

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at HMP Isle of
Wight in June 2013**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man at HMP Isle of Wight in June 2013. A post-mortem examination found that he died of heart disease complicated by high blood pressure. He was 69 years old. I offer my condolences to his family and friends.

A review of the clinical care which the man received in prison was undertaken. The prison cooperated fully with the investigation.

The man had been in prison since 2007 and moved to the Isle of Wight in 2008. He suffered from diabetes and chronic heart and lung problems. In June 2013, the GP introduced some new medication for pain related to his diabetes but not in line with the advice of a hospital consultant. On 22 June, he felt unwell and had to be helped back to his cell. The officer in charge of the prison went to check on him three times during the night and considered moving him to the prison's inpatient unit, but he preferred to stay in his cell. The next morning, a nurse came to check him and found him dead.

Overall, the clinical reviewer did not consider that the standard of the man's care at the prison was equivalent to that he could have expected to receive in the community. Accordingly, the investigation identifies a number of lessons from his case. He had been in poor health for some time and a large amount of medication was found in his cell after his death, suggesting that he did not take it as prescribed and that arrangements for in-possession medication require improvement. As he did not appear to respond well to his new medication, it would have been preferable to introduce it more gradually as the consultant had advised. While he seemed to recover, a nurse should have assessed him in person rather than relying on an account of his symptoms from prison staff. Finally, as he had been unwell during the night, I am concerned that wing staff did not check his wellbeing on the morning of the incident and he was not found until a nurse arrived after 10.00am.

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

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SUMMARY

1. The man received a 12 year prison sentence in 2007. In March 2008, he moved to HMP Albany (now part of HMP Isle of Wight). He had a number of pre-existing health problems, including diabetes, heart disease and lung problems, for which he was prescribed a range of medication.
2. The man continued to receive treatment for his pre-existing health problems and lived in the same cell for the next few years. On 6 June 2013, he saw a hospital consultant, who wrote a letter to the prison GP clearly outlining how his diabetic nerve pain should be treated. On 18 June, the GP prescribed medication which was not fully in line with this advice and did not record the reasons for his decision.
3. On 22 June, the man felt unwell and had to be helped back to his cell. A nurse examined him and stopped the newly prescribed medication because she thought that it was affecting him adversely. During the night, he fell and the orderly officer in charge of the prison visited his cell three times to check him. The orderly officer spoke to a nurse about him, but the nurse did not come to the wing to examine him and he was not taken to the inpatient unit to be assessed. He declined an offer to be admitted to the inpatient unit for monitoring because he said he felt better.
4. At 6.50am the night patrol officer completed his final roll check and was satisfied that the man was alive at that time. Although he got no verbal response, he said that he gestured to him. The cell doors were unlocked electronically at about 9.20am and a prisoner said he saw him alive on his bed at about 9.30am. At 10.10am, a nurse went to check him and found that he was dead. The nurse did not attempt resuscitation as he was cold. When the GP certified death an hour later, he thought that he had been dead for approximately three or four hours, so it appears unlikely that he was alive at 9.30am as the prisoner reported. He was found to have died from heart disease complicated by high blood pressure.
5. The investigation found that the prison GP did not follow a consultant's advice when prescribing new medication for the man shortly before he died. The clinical reviewer cannot say whether this was a factor which contributed to his death. The clinical reviewer found that this and a number of other aspects of his care, while not necessarily contributing to his death, were not equivalent to the standards of community care. We are concerned that, although he was unwell on the night of 22 June, a nurse did not examine him in person but instead relied on a prison officer's report of his symptoms. This is a matter that we have previously commented on in other investigation reports and which the Governor needs to resolve. Although it appears unlikely that it would have affected the outcome for him, we consider that prison staff should have checked him promptly on the morning he was found, as he had been unwell the night before. We make four recommendations as a result of the investigation.

