discovered collapsed in his cell, and we have made a further recommendation.

THE INVESTIGATION PROCESS

9. The investigation into the man's death was opened on 20 January 2012, when the investigator and her colleague visited Nottingham. They were met by the liaison officer. Later, they met the Governor and Head of Healthcare. The investigators then visited the man's cell and spoke to three prisoners who knew him.
10. Notices to staff and prisoners about the investigation had been sent in advance of the investigators' visit. The Independent Monitoring Board (IMB) and the Prison Officers' Association (POA) were notified of the investigation and the investigator's details passed to them should they wish to contact her. (The IMB consists of volunteers drawn from the local community who monitor the day to day life of the prison, to ensure proper standards of care and decency are maintained. The POA is the prison officer's trade union.)
11. The local PCT appointed a clinical reviewer to carry out a review of the man's clinical care.
12. One of the Ombudsman's family liaison officers wrote to the man's son as his named next of kin, to explain the purpose of the investigation and invite him to raise any issues for consideration. To date, he has chosen not to make contact with this office and has not seen the report.
13. On 8 February, the investigator and the clinical reviewer interviewed healthcare staff at Nottingham. Both investigators visited HMP Shrewsbury on 14 February, to speak to a prisoner who had acted as the man's carer in Nottingham.
14. The investigators returned to Nottingham on 23 February to carry out interviews with prison staff. Later, they gave feedback on the initial stages of the investigation to the Deputy Governor. The investigator then confirmed the points raised at the feedback meeting in a letter, to the Governor on 27 February.
15. In March 2012, the carer wrote to Her Majesty's Inspectorate of Prisons (HMIP) about the ongoing distress that caring for the man has caused him. HMIP referred the correspondence to this office. His letter has also been taken into account as evidence for this investigation.

HMP NOTTINGHAM

16. HMP Nottingham is a category B local prison serving the courts in the Nottinghamshire area. The prison expanded in 2010 to hold up to 1,060 prisoners. The prison has no inpatient healthcare unit and prisoners who need nursing care live in one of the ten cells in the Enhanced Care Area (ECA) on A wing. Nurses provide a 24 hour service for prisoners in the ECA.
17. Following its most recent inspection in February 2010, Her Majesty's Inspectorate of Prisons (HMIP), described healthcare services available at Nottingham:

“The health care centre provided GP and specialist clinics. The mental health in-reach team was based in the same building that housed pharmacy and dental services. Medicine administration and, on occasion, some minor treatments were carried out in treatment rooms on each of the wings. All areas used for the treatment and care of patients were appropriately equipped, clean and well decorated.
18. The IMB's latest annual report for 2010-2011, commented on the healthcare service as follows:

“Healthcare moved successfully into new premises on 1 March 2010. The expansion of the prison population took place more rapidly than recruitment of new nursing staff but this was achieved by December 2010. There is no doubt that a very comprehensive healthcare service is available to the prisoners which, it can be argued, is significantly better than healthcare they would receive in the community.”
19. Since January 2010, there have been two deaths from natural causes at Nottingham, neither of which had any similarities with the man's death. Another prisoner has died of natural causes at Nottingham since the man, but again there was no shared learning from that investigation.

KEY EVENTS

20. The man was born in 1941. He was divorced with two grown up children. On 10 August 2007, he was sentenced at Crown Court to 12 years imprisonment for serious sexual offences. He began his sentence at Bedford, moved to the Isle of Wight and after he became a category C prisoner, then he transferred to Whatton, a category C (medium security) prison, on 15 December 2010.
21. On arrival at Whatton, the man was assessed by a doctor. She noted that he was a diabetic, with a history of heart disease. He had been prescribed insulin for his diabetes, however the doctor noted that there was a poor history of information regarding his diabetic medication. She renewed his prescription and noted that he needed an early review with the diabetic nurse. He was also referred to the mental health in-reach team because of his history of schizophrenia, diagnosed in 1965, for which he received clopixon by injection, and quetiapine orally (both antipsychotic medications).
22. A nurse assessed his health risk following his appointment with the doctor. His blood pressure was within normal limits. He told the nurse he had self-harmed some years ago and before his arrest. However, he said he had no thoughts of self-harm.
23. He saw mental health nurse on 30 December for an assessment. He told the nurse he was feeling well with no thoughts of self-harm and he spoke about a preoccupation with religious ideas. Following the assessment, the nurse spoke to a senior mental health worker and a nurse at the Isle of Wight, who confirmed that he was prescribed clopixon fortnightly and he should receive his next dose that day. The nurse administered the injection to him.

