PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in hospital in February 2013, while a prisoner at HMP Highpoint

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 hospital in February 2013, while in the custody of HMP Highpoint. A post-mortem showed that he died of a brain haemorrhage. He was 60 years old. I offer my condolences to his family and friends.

A clinical review of the clinical care the man received while in custody was carried out. HMP Highpoint cooperated with the investigation.

The man had undergone weight loss surgery in March 2012, before he went to prison, which resulted in him losing eight stones. In June, he began a three year prison sentence. When he arrived he said he was due a follow up appointment after his operation and that he had suffered various health problems in the past, including high blood pressure. He was prescribed a range of medications. He spent a short time at HMP Hewell and then moved to HMP Oakwood before moving to HMP Highpoint in November. Although he had frequent contact with healthcare staff at each of the prisons, his full medical history was never obtained and no overall care plan formed. His blood pressure was not monitored or managed in any planned way.

The clinical review found that the standard of the man's healthcare in prison was not equivalent to that which he could have expected in the community. The investigation identified that improvements are needed in each of the prisons he was held in, particularly to ensure that there are appropriate care plans for prisoners with complex needs. I am also concerned that there was a delay in summoning an emergency ambulance and that he was restrained when taken to hospital, even though he was unconscious at the time.

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 **November 2013**

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SUMMARY

1. In March 2012 the man had bariatric surgery, a weight loss procedure to reduce the size of the stomach. After the surgery, he lost approximately eight stones in weight. On 15 June, he was sentenced to three years imprisonment and missed a follow up appointment scheduled for 27 June.

2. The man was taken to HMP Hewell. When he arrived, he gave his medical history and was prescribed various medications. He told staff about his outstanding hospital appointment, but he was not taken to the appointment and a new one was not arranged. He had raised blood pressure and he was prescribed medication for this. He saw prison doctors twice because of problems with his stomach and digestion. His medication was altered each time.

3. In July 2012, the man moved to HMP Oakwood. At his reception health screen, he said that he had suffered a heart attack 20 years previously and a bleed in the brain approximately 18 years previously. He had still not had a follow up appointment after the bariatric surgery. The following month, he complained of angina. He told the nurse that he had had an angiogram with a stent and that he had suffered a mild stroke just over two years before. The results of tests on his heart were abnormal. Three days later, he suffered from chest pain and was taken to hospital as an emergency but a panic attack was diagnosed.

4. The man continued to be monitored by the healthcare team in Oakwood, but the checks on his blood pressure were only at irregular intervals. In November 2012, he transferred to HMP Highpoint.

5. At his reception health screen, the man again said that he had still not had a follow-up hospital appointment after his bariatric surgery. The prescriptions for his medication were confirmed. A few days after his arrival, his blood pressure was found to be high and he was referred to the doctor. He was given blood tests and his medication was reviewed.

6. The man was allocated to Unit 10, a small wing in Highpoint. He settled in well, working as a cleaner and was waiting to find out whether he could move to an open prison, nearer to his home. In early January 2013, he complained of pain, and was taken to hospital where he was diagnosed with a twisted hernia and referred for surgery. On 7 February, he was taken to hospital suffering from further pain and returned to the prison the same day after receiving treatment.

7. One morning a few days later, after the cells were unlocked, another prisoner went into the man's cell and found him unresponsive. He called staff, who called for medical assistance. He was breathing but unconscious, and was taken to hospital where he was found to have suffered a bleed on his brain. The doctors were unable to treat the condition and he died that evening. His family were with him when he died.