THE INVESTIGATION PROCESS

6. Notices to staff and prisoners were put up at HMP Isle of Wight, inviting anyone with information about the man's death to contact the investigator. No one responded.
7. The investigator interviewed six members of staff and three prisoners at HMP Isle of Wight on 30 and 31 July. He visited E wing, where the man had lived, and gave initial feedback to the Governor about the investigation. He interviewed two further members of staff by telephone.
8. A clinical reviewer was appointed by the local PCT to review the man's clinical care.
9. The local Coroner has been sent a copy of this report.
10. Our family liaison officer initially contacted one of the man's friends who he had named as his next of kin. She did not have any specific issues which she wished the investigation to cover. Our family liaison officer subsequently spoke to his son and daughter, who wanted to know more about the cause and circumstances of his death.
11. The man's family received a copy of the draft report. They did not make any comments.

HMP ISLE OF WIGHT

12. HMP Isle of Wight is an amalgamation of two prisons, Parkhurst and Albany. The prison holds mostly sex offenders. The man lived on the Albany site.
13. Care UK has provided health services at the prison since 1 June 2013. There is an inpatient healthcare unit (IHU) with 18 beds on the Albany site. At night, two nurses and an officer staff the inpatient unit. The nurses do not visit the wings at night. If a prisoner is unwell, an officer telephones a nurse to describe his symptoms. The nurse can then call the out of hours doctor for advice or can ask for the prisoner to be brought to the inpatient unit.

Her Majesty's Inspectorate of Prisons

14. HM Inspectorate of Prisons (HMIP) most recently inspected Isle of Wight in May 2012. HMIP noted that health services had improved considerably from their previous inspection, although there were some delays in accessing primary care services for prisoners at Albany. Inspectors found that prisoners with chronic diseases were regularly reviewed and there were suitable nurse-led clinics for diabetes, asthma, chronic obstructive pulmonary lung disease, heart disease and high blood pressure.

Independent Monitoring Board

15. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that prisoners are treated fairly and decently. The IMB annual report for 2012 noted that the almost a third of the prisoners at the Albany site were over 50 and this placed considerable demands on healthcare services. The older population meant that there had been a number of deaths at the prison and the IMB was satisfied that these had been handled with care and compassion. The IMB considered there was an excellent system of patient feedback to determine the levels of satisfaction with health services. The IMB did not comment on out of hours healthcare provision.

Previous deaths

16. We have investigated 14 previous deaths at HMP Isle of Wight since the start of 2012. Thirteen of these were the result of natural causes, the other self-inflicted. The inability of nurses to leave the inpatient unit at night to examine prisoners on the wings has been identified as an issue in other investigations. We raise this issue again in this case.

KEY EVENTS

17. On 10 January 2007, the man was remanded into custody at Crown Court and taken to HMP Lewes. On 11 April, he received a 12 year prison sentence for sexual offences against children. He transferred to HMP High Down shortly afterwards and then to HMP Albany on 5 March 2008. (Albany became part of HMP Isle of Wight in 2009.) He moved to cell 20 on the first landing of E wing in January 2009 where he lived until his death.
18. The man had a number of health problems. He was diagnosed with Type 2 diabetes when he first came to prison, which he was likely to have had for several years. He suffered from chronic obstructive pulmonary disease (COPD), coronary heart disease including atrial fibrillation (heart rhythm disorder) and peripheral vascular disease (obstruction of the large arteries).
19. The man was prescribed three different drugs for diabetes: gliclazide, insulin and metformin. The healthcare staff and one of his fellow prisoners who spoke to our investigator did not consider that he controlled his diabetes well.
20. For his coronary and vascular problems, the man was prescribed medication to lower his cholesterol, GTN spray (for angina attacks), ramipril (for high blood pressure) and, from July 2011, he was prescribed warfarin to thin his blood. This drug was administered regularly and closely monitored.
21. The man had mobility problems because of his poor circulation and diabetes. In February 2012, he was given a footstool to help ease the pain of his swollen ankles. In March 2012, he was identified as a prisoner who would need help in an emergency evacuation of the wing and in October 2012 he was given a pair of crutches.