January 2011 – September 2011

24. The man was seen daily by nursing staff for his insulin and medication. He received regular reviews for his mental health including six weekly assessments by a psychiatrist. His mobility was poor and he often used a wheelchair.
25. In April, he was recorded as incontinent of urine and pads were given to him to help with this condition. His cell and personal hygiene were also becoming a problem. Healthcare staff visited him twice a day to assist with showering and prompting him to help himself with his daily tasks.
26. In May, wing staff reported to a mental health nurse that the man's unpredictable behaviour was becoming problematic. They were concerned about his inappropriate dress and incontinence of both urine and faeces in his cell. The nurse said she would refer these concerns to the psychiatrist. In the meantime, he was seen weekly by the mental health team on the wing and encouraged by other healthcare staff to take care of his own personal hygiene. On 22 July, he was seen by a psychiatrist, who noted that he was feeling better and that his thoughts were clearer. The doctor prescribed a higher dose of clopixon and stopped the quetiapine.
27. On 27 July, he was admitted to hospital for an assessment, because he had become confused, with no obvious explanation. He returned to

Whatton two days later without any information about diagnosis or prescribed treatments from the hospital.

28. A month later, on 26 August, a doctor arranged for the man to be admitted to hospital again for observations because he was short of breath and unwell. While in hospital, he had a computerised tomography (CT) scan. (A CT scan takes internal body images for diagnosis.) According to the discharge summary, he denied chest pain, but reported feeling very anxious. The hospital suggested that he discuss his anxiety symptoms with his mental health nurse. Healthcare staff continued to visit him daily and the mental health nurse visited him every week.
29. On 16 September, the psychiatrist arranged for him to have a full mental health assessment with a psychiatrist to see if he would benefit from intensive psychiatric therapy.

October – November 2011

30. On 25 October, the man was admitted to hospital after being found on the floor of his cell. He was an inpatient for six days before he returned to Whatton on 31 October, after being diagnosed with a chest infection and poor diabetes control. His insulin dose was decreased and he was prescribed antibiotics.
31. On 1 November, the day after his discharge, he was again admitted to hospital after being found unresponsive in his cell. He was discharged from hospital again on 5 November and advised to take his meals and medication as directed. His diabetes was not being effectively controlled by either food or medication. Healthcare staff monitored him daily and ensured he ate his meals and ate regularly, but they were only able to carry out this level of care within their duty times. (Healthcare staff are on duty daily from 7.30am until 6.00pm, with the exception of weekends, when there is very limited staff cover in the mornings only.)
32. A psychiatrist from an intensive psychiatric care hospital in Luton visited Whatton on 16 November to assess whether the man met the criteria for admission to the unit. After the consultation, the psychiatrist assessed that he did not meet their criteria for admission. There was no explanation of the decision. Later that day, he was admitted to hospital as his sugar levels were too low. He returned to Whatton the following day, with a care plan.
33. A nurse noted that he could no longer be cared for at Whatton, and to monitor his diabetes he needed a prison with 24 hour nursing cover. A transfer agreement was made with HMP Nottingham so that he could be monitored by nursing staff. (Nottingham has a 24 hour healthcare service.) It was also noted that a referral was made to the hospital for him to have a colonoscopy procedure to investigate his irregular bowel habits. (A colonoscopy procedure is an examination of the bowel by inserting a camera into the rectum.)

November 2011 – January 2012

34. The man transferred to Nottingham on 19 November. After an initial health screen, he was located in the Enhanced Care Area (ECA). According to his care plan, he was to receive two visits a day from healthcare staff to assist with his personal hygiene, check his sugar

levels and oversee the administration of his insulin and other medication. The following day, a mental health nurse recorded that he was incontinent of faeces and urine, and displayed classic schizophrenic behaviour. The nurse also noted that his cell needed a full clean.