8. We are concerned that the standard of healthcare that the man received at all three prisons was not equivalent to community standards and the clinical reviewer assesses the medical care he received in prison as poor. His review contains a number of recommendations. There was no follow up to the bariatric surgery, which should have been supported by a care plan and there was no

plan for managing his high blood pressure. Although he was prescribed warfarin, the clinical reviewer found that there was no clear rationale for this and it could have been dangerous if he had suffered, as he claimed, a previous bleed on the brain. The diagnoses of his chest pain (angina and atrial fibrillation) were not properly investigated. We are also concerned that prison staff delayed calling an ambulance while waiting for healthcare staff to attend and that he was restrained when he was taken to hospital unconscious. We make five recommendations, one to the Heads of Healthcare at Hewell, Oakwood and Highpoint, one to the Heads of Healthcare at Oakwood and Highpoint and three to the Governor of Highpoint.

THE INVESTIGATION PROCESS

9. This office was informed of the man's death on 11 February 2013. The investigator issued notices to staff and prisoners at Highpoint informing them of the investigation and inviting anyone with relevant information to contact him. No one came forward.

10. The investigator contacted the prison and obtained the man's prison and prison medical records. He visited the prison on 11 June and spoke to staff and prisoners who knew the man, including on the wing where he lived. He interviewed four members of staff and two prisoners. He gave feedback to the Governor of Highpoint about the preliminary findings of the investigation.

11. A clinical reviewer was appointed to review the medical care the man received in prison. He was given a copy of the man's prison medical record.

12. HM Coroner for Greater Suffolk was informed of this investigation and provided a copy of the post-mortem report. This report has been sent to the Coroner.

13. One of the Ombudsman's family liaison officers contacted the man's wife to explain the purpose of the investigation and invite the family to identify relevant matters they wished the investigation to consider. His family was particularly concerned about the quality of healthcare that he had received at HMP Oakwood, before he arrived at Highpoint. They were concerned that he had not been given the proper follow up, including hospital checks after his operation, and that he did not get the medication and diet that he required. His family was also concerned that, at one point during his time at Oakwood, he had not received his medication for a number of days and that his blood pressure was not monitored effectively.

14. The man's family received a copy of the draft report. The solicitor representing them wrote to us raising some questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

15. The National Offender Management Service received a copy of the draft report. The action plan formed in response to this is included in this report.

HMP HIGHPOINT

16. HMP Highpoint is on two sites, Highpoint South which was the original HMP Highpoint, and Highpoint North, which was previously known as HMP Edmunds Hill. The prison is at Stradishall, 13 miles from Bury St Edmunds in Suffolk. Highpoint is a prison for category C adult male prisoners. (Category C prisoners are those who are not judged ready for open conditions but who are unlikely to escape and do not require high security.) The man was based at Highpoint South.

Her Majesty's Inspectorate of Prisons

17. The last report published report on Highpoint by HM Inspectorate of Prisons (HMIP) followed an inspection in September 2012. The report found that, while there were some problems, the prison largely provided a decent and safe environment. Inspectors noted that a high proportion of patients did not attend healthcare appointments. HMIP also found that the electronic health records system (SystmOne) was not used routinely for care planning for prisoners with complex conditions.

Independent Monitoring Board

18. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. In their latest published report the IMB had serious concerns about the management of healthcare, which had just transferred to a new provider. They hoped that new systems would help improve provision. A member of the IMB told the investigator that healthcare services in the prison were improving, although there sometimes remained problems with issues such as dental appointments.

Previous deaths at Highpoint

19. In the two years before the man's death, there was one other death in Highpoint. In our report into that death, we made a recommendation about use of restraints in hospital as we do in this case. There have been two further deaths at the prison since that of his.

KEY EVENTS

20. The man was born in May 1952. He had a number of previous convictions and had served previous periods of imprisonment. In March 2012 he underwent bariatric surgery[1], as a result of which he lost approximately eight stones in weight.

21. On 15 June 2012, the man was convicted of conspiracy to supply a controlled drug and sentenced to three years imprisonment. He was taken to HMP Hewell.