2013

22. On 16 January 2013, the man attended the prison diabetic clinic and was advised to increase his dose of insulin. He saw a doctor on 31 January, who diagnosed a urinary tract infection and a worsening of his COPD. The doctor prescribed an antibiotic.
23. The man smoked 25 cigarettes a day but gave up smoking at the beginning of February. On 15 February, he attended the prison blood pressure clinic. On 26 February and 13 March, he went to the prison smoking cessation clinic.
24. On 20 March, the man attended his COPD annual review. The next day, he attended the prison diabetic clinic. He was told to monitor himself for three months before his diabetes treatment would be reviewed again.
25. The man attended the smoking cessation clinic again on 8 April. He was still not smoking. On 17 April, he attended the prison coronary heart disease clinic and reported chest pains, twinges, gasping for breath, a tingling sensation in his arm, nausea and sweating. He had lost weight. His blood pressure was stable but his ankles and feet were swollen.

26. The man saw the doctor the same day, and said that he was losing sensation in his feet because of his diabetes. The doctor referred him to a hospital diabetologist for a review before an operation on his knee.
27. The man attended the smoking cessation clinic again on 22 April and 8 May. He was now regarded as having successfully given up smoking. On 9 May, he felt too unwell to attend a hospital pre-operative assessment for a total knee replacement which was planned for July. His appointment was rebooked and he attended on 15 May. In May, he suffered an acute exacerbation of his COPD and was prescribed an antibiotic and steroids to try and improve his lung capacity before surgery.
28. The man fell over on 28 May. He saw a diabetes consultant at hospital on 6 June. The consultant diagnosed chronic diabetic neuropathy (nerve pain) and advised good diabetes control, paracetamol, a pain killer such as tramadol and, if necessary, duloxetine (which relieves symptoms of diabetic neuropathy). The consultant also suggested that he could progress to pregabalin (for nerve pain relief), with the dose gradually increased over a short period. He recommended a 'stepwise treatment approach', starting with paracetamol and adding the others as necessary in sequence. He suggested that judicious use of paracetamol and tramadol would be best and might be sufficient to manage his pain.
29. The prison GP reviewed the man's diabetes on 10 June and scheduled another review for two or three weeks later. He saw him again on 18 June after tests showed that his blood pressure was abnormal. He prescribed amlodipine to help control his blood pressure better. He had received the consultant's letter about controlling the man's diabetic nerve pain but prescribed 300mg of gabapentin three times daily to relieve his pain, which was not in line with the consultant's advice.
30. On 19 June, the man attended the prison's nurse-led diabetic clinic. He was still prescribed gliclazide, metformin and insulin for his diabetes. The nurse planned to increase his dose of gliclazide but this change had not been actioned when he died. The nurse scheduled a review for three months later.
31. On 21 June, nurses tested the man's blood to make sure that his warfarin dose was correct. The result was within the target range.

Saturday 22 June

32. The man became unwell on the morning of Saturday 22 June. An officer saw the man having to steady himself as he made toast in the wing association area at breakfast time. He was breathing heavily and had to make an effort to walk. The officer and Prisoner A helped him back to his cell. He said that his medication was making him feel unsteady. The officer told him to call staff by pressing his cell bell if he continued to feel unwell. He seemed to recover a little once he was back in his cell. The officer asked Prisoner B in the neighbouring cell to keep an eye on him.
33. A little while later, Prisoner B suggested to the officer that he should collect the man's medication for him. The officer telephoned the healthcare team and spoke to a nurse, who established that he was not due any medication at

that time. She was concerned to hear that he was feeling unwell, so she came to the wing to check him.