35. Over the following ten days, the man's health improved with 24 hour healthcare and monitoring of his diabetes. On 30 November, healthcare staff at Nottingham discussed his possible transfer back to Whatton but it was agreed he still needed 24 hour healthcare services to keep his diabetes under control and he would remain at Nottingham. He was not entirely happy with this decision, but he said he understood there was no alternative for his ongoing medical care.
36. A nurse wrote on 1 December, that he would move to the vulnerable prisoners' unit (VPU). (The VPU accommodates prisoners at risk of violence or intimidation from others because of their offending history, physical or mental health.) Living in the VPU, he would have the opportunity to socialise with other prisoners and be encouraged to look after himself. A care plan was logged into his medical record for twice daily visits and medication rounds.
37. On 4 December, a prisoner and wing cleaner was asked by the wing manager, a Senior Officer (SO), if he would act as a carer for the man. The work would be to help clean his cell, fetch meals and generally assist him in his day to day tasks. The prisoner agreed to take on this role as he had previously helped his own elderly parents. He was told by the SO that he would gain enhanced incentive privileges. (The Incentives and Earned Privileged Scheme (IEPS) is a scheme that is designed to encourage and reward good behaviour in prisons. There are three tiers – Basic, Standard and Enhanced).
38. The prisoner said that most days on entering the man's cell, he would find faeces and urine on the floor, a blocked toilet and "general mayhem" and it would be his job to clean this up. He said that he often took him to the shower after finding him in soiled clothing and helped him to change his incontinence pads when he had been sitting in soiled clothing for several hours. He told the investigators that he told wing staff that he found the role of being a carer to be challenging. However, he wanted to carry on assisting him and he did not want to put his enhanced earned privileges at risk. He said he was not given any special clothes to wear or antibacterial gels to guard against infections that could be passed on when he was cleaning up his soiled bedding and clothes.
39. A nurse had noted on 5 December, that the man's toilet was dirty and he was in need of a shower. Following a discussion with the Developing Prison Service Manager (DPSM) over his personal and cell hygiene, a case review was noted in his medical record and a new care plan drawn up. The plan repeated that he must have two visits a day from healthcare to tend to his personal hygiene, bedding and physical health needs. He needed help to complete his menu card to avoid high sugar foods. All interventions had to be documented and any issues discussed at the 1.00pm daily healthcare handover meeting.
40. Over the next few days, healthcare staff visited at least twice a day and noted that the man's cell was already cleaned. (By the carer.) A specialist diabetic nurse visited him on 8 December and discussed his diet and medication with him. She explained the diabetic plan which

included monitoring his sugar levels twice a day and adjusted his medication. The nurse advised him not to eat sugary foods, biscuits and sweets, which he told her he enjoyed. Two days later, he was transferred back to the ECA after becoming disoriented and soiling his cell floor.

41. The man returned to F wing on 12 December, and a nurse attended the wing staff meeting to pass on concerns about his behaviour. It was agreed that healthcare staff would continue to visit twice a day to carry out personal care, medication and blood sugar monitoring.
42. The carer told a wing officer on 19 December, that the man had asked him to help him commit suicide. Assessment, Care in Custody and Teamwork (ACCT) procedures were started. (ACCT is an assessment and care planning system, which aims to identify the prisoner's needs and offer personalised care and support before, during and after crisis, in a safe and caring environment.) He was assessed as low risk and observations set for at least one per hour. At the next ACCT review 26 December, the case manager noted that he was feeling positive with no thoughts of self harm and felt supported by the carer. His observations remained at one per hour.
43. A full ACCT review was held on 2 January 2012, and the man was recorded as "a little confused". His observations remained hourly. The review recorded that a representative from healthcare should attend the next review. On 5 January, a Registered General Nurse (RGN) attended an ACCT case review for him. The panel noted that he wanted to take his own life and felt low in mood. He was still assessed as a low risk of harming himself and observations remained hourly.
44. According to his ACCT ongoing record, the man was "a little messed up with excreta on his bedding and on himself" on the morning of 7 January. The case manager recorded that he took a shower and his "wing support worker" cleaned his cell. The carer told the investigators that that day he was finally given some protective clothing before cleaning the cell.
45. On 10 January, a doctor recorded that the man had refused to attend his latest hospital appointment for a colonoscopy to review his bowel function because he felt nauseous. The doctor recorded that his current medication and the care plan should be continued.