22. The person escort record (PER) that accompanied him from court to prison noted that the man suffered from sleep apnoea[2], angina, and had a stomach sleeve (reduced stomach from the bariatric surgery). He did not have any medication with him. A routine health screen when he arrived at Hewell (to identify any immediate mental or physical health problems) noted that he had recently had bariatric surgery and that he had a follow up appointment scheduled at hospital in London on 27 June. The record notes that he would be unable to keep this, but that follow up to bariatric surgery in the Worcestershire NHS area was only available to private patients. The screening noted that he had hypertension (high blood pressure) though this had improved as he had lost weight. The medical record noted his sleep apnoea. He had not received any treatment for any mental health issues and had never self-harmed. It was noted that he had been taking dilatiazem (for high blood pressure) and lansoprazole (to reduce the amount of stomach acid). It is not clear from the medical record whether these were re-prescribed to him at this stage. His blood pressure was noted to be 180/35 which was high. He was referred to the prison GP.

23. On 16 June, a doctor saw the man and prescribed ramipril for high blood pressure. A further note refers to a testicular lump, but there is no further information about this. A letter was sent to his community GP asking for confirmation of his prescribed medication and any other important information. On 18 June, his blood pressure was recorded as 140/95, which was still higher than normal.

24. On 19 June, the medical record shows that the man was further prescribed ramipril, dilatiazem and lansoprazole. A note on the record shows that his London hospital appointment had been cancelled and the relevant letters were passed to the duty doctor to see if he needed to be seen locally. The records do not show what action was taken.

25. On 22 June, the man saw a doctor, complaining that the lansoprazole was causing diarrhoea. He said that he had previously taken omeprazole (to reduce stomach acid) with no problems and asked if he could change to this. The doctor agreed and amended the prescription accordingly. On 23 June, a doctor noted on the medical record that he had follow up appointments scheduled from his bariatric surgery. She noted that he needed to be seen so a decision could be made as to whether he needed to be referred locally. It is not apparent from the records that a GP examined him for this purpose and no local referral was made.

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[1] An operation to reduce the stomach for severely overweight patients

[2] Disturbed breathing during sleep

26. On 28 June, a doctor saw the man, who asked if he could be moved to a single cell because the prison food was making him go to the toilet a lot and he was often sick because of the size of his stomach since his bariatric surgery. He also asked if he could be given some vitamins. The doctor prescribed forceval capsules (for the treatment of vitamin deficiencies). The next day, the doctor changed the prescription from forceval to multivitamins as they cost less.

27. A note on his medical record dated 10 July, shows that the hospital had written to the man at his home address. The note said that he needed to be referred locally. He was put on the waiting list to see the prison doctor.

28. On 11 July, the man transferred to Oakwood. When he arrived, he saw the Nurse Manager. He told her that he had had a heart attack 20 years before and had suffered a bleed in the brain approximately 18 years previously. The notes said that he had a history of heart problems and a stroke, but that there were no current concerns. His blood pressure was recorded as 258/208 which is very high, but there is nothing on the record to show that anyone was alerted to this reading. Despite the high blood pressure reading, the record shows that he was assessed as fit to attend the gym.

29. On 12 July, the man's prescriptions were confirmed and, on 15 July, he was given supplies of his medication to keep himself, known as "in-possession". On 18 July, he asked a doctor about his outstanding hospital appointments and the doctor wrote a letter of referral to the local hospital.

30. On 31 July, a doctor explained to the man that in some areas the NHS would not pay for the follow up to bariatric surgery if the procedure was considered to be cosmetic. He told her that he vomited or made himself vomit if he ate too much or if he drank too quickly. He was prescribed thiamine tablets, vitamin B compound and folic acid (all vitamin B medications), and was referred for exercise therapy.

31. On 20 August, the man complained of mild angina. At 9.45am he saw a nurse and said that he had previously had an angiogram with a stent implanted. He said that he had also had a mild stroke two years previously. He was short of breath and felt dizzy. The nurse issued him with a GTN spray[3], arranged an ECG test[4], and referred him to the doctor. His blood pressure was recorded as 106/83. At 11.46am, a doctor saw him and noted that he complained of being "dizzy at work", had atrial fibrillation[5] and that the ECG reading was abnormal. The record does not show whether any action was taken about the abnormal ECG reading.