34. The nurse took the man's blood pressure and checked his blood sugars, which were both raised. He said he felt fuzzy headed and dizzy. He showed the nurse the gabapentin which he had recently been prescribed. She took away the gabapentin as she thought that his unsteadiness might have been a side effect. She booked him an appointment with a GP on Monday to review his medication.
35. Prisoner A told the investigator that he had to help the man back to his cell a second time that day at about 5.00pm, as the prisoners were being locked up for the night. He said he was confused and disorientated.
36. At 9.10pm, Prisoner B thought he heard the man fall over in the neighbouring cell. He pressed his intercom to be released to go to the landing toilet. (The cells on E wing do not have integral sanitation and there is an electronic unlocking system to allow prisoners onto the landing one at a time to use the toilet at night.) Instead of going to the toilet, he looked through the man's observation panel and saw him lying on the floor. He then returned to his cell and used the intercom to alert the night patrol officer on E wing that night.
37. The officer came to the man's cell and saw him lying half on the bed and half on the floor. He radioed the control room and asked for the night orderly officer (NOO) to come and unlock the cell. The NOO and the assistant night orderly officer unlocked the cell at about 9.20pm and helped him back onto the bed. He was visibly shaken, confused and disorientated but responded to the NOO's questions. He blamed the change in his medication for his fall. The NOO checked his head for lumps and cuts and could not see any signs of injury.
38. The NOO had current training in emergency first aid at work and took the man's pulse, which was fairly strong. He told the NOO that he had not needed his angina spray for a few days and was not having any breathing difficulties. The NOO asked the officer to monitor him and told the man to stay in bed. He collected a urine bottle for him from the inpatient healthcare unit so he did not have to leave his cell to use the toilet and spoke to a nurse about him in passing.
39. At about 11.30pm, the officer radioed the control room and asked the NOO to check the man again. He was sitting in his chair watching television and seemed more coherent. The NOO went into his cell, saw a diabetic testing kit and asked him to test his blood sugar. He tested himself with a result of 15.5 (a high level but not so high as to require emergency treatment). The NOO told him that he had an appointment booked with the GP on Monday 24 June but that the healthcare staff would consider asking the out of hours GP to visit the prison on Sunday after he was reviewed the next morning. The NOO left the wing at about 11.40pm.
40. The NOO telephoned a nurse, who was based in the inpatient unit, to update her. He explained that the man had fallen and was more confused than normal. The nurse checked his electronic clinical record while they were on the telephone and saw another nurse's entry from earlier in the day. The

nurse had not met him before. She told the NOO that he could be admitted to the inpatient unit for monitoring and assessment overnight and she offered to call the out of hours GP. The NOO thought it unlikely that he would want to leave his cell and his budgie, so they agreed that he would get in touch if he had further concerns and that he would be checked hourly during the night.

41. The nurse wrote in the man's clinical record that a GP could check him the next day and that his urine might need to be tested to see if he had an infection that was making him unwell. She told the investigator that she considered calling the out of hours doctor, but ultimately did not because he was not admitted to the inpatient unit and she received no further telephone calls from the wing about him. She saw the NOO on the inpatient unit again during the night but neither mentioned him.

Sunday 23 June

42. At 12.15am, the NOO attended E wing to see another prisoner who had asked for the dedicated cordless telephone to call the Samaritans. He decided to check the man while he was there. The officer and NOO found his spur locked because a prisoner was out of his cell using the toilet. They were surprised to see that he was the prisoner coming out of the toilet, because they thought he had been too shaky and disorientated to walk from his cell to the toilet, which was about 25 metres away.
43. Once the man returned to his cell, the NOO unlocked him and went into his cell for a third time. He said that he felt much better and the NOO thought that he had markedly improved and was much more coherent. The NOO offered to move him to the inpatient unit for the night for observation, but he declined and said that he would rather stay in his own cell with his budgie. The NOO asked the officer to continue to check him during the night.
44. The officer told the investigator that he checked the man again at 1.00am and he was asleep. He did not then carry out hourly checks as the NOO had suggested. He completed a roll check at about 6.50am. He said that he kicked the man's door slightly to rouse him and he gave him a 'thumbs up' gesture. The officer was quite certain during interview that he saw him move. He asked him if he was okay, but did not get a verbal response.
45. Before he finished his shift, the NOO completed the Morning Operational Briefing for 23 June. A copy was placed in the E wing pigeon hole for the wing manager to read and brief the day staff with. He wrote:

'Approximately 21.10 called to HB 11 (E wing), the man 1-20 had fallen in cell and was visibly shaken. He was put to bed and IHU contacted and advice taken. NOO re-attended at approximately 23.32. Appointment made for Monday with the doctor but may be seen Sunday. To be monitored throughout the night.'
46. At 7.30am, the nurse handed over to two other nurses in the inpatient unit. She suggested that they should check the man.
47. The early start member of day staff on E wing began his shift at about 6.45am and completed a roll check between 6.45am and 7.15am. He told the

investigator that he looked through the man's observation panel during the roll check and observed him until he saw him move under his bedcovers. He did not speak to him. After this roll check, officers are not required to check prisoners again until lunchtime.