January 2012

46. In early January the carer was transferred from the prison. He was told at 7.30am and instructed not to tell the man that he was leaving. At 8.00am an ACCT case review was undertaken by a SO, officer and the man present. During the case review, he was told that his carer was leaving the prison and he told the SO he would miss him.
47. At 9.00am he was recorded as having showered, and was eating and drinking in his cell. A Healthcare Assistant (HCA) visited him at 9.47am and attended to his personal hygiene. The HCA noted in his medical record that he should be attended to by male staff as he had spoken and acted in a way that made her feel uneasy. An officer wrote in his ACCT document at 1.00pm that "he appears asleep and movement observed".

48. At 3.29pm, two HCAs arrived at the man's cell and asked an officer to open the cell door so they could attend to his personal hygiene. The officer opened the door and walked away to carry on with his duties. The HCAs entered the cell and found him on his side on his bed in the foetal position.
49. One HCA got no response when he gently shook the man, so checked his pulse but there was none. The healthcare assistant noticed that he face was very grey. He left the cell and went downstairs to where two officers were sitting and asked one of the officers to put out a radio call for "Hotel 9 'code blue'". (Hotel 9 is the on duty emergency nurse. A code blue indicates a patient is in breathing difficulty and/or unresponsive.) The HCA then made his way back up the stairs to the cell.
50. A nurse was in the senior officer's office nearby on the wing when he heard the call over the radio for Hotel 9. Within a very short while he heard repeated calls for Hotel 9. Although he was not the emergency duty nurse that day, he was close, so he left the office and together with a Principal Officer (PO) went to the cell. In interview, he said that he got to the cell "a little after 3.30pm".
51. On arrival at the cell, the nurse spoke to the HCA, who told the nurse that he thought the man was dead. The nurse saw that both the HCAs were standing in the doorway, looking shaken and uncertain. On entering the cell, he noticed saliva around the man's mouth and he was unresponsive. He walked over to the PO, who was standing in the cell door way and told him that he thought he was dead. He asked the PO to call on his radio for a doctor and Hotel 1 (the on-duty senior healthcare staff). He then reconsidered and asked the PO to call for an ambulance, as a doctor was not on duty in the prison. The ambulance was called at 3.32pm. The communication rooms (who take all radio calls) asked the PO for more information about the man. The nurse then made his way to a nearby treatment room so he could speak by telephone to the communications room.
52. A Healthcare Senior Officer (HSO) was Hotel 1 that day and had earlier heard the unanswered calls for Hotel 9, so he was on his way to the cell already. In his statement, he guessed that it took him five minutes to reach the cell after Hotel 9 was called and when he got there, he saw the HCAs, PO and SO outside the cell. He looked through the cell door and saw the man lying on the bed as if asleep. He said in his statement, that the PO told him that the nurse had checked him and that he was dead. The nurse was in the treatment room speaking to the communications room.
53. The HSO went to the treatment room and telephoned the healthcare manager for urgent assistance. He took the emergency bag, containing oxygen and equipment for resuscitation and told the nurse that he was going to use cardiopulmonary resuscitation (CPR, an emergency procedure to assist someone whose heart has stopped beating) and a defibrillator on the man. (A defibrillator sends a shock wave to re-start the heart if there is traceable heart activity.)
54. When he got back to the cell, the HSO said that the cell door was locked shut and that the PO had secured the cell after the nurse Hewitt said that the man was dead. The HSO told the PO he would have to enter the cell

to start resuscitation. The PO unlocked the cell and he went in, checked the man and found that although his was still warm to touch, there were no other signs of life.

55. The HSO was joined by the healthcare manager and they started CPR and used the defibrillator. The defibrillator indicated that no shock should be used, a sign that there was no heart activity. Healthcare staff continued with CPR until the arrival of the paramedics at 3.45pm. The paramedics continued with resuscitation until 4.05pm, when they pronounced the man dead.