32. At 12.15pm, the man felt chest and back pain which spread to his left arm and left side. He again saw a doctor and said that it was similar to his angina pain and made him feel faint. The doctor noted that he was pale. He said that he had used his GTN spray and the pain had now gone. The doctor said that she would review him the next day and discuss the possibility of prescribing warfarin, a blood-thinning medicine. The record indicates that his main concern was the possibility of a stroke and that he was reluctant to start warfarin. The

[3] a pump containing glyceryl trinitrate, used to ease angina pain
[4] electrocardiogram, a test that assesses the rhythm of the heart
[5] an abnormal heart rhythm

medical record also notes that he had run out of medication six days before. The next day, he agreed to begin taking a daily prescription of 1mg of warfarin. There is no clear explanation in his record why warfarin was prescribed. It was noted that he had run out of dilatiazem for six days.

33. During the evening of 23 August, the man complained of pain in his chest. Healthcare staff assessed him. He was tearful and in pain. His blood pressure was high at 160/112. He was given a GTN spray and oxygen, and an ambulance called. He was then given aspirin. At 9.00pm was taken to hospital.

34. The next day the man returned to the prison. He had been diagnosed as having had a panic attack. A doctor noted that he should be reviewed over the weekend. On 25 August, he went to the gym and said that he felt fine. His blood pressure was recorded as 120/90 which is within normal limits. No further problems were reported until 29 August when he complained to healthcare staff of angina pains which were relieved by using a GTN spray.

35. On 26 August, the man's blood pressure was again raised at 161/102. Three days later, on 29 August, a nurse saw him when he reported angina pain. His blood pressure was noted to be 126/82, within normal limits. The angina pain was relieved by a GTN spray and he was advised to go back to the wing and rest.

36. On 31 August, an entry in the man's prison record indicates that he was waiting for a transfer to another prison due to ill health. The record refers to him as a very polite man, who caused no problems.

37. On 4 September, the man's medical record indicates that he walked out of an appointment with a doctor. The reason for him leaving is not given and it is not clear what the appointment was for. On 6 September, his offender supervisor introduced herself to him. He asked whether there was any news about his transfer and whether he would be recategorised to security category D, which would allow him to move to an open prison. His offender supervisor agreed to seek an update.

38. The man had an appointment for a blood test on 7 September and, while there is a record which indicates that he did not attend, there his also a record of his blood test results in relation to his warfarin prescription. His INR (International normalised ratio – a test of the level of blood clotting) was 1.1 mmols and he was taking 2mg of warfarin. It was noted that his blood should be rechecked on Monday 10 September and that a GP should examine the results.

39. On 10 September, the man saw a nurse. He was tearful and said that he found it difficult being so far from his home in Essex and was waiting for a transfer somewhere nearer. He was on Beech wing and said he did not like it there as there were many younger prisoners who played loud music and he found the environment volatile. He said that he was often tearful, though only in private. He said he had no intention of harming himself and declined to be seen by the mental health team. His blood pressure was recorded as 130/110, which was high. He agreed to see the doctor the next day about his anxiety. On 11 September, he saw a doctor, but told her that he did not want to waste the team's time. The doctor sent a note to the offender management unit saying that he would benefit from a transfer closer to his home as his anxiety about

family issues was exacerbating his other health problems. His INR level was still recorded as 1.1mmols and the doctor increased his warfarin to 3mg daily. His INR levels were reviewed regularly over the next few days. His warfarin was increased to 4mg on 14 September and then to 5mg on 17 September.

40. On 23 October, the man saw a doctor, who reviewed his warfarin prescription and noted that his blood was stable on a 5mg dose. Records on 26 October show "missed doses" of warfarin for three days. His INR was checked again on 26 October and he saw another doctor the same day. The doctor noted that he should continue to take 5mg warfarin and the INR should be repeated in two weeks. On 9 November, he did not attend for a blood test and an appointment with the GP. The notes do not show why.