48. The night officer then finished his shift and handed over to the early start officer. He told the officer that the man had had a fall during the night and showed him his entries in the wing diary. He did not ask the officer to make any extra checks on him.
49. A nurse began work at 8.00am with her colleague. They deliver health services on the wings and do not work in the inpatient unit. They spent the first 45 minutes preparing medication. One of the nurses from the inpatient unit telephoned another nurse to update him about what had happened the night before. The nurse suggested a nurse might want to check him again because he had apparently been unwell overnight.
50. The rest of the E wing day staff started work at 9.00am. Before he left the wing, an officer handed over to another officer and told him about what had happened with the man. There was an entry about this in the wing diary. The officer told the investigator that he did not think that he needed to be checked urgently that morning.
51. The man's door was automatically unlocked at the same time as the other prisoners on the first landing, at approximately 9.20am. Because of the electronic unlock system, there is no need for an officer to be present and there is no routine check on prisoners' wellbeing at this stage. The door was now unlocked but remained closed.
52. Prisoner B was due to go to the chapel when he was unlocked, but as he was concerned about the man after his fall the night before, he looked through his observation panel to check on him. He did not open the door because he did not want to disturb him if he was sleeping and said that he could see him lying on the bed. He did not see him move and did not try to get a response from him as he assumed he was asleep.
53. As Prisoner B was leaving the wing, he spoke to another prisoner who sometimes acted as the man's carer and asked him to check him. The prisoner told the investigator that he went to the cell between 9.30am and 9.40am, opened the door and spoke to him. He recalled that he was lying on his bed and had said that he was tired. He told the investigator that he told him that he would check him later and closed the cell door.
54. Two nurses handed out medication to prisoners between 9.00am and 9.45am. Afterwards, one of the nurses checked another nurse's entry about the man on the electronic patient record. She then headed for E wing intending to perform a complete set of medical observations on him before possibly either calling the out of hours doctor or admitting him to the inpatient unit. She suspected from the entry that he was suffering from a urinary tract infection based on his symptoms over the previous 24 hours and took a pot to collect urine and a blood sugar monitoring kit.

55. The nurse arrived on the wing to check the man at 10.10am and she and an officer went to his cell. The officer knocked on the door but got no response from him. He went into the cell and found him lying on top of the bed covers in his underwear, apparently dead. The nurse checked him and immediately established that he had died. She advised against any attempt at resuscitation because he was cold.
56. The officer radioed the control room and a nurse came and agreed with the first nurse that the man had died. He told the orderly officer that an ambulance was not needed and that the on-call doctor could formally certify death. However, at 10.48, the duty governor asked for a non-emergency ambulance to be called. The on call doctor came to the prison and at 11.12am certified death. He asked for the ambulance to be cancelled. He thought that he had probably died three or four hours previously.
57. Later that day, officers in both parts of the prison reviewed all the prisoners subject to self-harm monitoring in case they had been adversely affected by the man's death.
58. The post-mortem examination found that the man had died as a result of hypertensive heart disease. His heart failure had been complicated by high blood pressure. The toxicology report confirmed that he was not under the influence of any illicit drugs or alcohol when he died. An amount of gabapentin, in line with the prescribed dose, was detected. The tests showed that his control of his blood glucose and diabetes had been poor.
59. A few days after the man died, the security manager and an officer went to the man's cell to collect his medication for the Coroner. The officer told the investigator that there was a lot of medication hidden in the cell, in drawers, in lockers and under the bed. He described collecting armfuls of medication and filling carrier bags with them.
60. Initially the prison's family liaison officer visited a family friend, who was listed as the man's next of kin to inform her of his death. However, on 3 July she contacted the man's son and daughter and explained what had happened. The prison offered to pay towards the cost of the funeral in accordance with Prison Service guidance. The funeral was held on 23 July and the family liaison officer attended.