Prisoner support

56. All the prisoners on the man's landing were told personally by the PO that he had died. Those who were on open ACCT documents were reviewed. The Governor and the care team came onto the wing to provide support to both prisoners and staff.
57. The man's carer was told the news by staff at HMP Shrewsbury, where he had transferred. He was upset, and has received counselling as a result of his experience caring for him.

Family liaison

58. Later that evening, the family liaison officer and the PO went to inform the man's next of kin of his death. The next of kin decided not to attend the funeral and did not wish to be involved in any of the arrangements. A funeral service was held for him on 10 February, attended by the family liaison officer and the Governor. The service was conducted by the prison chaplain. A memorial service was held in the prison chapel.

Staff support

59. A hot debrief was held for the staff involved. (A hot debrief is a meeting after a serious incident to provide information and support to staff.) They were reminded that they could access the care team for any ongoing support. All staff interviewed for this investigation felt well supported after the man's death.

Post-mortem report

60. According to the post-mortem report, the man died of ischaemic heart disease, when the blood supply to the heart is reduced. It has been established that diabetes increases the risk of heart disease, and also its severity, leading to the death of approximately 80 per cent of diabetics.

ISSUES

Clinical care

The management of the man's diabetes

61. The clinical reviewer concludes that the man's diabetes was appropriately monitored by healthcare staff and specialist nurses. His blood sugar levels were measured at frequent intervals and the decision to attempt twice daily insulin was reasonable. However, he struggled to manage his diabetes, as evidenced by several admissions to hospital, which had an impact on his overall physical condition. The clinical reviewer says:

"The man's mental health problems are likely to have contributed to his poor understanding of his medical condition and his poor compliance with his medication and diet. This made the control of his diabetes very difficult. The decision to transfer him to Nottingham to improve his diabetic care was sensible."

62. The clinical reviewer notes that the man's diabetic care at Nottingham remained problematic. He had difficulty injecting himself with insulin and did not follow the correct diet, often eating sugar based foods and not eating his meals. The clinical reviewer says:

"Although the oral medication that he [the man] was being given had not yet achieved the desired result, there is no evidence that this contributed to his subsequent collapse and death."

63. The clinical reviewer notes that the man received greater attention for his diabetes than he would have done if he had been cared for in the community. In light of the clinical reviewer's opinion, we are satisfied that healthcare staff tried to control his diabetes adequately, given his mental health condition.

The clinical management of the man's incontinence

64. The clinical reviewer writes that the man's urinary incontinence had not been referred for further medical investigation, despite being well documented at both Whatton and Nottingham. This must have been distressing not only for him, but for other prisoners and staff. The clinical reviewer comments:

"I was surprised that [the man's] urinary incontinence was attributed to behavioural causes without apparently giving consideration to prostatic hypertrophy [enlargement of the prostate] as a possible cause."

65. Although he records his surprise that no further investigation was made into the cause of the man's urinary incontinence, the clinical reviewer does not make a related recommendation.
66. In relation to his incontinence of faeces, the man had several colonoscopies to monitor his bowel function, although he refused to attend the hospital on the last occasion because he felt sick. The colonoscopies confirmed that his bowel function was normal and no associated medical treatment was needed.

67. The clinical reviewer does not comment, but the man's medical records show that he was routinely referred for further investigation as to the cause of his faecal incontinence and we are satisfied that the prison responded appropriately to the clinical aspect of this condition.

The management of the man's mental health

68. The man was diagnosed with schizophrenia in 1965. The clinical reviewer notes that his mental health problems were likely to have contributed to his poor understanding of his physical medical conditions, but does not suggest that his mental health itself was badly managed. He was visited at least weekly by a registered mental health nurse at Whatton and reviewed by a GP every week at Nottingham. His mental health medication was under review at the time of his death in an attempt to control his symptoms better. The clinical reviewer raises no concerns about his mental health treatment.