41. On 13 November, the man transferred to Highpoint after an overnight stop at HMP Bullingdon. His PER contained information about his angina and hypertension, he told healthcare staff at Bullingdon that he had all his medication, felt well, and had no concerns. When he arrived at Bullingdon his blood pressure was recorded as 172/109, which was high. The next day, 14 November, he arrived at HMP Highpoint.

42. The man had a standard health screen when he referred to having a heart attack in March 2012. He said that he had an outstanding hospital appointment at Homerton Hospital for December. His blood pressure was not recorded. The next day a doctor saw him and confirmed the prescriptions for his medications.

43. On 14 November, a nurse saw the man and noted that he said he had not had an INR test for a month. (The records show that in fact his last INR test had been on 26 October.) A blood test was taken the next day which showed his INR was 1.9mmols and no further action was required.

44. On 19 November, the man's blood pressure was recorded as 145/119, which was high. A doctor saw him the next day when his blood pressure was recorded as 140/90. The tests also showed raised cholesterol and triglycerides (types of fatty substances found in the blood). The doctor referred him for further tests, and said that his medication would be reviewed after three weeks.

45. On 24 November, an officer introduced herself to the man as his personal officer, who should be his first port of call for any queries or problems. She noted that he had only recently arrived on Unit 10, a small unit in the prison for prisoners with enhanced status (those allowed extra privileges for proven good behaviour). He had settled well, was polite to staff and mixed well with other prisoners. He told her that he was due for a review of his security category. The officer agreed to find out what was happening about this.

46. On 27 November, the man's blood pressure was recorded as 150/100, which was high. On 28 November, he told a doctor that he had a poor appetite, and was awaiting follow up action with his surgeon at the hospital. There is no record of any action being taken about this. The doctor noted that the INR blood tests should be repeated fortnightly.

47. On 13 December, the man's personal officer noted he was settling well on the unit, where he worked as a cleaner. She told him that his application to be recategorised to D had been submitted and was with the security department.

48. The records show that on 14 December, the man did not attend an appointment with the GP, but there is no record why.

49. On 3 January 2013, the man saw a doctor and told him that he had had a swelling in the left side of his groin for the previous six months. The doctor diagnosed a left inguinal hernia[6], which was at risk of becoming strangulated[7]. He referred him for urgent surgery.

50. At 9.45am on 6 January, the man collapsed in his cell. The community team manager examined him. His blood pressure was 160/90, which was in the high range, but his other observations were normal. She said that there was no need for him to go to hospital at that time, but that she would chase up his referral for surgery.

51. On 7 January, the man declined a hepatitis vaccination. On 21 January, an officer noted in his record that he had settled well into the prison, got on well with other prisoners, and was performing well in his work. He was still waiting for news about his security categorisation.

52. On 11 January, the man had a blood test and his INR was recorded as 1.8mmols. The notes show that no further action was considered necessary.

53. On the morning of 6 February, the man complained that he had been suffering from abdominal pain throughout the night. A doctor examined him and noted that he said he had a history of renal stone and cholecystitis[8]. His strangulated hernia was tender and the doctor diagnosed a possible bowel ischaemia.[9] The doctor referred him to hospital. He went in an ambulance at 9.30am and returned to prison later that day. The records do not show what treatment he received.

54. On 8 February, a nurse went to see the man after he complained of discomfort. She explained that he had a further hospital appointment scheduled in relation to his hernia, and he said that he had been told by the hospital he would be having an operation in four weeks time.

55. During the night of 9 –10 February, no issues were noted in the wing observation book about the man. There is no electronic record of cell call bells but there are no indications that he rang his bell during the night.