ISSUES

Clinical care

61. The man died from hypertensive heart disease aggravated by high blood pressure. The clinical reviewer completed a review of his clinical care at the prison. He commented that he received a good range of proactive care for his diabetes, blood pressure and atrial fibrillation. The use of warfarin to thin his blood was well monitored and controlled.
62. However, the clinical reviewer had concerns about some aspects of the man's care. Although he had Chronic Obstructive Pulmonary Disease, a smoking related illness, he did not appear to have had any spirometry (lung function) tests to confirm this diagnosis, which the clinical reviewer thought was unusual, but he nonetheless received treatment for COPD and responded well to it. His blood pressure was latterly managed in accordance with national guidelines, but the clinical reviewer found that initially it was poorly managed and the treatment was slow. His cholesterol level was well controlled by simvastatin but he suffered from side effects and alternative statins were not considered. A number of hospital appointments were delayed, although the clinical reviewer did not think that this had any serious consequences for him.
63. Overall, the clinical reviewer found that the care provided to the man was not equivalent with that offered to the wider community. While he did not consider that any of the omissions and delays led directly to his death, he thought that they could cause serious harm to others in different situations. He makes some recommendations about the clinical care which do not relate directly to his death and are not covered in this report, but which the Head of Healthcare will need to consider.

Medication

64. After a hospital appointment at the start of June, the consultant wrote to the prison GP advising what medication the man should be prescribed for his diabetic nerve pain. The letter made a number of suggestions for treatment and indicated that there should be a gradual approach to medicating him.
65. When the prison GP addressed this issue at an appointment on 18 June, he prescribed 300mg of gabapentin three times daily. This was a high dose and was not in line with the consultant's advice. The clinical reviewer comments in his clinical review that this amount was at the upper limit of the British National Formulary (BNF) guidelines for a starting dose, but not outside the guidelines. He states that diabetic nerve pain can require higher doses.
66. The prison GP was frank during interview in saying that he had made a poor prescribing decision. He could not recall why he had not followed the consultant's suggested course of action. He said that changes in the provision of healthcare at the prison at the time and his associated workload had caused him stress, which then affected his practice as a GP. The clinical reviewer accepted that most areas have a prescribing policy to use gabapentin rather than pregabalin and that GPs are encouraged to use it as a first line medicine.

67. However, the prison GP did not record his reasons for prescribing in the man's clinical record. In retrospect, he thought that he had been unwise to prescribe amlodipine and gabapentin together. On reflection, he said that he would not have attempted to treat the blood pressure at the same time as addressing his nerve pain. It is important to remember that the man had very poor health and could have died from heart disease at any point. It is not possible to know whether the change in his medication contributed to his death in any way and the clinical reviewer has not found this to be the case. We make the following recommendation:

The Head of Healthcare should ensure that GP's fully record in the clinical record the reasons for prescribing decisions, particularly when they are not in accord with consultants' advice.

68. The man was allowed to keep his medication in possession following a risk assessment by healthcare staff. After he died, staff discovered that he had concealed a very large quantity of prescription drugs in his cell which had not been identified during routine daily accommodation fabric checks. These are quick daily checks by staff to make sure that the cell door, windows and fixtures have not been tampered with by the prisoner. They do not constitute a full cell search.
69. The investigator spoke to the Head of Healthcare. He said that additional compliance checks have recently been introduced, unconnected to the man's case. A nurse and an officer are now expected to conduct a daily random check on a prisoner who is allowed to keep prescribed medication in his cell to confirm that he has the correct amount of medication. This measure is designed to address hoarding and trading of medication and any potential bullying that may result. The scheme is presently targeting prisoners prescribed medication with the highest tradable value, such as gabapentin.
70. The investigator also spoke to the Head of Security and Intelligence. He was concerned about the amount of medication in possession on the wings and the tendency of older prisoners to hoard this. We believe that greater cooperation between the security and healthcare staff is needed to ensure that a prisoner's ability to keep medication in his cell is regularly reviewed and not abused and to help ensure that prisoners take their medication as prescribed. Healthcare staff often require information from wing staff to make a properly informed decision. The amount of medication that was found in the man's cell would suggest that he had not been complying with his medication regime as prescribed for some time, which cannot have assisted his ongoing treatment plan. We make the following recommendation:

The Governor and the Head of Healthcare should ensure that there are robust risk assessments to allow prisoners to keep medication in their possession which are regularly reviewed and that frequent cell checks help ensure prisoners have the correct amount of medication and are taking the medication they need.