The man's daily care

69. A fellow prisoner was asked by a SO to act as a carer for the man. He was to assist him with his day to day tasks, cleaning the cell and fetching meals. However, in his correspondence with this office and in interview with the investigators, he has indicated that he believes his responsibilities as carer were unreasonable and beyond his capabilities. He was not trained or given adequate equipment to cope with the man's incontinence and behavioural issues.
70. At interview, the carer told the investigators that he saw the man at least twice a day to tend to his personal and hygiene care. He would often find that healthcare staff had not visited him by the time of his first visit, so he was left to clear up his incontinence without protection.
71. At interview, the SO told the investigators that cleaning up after the man was not seen as the carer's role. However, there was some disagreement with the healthcare staff over the times they visited him to carry out personal hygiene duties. The SO said:
- "My staff and the other managers on the wing were in conflict with healthcare over it all the time. They maintained they came across and did it. I probably saw them do it two or three times in the period that we had him [the man] with us. It caused quite a lot of friction between us and healthcare."
72. Her Majesty's Inspectorate of Prisons in September 2004 published a thematic review of older prisoners in England and Wales, 'No problems – old and quiet': An extract from that report is noted as follows:
- "Prisoners' personal care was of concern to healthcare staff, discipline staff and prisoners alike. Some prisoners told us that they had incontinence problems, which were embarrassing for them, but they received little help and were expected to manage somehow. Healthcare staff told us that they often did not have sufficient resources to deal with prisoners who needed assistance with hygiene. Nevertheless, residential staff still referred such prisoners to healthcare for assistance, as well as trying to give what help they could."

While this review was written over seven years ago, and in some respects there have been some improvements, the man's experiences suggests there is still much to be done to meet the needs of the ever growing number of elderly prisoners.

73. A care plan was in place for a member of healthcare staff to see him twice a day to deal with his personal hygiene needs and medication. According to the entries in his medical record, by the time healthcare staff visited him on the wing, his cell had often already been cleaned. It is evident that it was usually the carer who attended to, and cleaned up after, him.
74. The disagreement between healthcare and wing staff described by the SO should have been resolved to ensure that it did not interfere with the level of care that the man received. However, too much responsibility was placed on the carer and staff failed to deliver the care that the man needed. The carer should have been an additional measure to support him, rather than a substitute for staff not discharging their own responsibility.

The Governor and the Head of Healthcare should ensure that staff do not rely on prisoners to manage another prisoner's needs identified as the responsibility of healthcare staff.

75. In the letter passed to this office by HMIP, the carer wrote that he is still affected by the experience of caring for the man. He explained that he has had tests to determine whether he contracted any contagious diseases from handling bodily fluids without appropriate protection. He is receiving counselling to come to terms with the affect this experience has had on his life.
76. Training and equipment should be provided for prisoners acting as carers so those duties can be carried out safely and with dignity and respect. The carer was not trained; neither did he have access to specialist equipment or resources to care for the man. He did not receive adequate support from wing or healthcare staff. The Inspectorate thematic report on older prisoners identified the need for carer schemes to be developed under social service supervision with carers properly selected, supervised and trained. We make the following recommendation:

The Governor and the Head of Healthcare should ensure that where prisoner carers are used, they are appropriately selected as part of a formal carers' scheme and trained, supervised and equipped for personal social care.

Emergency response in January 2012

77. When both HCAs entered the man's cell they found him unresponsive on his bed. After checking for signs of life, one HCA left the cell and asked an officer to call for healthcare assistance and a code blue. At interview, the HCA told the investigator that he had not been trained in CPR. (Since the man's death, the HCA has undergone CPR training.)
78. When the nurse got to the cell, the nurse checked for signs of life and told the PO that, in his opinion, the man was dead.

79. Referring to the current Nottingham City NHS policy for healthcare staff, 'The Resuscitation, including Emergency Oxygen use in Adult Patient', 1.2 of the introduction says:

"Resuscitation must be initiated in all instances of cardiac and/or respiratory arrest unless the responsible healthcare team had taken a prior decision to make a "Do Not Attempt Resuscitation Order" (DNAR), through a process that has involved the next of kin and which has been recorded in the patient's healthcare records and communicated to staff. "

80. The man did not have a DNAR (also known as a DNR) in his medical record, therefore the HCAs and nurse should have started CPR as soon as they discovered him collapsed. At interview, the clinical reviewer asked the nurse if he considered attempting CPR. The nurse said:

"I've been in the situation in the past and I just get into that routine of doing airway breathing, call for help and then start but for some reason when I left the cell I just got confused about something and I don't know why. I mean certainly the man had been dead in my opinion a bit more than a minute or two."