56. In the morning the prisoners were unlocked at approximately 8.30am. An officer unlocked the man's cell but she did not look in or check on him. At approximately 9.00am, Prisoner A, a friend of the man's, went into his cell and found him unconscious. He went to the unit office and told staff. An officer went to the cell and saw he was unconscious and not breathing. He radioed an emergency code blue which indicates a prisoner suffering from respiratory

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[6] A lump caused by part of the intestine pushing through a weakness in the abdominal wall.
[7] Cutting off the blood flow to the intestine.
[8] Inflammation of the gall bladder
[9] Inflammation of the intestine due to reduced blood supply

problems. The records show the emergency call was made at 9.01am. The officer moved him into the recovery position[10] and some fluid emptied from his mouth. At this point he began to breathe on his own. Prisoner B, a friend of the man's, then came into the cell. He noted that the man was partially dressed and wearing his glasses.

57. The designated emergency response nurse that morning acknowledged the code blue at 9.02am and went to unit 10, collecting emergency equipment from the healthcare centre on the way. As she approached unit 10 she met a Senior Officer, who told her that a prisoner had stopped breathing but was now breathing again. She asked the SO if an ambulance had been called, but this had not been done. When she arrived at the man's cell at approximately 9.09am, she found the officer supporting him in the recovery position. He had lost control of his bladder and bowel and was unresponsive but now breathing.

58. The nurse immediately asked for someone to call an emergency ambulance. Records show that this was requested by the communications officer at 9.11am. She applied an oxygen mask to the man to assist with his breathing. He was cold and clammy to touch. Although he was now breathing again, she was aware that this could indicate that he had had a heart attack and it was possible that he could have another. She therefore prepared the defibrillator[11] so that it could be used immediately if needed. She radioed for further healthcare assistance, then continued to monitor his breathing.

59. The senior nurse in the healthcare team responded and went to the man's cell. When she arrived, he was in the recovery position and breathing with the aid of the oxygen mask. She noted his pulse was strong and regular, so she continued monitoring him while the emergency response nurse went to get copies of his medical record to pass to the ambulance crew.

60. A paramedic responder and an ambulance were despatched to the prison. They both arrived at the prison at 9.30am, reaching the man's cell at 9.33am. Their Initial suspicions were that he had suffered a stroke.

61. The man was due to receive a visit from his family that day and, at 9.35am, his wife, daughter and son-in-law arrived in the prison's visits hall. The duty governor met them and explained that he been taken ill. His family said that they would wait in the visits hall for further news.

62. At 9.48am, the man was transferred to the ambulance. A risk assessment was completed and it was decided that he should be accompanied by two prison officers. Because he needed medical treatment in the ambulance, the duty governor agreed that, instead of standard handcuffs, he should be cuffed to an officer with an escort chain (a long chain with handcuffs at each end, one attached to the officer the other to the prisoner).

63. At 10.00am, the duty governor told the man's family that it was suspected that he had had a stroke and he was being taken to hospital. The ambulance left the prison at 10.05am. He advised the family to go to the hospital.

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[10] A first aid position which allows someone who is unconscious but breathing to maintain a clear airway so they continue to breath unaided.

[11] a machine that analyses heart rhythm and advises whether to apply an electrical impulse to the heart, which can rectify a failing rhythm

64. At hospital, the man was assessed. He was thought to have suffered a bleed on the brain. Hospital staff requested that the escort chain should be removed and the duty governor authorised this at 10.30am. At 11.30am, the man's family were able to visit him.

65. At 11.40am, the escorting prison officers reported to the prison that the man had had a computerised tomography (CT) scan[12]. This had revealed that he had suffered a serious bleed on the brain and there was no further medical treatment that could be offered.

66. The prison chaplain went to the hospital and soon afterwards an officer was appointed as the prison family liaison officer and also went to the hospital. Later in the afternoon the duty governor also attended.