Monitoring prisoners at night

71. During the night of 22 June, the NOO visited the man three times in his cell. He had fallen and initially seemed confused and disorientated, but seemed much improved after the third visit. The NOO consulted a nurse on the inpatient unit, and they considered admitting him to the inpatient unit. He then discussed this with the man, and he declined. The nurse did not visit him on the wing or speak to him on the telephone.
72. There is nothing to suggest that the man's death could have been prevented by admission to the inpatient unit that night. However, we consider that a nurse should have assessed him personally during the night, either on the wing or the inpatient unit. The nurse could also have discussed his care with the out of hours GP, which would have been prudent in the light of the concern already expressed about him earlier that day.
73. As the clinical reviewer comments in his clinical review, a prisoner's symptoms can be miscommunicated if reported third hand by a prison officer to a nurse and possibly then fourth hand by a nurse to the out of hours GP. Some of our previous investigations have demonstrated how nurses cannot easily leave the inpatient unit at night. Usual practice has been for an unwell prisoner to be brought to see a nurse on the inpatient unit, or for the nurse to advise a prison officer over the telephone.
74. In other prisons with inpatient facilities (predominantly local prisons) nurses are usually escorted by an orderly officer to the wing. We accept that Isle of Wight is a challenging working environment and it would be particularly difficult to implement across two sites, but it does not appear that the current practice makes the best use of on-site resources for the good of prisoners' health.
75. The Governor told the investigator that he expects a 24 hour response from healthcare staff if a prisoner feels unwell. He said that there is no policy to prevent nurses from the inpatient unit being escorted to check prisoners on the wings at night, if that is considered necessary. Care UK have been responsible for healthcare provision since 1 June 2013 and the service they must provide is detailed in a specification, which states:

'Response must be provided on a 24 hour basis.'

76. We understand that the Governor is currently discussing with Care UK exactly what tasks nurses will perform at night. The clinical reviewer suggests that Care UK could look at what is best practice at other prisons with inpatient units. While we would not wish to be prescriptive about how services should be provided locally, it is apparent that the current arrangements cause some problems. We make the following recommendation:

The Governor and the Head of Healthcare should agree with Care UK a precise definition of the responsibilities of nurses working at night to ensure that prisoners at HMP Isle of Wight receive an appropriate standard of care.

Monitoring at unlock

77. The NOO visited the man for the third and final time at about 12.15am. He was satisfied that he was feeling better but told the officer to keep checking him. The officer told the investigator that he checked him at 1.00am, when he was sleeping. He then did not check him again until his final roll check at about 6.50pm, when he is certain he moved and was alive. Another officer then completed his own roll check at about 7.30am and told the investigator that he saw him move on his bed.
78. The rest of the day staff started work at 9.00am, but nobody checked the man at this point. Although the officer had written about him in the wing observation book and wing diary, and he had written about him on the daily briefing document, none of this information appeared to raise sufficient concern about him for staff to check him. His cell door was automatically unlocked at 9.20am. This is done electronically from the control room and does not require an officer to check the prisoner.
79. A nurse claims to have looked in the man's cell at about 9.30am and seen him alive. He was quite certain of this during his interview with the investigator, but this seems at odds with the opinions of the healthcare staff who subsequently independently checked him and were both sure that he had been dead for quite some time.
80. A nurse arrived to check the man at 10.10am. The first couple of hours of her shift were spent preparing and then issuing medication to other prisoners. A message about him had been passed on, but there was no request for an urgent assessment, so the nurse went to the wing only after the medication round was completed.
81. This sequence of events meant that staff did not check the man until mid-morning. It is regrettable that wing staff did not go to check him as soon as the cells were unlocked. We were surprised to learn that staff do not check the welfare of prisoners after the electronic unlock, especially as the prison has a high proportion of older prisoners, but it is particularly important that those in poor health are checked. We make the following recommendation:

The Governor should ensure that wing staff check prisoners at unlock about whom concerns have been raised during the night and others who have known chronic conditions.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that GP's fully record in the clinical record the reasons for prescribing decisions, particularly when they are not in accord with consultants' advice.
2. The Governor and the Head of Healthcare should ensure that there are robust risk assessments to allow prisoners to keep medication in their possession which are regularly reviewed and that frequent cell checks help ensure prisoners have the correct amount of medication and are taking the medication they need.
3. The Governor and the Head of Healthcare should agree with Care UK a precise definition of the responsibilities of nurses working at night to ensure that prisoners at HMP Isle of Wight receive an appropriate standard of care.
4. The Governor should ensure that wing staff check prisoners at unlock about whom concerns have been raised during the night and others who have known chronic conditions.