81. The clinical reviewer asked the nurse if he was aware of resuscitation policies, and the nurse replied, "I found one, a prison policy, but I haven't yet found a healthcare policy".

82. At interview, the investigator asked the PO if he should have attempted CPR. The PO said:

"I saw the nurse go over and he put his hand on his, well, I presume it was his [the man's] throat and then he said yes, he's dead and I was like, I've come expecting a self-harm and I was like, I said sorry, what did you just say and he said he's dead. I said right, okay, I said what do you need, I said shall we start doing CPR and he said no, he's too long gone, he's cold."

83. With regard to first aid, Prison Service Order (PSO) 2710, following a death in custody said: "Prompt assistance - even a few minutes - may save a prisoner's life". CPR should be started as soon as possible on discovery of an unresponsive prisoner, unless rigor mortis has clearly set in.

84. The clinical reviewer concludes:

"There was a delay of approximately ten minutes in initiating resuscitation at the time the man was found in a collapsed state. Standard procedures were not followed and at least some of the staff present were not aware of the need to attempt immediate resuscitation in all cases (unless a Do Not Resuscitate order is in place). The staff present at this time all appear to be reliable witnesses and from the descriptions they gave I believe that this delay is very unlikely to have contributed to the man's death."

85. Clearly policies for administration of CPR on an unresponsive prisoner were not followed on this occasion. We make the following recommendation:

The Governor and Health of Healthcare should put in place a clear policy, promulgated to staff, that ensures that CPR is carried out on an unresponsive prisoner unless there is a DNR order in place or there are clear signs of rigor mortis of the limbs.

CONCLUSION

86. The man was an elderly man with failing physical and mental health. His diabetes control was difficult to manage as he would often be non compliant with his diet and administration of medication. There was concern over his mental health and diagnosis of schizophrenia. Although a psychiatrist assessed him as not being in need of intensive treatment, his challenging personal habits made it difficult for staff to integrate him into normal wing accommodation.
87. The ongoing care of the man was shared between a prisoner acting as a carer, wing and healthcare staff. The carer's role was ill-defined and he compensated for a disagreement between wing and healthcare staff about the responsibility to look after him. As a result, he carried out duties which he was not trained to do, without adequate protection.
88. The man's age, poor diabetes control and deteriorating physical health were contributory factors in shortening his life expectancy however, his death was unexpected. The clinical reviewer notes that the clinical management of his diabetes was better than it would have been if he had been living in the community. However, the clinical reviewer is also concerned that cardiopulmonary resuscitation was not initiated in a timely fashion, although he concludes that this was unlikely to have contributed to his death.

RECOMMENDATIONS

1. The Governor and the Head of Healthcare should ensure that staff do not rely on prisoners to manage another prisoner's needs identified as the responsibility of healthcare staff.

Partially accepted. NOMS responded that the prison health partnership will agree a protocol for the management of cases involving social care.

2. The Governor and the Head of Healthcare should ensure that where prisoner carers are used, they are appropriately selected as part of a formal carers' scheme and trained, supervised and equipped for personal social care.

Accepted. NOMS responded that prisoners will be selected as part a formal carers' scheme and trained, supervised and equipped for personal social care when this is required.

3. The Governor and Health of Healthcare should agree a clear policy, promulgated to staff, that CPR should be carried out on unresponsive prisoner unless there is a DNR order in place or there are clear signs of rigor mortis of the limbs.

Partially accepted. NOMS responded that this recommendation raises issues because of the confidentiality and availability of the medical record. There is already guidance to prison staff on resuscitation. But the report will provide a valuable opportunity to review learning from the man's death and other relevant PPO reports and provide clear guidance to prison and healthcare staff. This will result in a new protocol being agreed by the prison health partnership board.