67. At 6.00pm the man was taken off life support. He died at 6.34pm, with his family present.

68. Notices were posted to staff and to prisoners the following morning, informing them of the man's death. The staff care team were deployed to speak to staff who had known him. The local Samaritans and Listeners (prisoners trained by the Samaritans to provide emotional support to other prisoners) were briefed so they could assist any prisoners who might need support. All prisoners who were being monitored as at risk of suicide and self-harm policy were reviewed in case they had been adversely affected by his death. The psychology and offender management departments examined whether any other prisoners might be affected by his death. They identified one particular prisoner and offered appropriate support.

69. A memorial service was held in the prison and the man's family were invited. In line with national guidance the prison offered to contribute to the costs of the funeral. With his family's agreement, the prison was represented at the funeral.

Debrief

70. It is usual after the death of a prisoner to hold a debrief meeting with the staff involved to ensure they have an opportunity to discuss any issues arising and to receive support. Because the man had died in hospital, a debrief was not held at the time, but the duty governor ensured that he spoke individually to all the staff who had been involved.

Post-mortem

71. A post-mortem examination was carried out by. The pathologist concluded that the man's death was due to:

    1(a) large acute intracerebral haemorrhage
    1(b) hypertension

72. This means that the man suffered a bleed on the brain, the underlying cause of which was high blood pressure.

[12] a specialised X-ray test to give clear pictures of the inside of the body, particularly of the soft tissues

ISSUES

Clinical care

73. Shortly before he was sentenced to prison, the man had undergone bariatric surgery. He said he had a history of health problems; telling staff at various times that he had had a heart attack, a stroke and a previous bleed on the brain. He had a reception health screen when he arrived at each prison but it does not appear that his community medical records, and therefore his previous medical history, were obtained from his GP. Records show that staff at HMP Hewell contacted his GP for this information, but there is no evidence of the records ever being received or that the request was chased up. Throughout his time in prison, he mentioned serious incidents in his medical history of which healthcare were unaware, but it does not appear that at any time any of this information was verified. The clinical reviewer notes that the prison medical records were poorly maintained. At no point was a full medical history drawn up.

74. When he arrived at Hewell, Oakwood and Highpoint, the man told healthcare staff that he was due to have a follow-up consultation after his bariatric surgery. The records indicate that staff acknowledged this and, on two occasions, letters of referral were sent to local hospitals, but the appointment remained outstanding at the time of his death. On more than one occasion, he complained of not being able to eat properly. Guidelines from the National Institute for Health and Clinical Excellence (NICE) recommend that following bariatric surgery patients should have a clear discharge care plan, including dietary advice and long term follow up. There is no evidence that such a plan existed for him. The clinical reviewer notes that no one at any of the prisons took responsibility for clarifying the position in relation to his bariatric surgery and what aftercare was needed.

75. The man also suffered from high blood pressure (hypertension) and this was noted at the post-mortem examination to be a contributory factor to his death. Although his blood pressure was taken on several occasions and found to be high, recordings were irregular and there was no care plan to manage his high blood pressure. When he arrived at Oakwood, his blood pressure was very high but it appears that no action was taken about this, to the extent that his record at the same time states that he was considered fit for the gym. When he arrived at Highpoint, his blood pressure was taken three times in the initial days. After that, there is no record of any blood pressure monitoring from 27 November until 6 January, when his blood pressure was taken after he collapsed.

76. The man's prison medical records do not include a care plan or a system to ensure ongoing monitoring of his blood pressure. When blood tests showed raised cholesterol and triglycerides in November 2012, this was not treated. The clinical reviewer writes that he was never put on any chronic disease register, nor was NICE guidelines on hypertension followed.

77. The man was prescribed warfarin in August 2012, when he had said in his reception screening the previous month that he had had a bleed in the brain 18 years previously. The clinical reviewer notes that if there is evidence of a

previous brain haemorrhage, it is not usually recommended that warfarin be prescribed. The reviewer notes that, if he did have a bleed in the brain, warfarin would increase the risk of a further cerebral haemorrhage but no one obtained his community medical records to check.