Protect - Casework

ACTION PLAN: The Man – HMP Isle of Wight

No	Recommendation	Accepted/ Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that GP's fully record in the clinical record the reasons for prescribing decisions, particularly when they are not in accord with consultants' advice.	Accepted	<p>This has been discussed within the local Clinical Quality and Governance Group Meeting and the GPs have been advised of the need to record the reasons for prescribing decisions fully in the clinical record. As advice by one healthcare professional to another may, due to prevailing or changing circumstances, not always be followed, it has also been agreed that, where prescribing decisions made by prison GPs are not in accordance with consultants' advice, these are shared within the weekly multidisciplinary team (MDT) meeting and open to challenge and scrutiny.</p> <p>Arrangements are being made to enable all directly employed prison GPs to undertake regular GP sessions outside of the prison environment to ensure exposure to wider mainstream health issues. The Head of Healthcare and Clinical Lead will request a meeting with the Medical Director of the local Trust to discuss management and prescribing decisions by consultants to ensure awareness of applicability within a prison context.</p> <p>An audit plan will be agreed with the Pharmacy Lead for prescribing decision making and documentation once the GP team has been fully recruited.</p>	January 2014	
2	The Governor and the Head of Healthcare should ensure that there are robust risk assessments to allow	Accepted	In-possession arrangements have been reviewed and a more robust and explicit contract has been developed that makes clear the expectations	Completed	

	prisoners to keep medication in their possession which are regularly reviewed and that frequent cell checks help ensure prisoners have the correct amount of medication and are taking the medication they need.		regarding medication compliance and the consequences of non-compliance. In addition a regular programme of both targeted and random in-cell compliance checks is now in place and undertaken with prison colleagues.		
3	The Governor and the Head of Healthcare should agree with Care UK a precise definition of the responsibilities of nurses working at night to ensure that prisoners at HMP Isle of Wight receive an appropriate standard of care.	Accepted	This matter will be discussed with the Commissioner (NHS England) as the specification is unclear on expectations of nurses working at night and has been subject to differing interpretations. In addition, the existing flow chart and guidance for staff has been reviewed by the local Clinical Quality and Governance Group Meeting and updated to make clear that the prison out of hours GP must be contacted for advice if out of hours admission to the Inpatient Healthcare Unit is offered but refused by the patient. All clinical staff have been advised of this update individually. The prison will also explore the provision of a cordless telephone system along the lines of the Samaritans telephone to enable prisoners to talk directly to nursing staff and/or prison out of hours GP.	January 2014	
4	The Governor should ensure that wing staff check prisoners at unlock about whom concerns have been raised during the night and others who have known chronic conditions.	Accepted	When specific concerns are raised through the night regarding a prisoner this information is passed to on-coming staff at the morning handover. These prisoners will be checked at unlock and this will be recorded in the observation book. It is not current practice to identify specific prisoners with chronic illness. Chronic disease is defined as illness that is prolonged in duration, does not often resolve spontaneously, and is rarely cured completely. Chronic diseases are complex and varied in terms of their nature, how they are caused and the extent of their impact on the community. While some chronic diseases make large contributions to premature death, others contribute	January 2014	

		<p>more to disability. Healthcare will provide Wings with outline information on relevant prisoners with chronic diseases who need to be checked routinely and where there may be concerns, subject to the usual governance constraints on confidentiality. These prisoners will be checked at unlock and residential staff will ensure that a record is kept in the Observation Book.</p> <p>Assurance checks will be completed by Supervising Officers and Custodial Managers. An operational instruction will be issued to this effect.</p>		
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