78. These issues occurred in all three prisons where the man was held. Although information about his previous medical history was requested by Hewell, the request was not followed up, either there or by Oakwood or Highpoint. After his admissions to hospital, discharge letters were not received and were not pursued.

79. On 20 August, an ECG reading was noted to be abnormal, showing that the man had atrial fibrillation. The clinical reviewer notes that NICE guidance on atrial fibrillation and angina both recommend further investigation, which did not happen in his case.

The Heads of Healthcare at Hewell, Oakwood and Highpoint should ensure that, where a complex medical history is indicated, all relevant information should be sought and obtained from agencies involved in the prisoner's care and a care plan formulated to ensure that all identified needs are met.

80. On 21 August 2012, the medical records note that the man had run out of medication six days before. Records again show "missed doses" of warfarin for three days on 26 October. One of his friends in Highpoint told the investigator that he said that he had to go without his medication for a few days. His wife also said that there was a period of four or five days when he did not receive his warfarin. As the clinical reviewer has pointed out there is an unresolved question whether he should ever have been have prescribed warfarin but nevertheless in the absence of information to the contrary medication should be supplied as prescribed.

The Heads of Healthcare at Oakwood and Highpoint should ensure that prisoners receive medication as prescribed.

Unlocking cells

81. The officer responsible for unlocking the cells, that included the man's cell on 10 February, told the investigator that she did not check on him when she opened the cell. Officers are told in their initial training that they should check the safety of prisoners when they unlock cells and Prison Service Instruction (PSI) 10/2011 contains guidance for officers unlocking prisoners:

> "Where prisoners are not necessarily expected to leave their cell, staff will need to check on their wellbeing, for example by obtaining a response during the unlock process."

82. Prisoner B said that when he went into his cell, the man was partially dressed and was wearing his glasses. It is quite possible, therefore, that when the officer unlocked the cell he was not unwell and collapsed subsequently, but he could have begun to get dressed earlier. The duty to check his wellbeing was not met. We consider that it is important that prison staff ensure that they gain

a response from prisoners or otherwise satisfy themselves of the prisoner's welfare when they unlock their cells.

The Governor of Highpoint should ensure that when a cell door is unlocked, officers satisfy themselves of the safety and wellbeing of the prisoner and that there are no immediate issues that need attention.

Emergency response

83. When Prisoner A found the man unconscious, he alerted staff and an officer came back to the cell with him. The officer called for emergency assistance. When he moved the man, he started breathing again. The emergency nurse brought emergency equipment with her, continued to monitor his breathing and, considering that possibility of heart problems, prepared the defibrillator in case it was required. From that point on staff monitored him until paramedics arrived and took over his care.

84. While there were no apparent delays in staff responding to the emergency, an ambulance was not requested until a member of healthcare staff. A letter from the Head of Offender Health and the Chief Executive Officer of the National Offender Management Service sent to all governors in February 2011, clearly states that the attendance of an ambulance should not be delayed for any reason and specifically states that it should not be a requirement for a member of healthcare to attend before an ambulance is called. In addition, a notice to staff in Highpoint dated November 2012 said:

> "Staff are advised that to avoid … delays, where it is clearly apparent that there is a need to summon an ambulance, any member of staff may do so … There is no specific requirement for the Orderly Officer or Healthcare staff to sanction this … examples of where staff may need to summon an ambulance may include … unconsciousness … respiratory problems".

85. It is therefore disappointing that an ambulance was not called earlier. Prison Service Instruction (PSI) 03/2013 was issued on 1 February 2013 and requires an ambulance to be called automatically when a code blue emergency is called. Although it did not come into force until 28 February, just after the man's death, the governor should ensure that all staff are aware of its provisions.

The Governor of Highpoint should ensure that all staff are aware that they should request an ambulance immediately in an emergency without waiting for healthcare staff to attend and that one is called automatically when an emergency code is called.

Restraints

86. The Prison Service has a duty to protect the public when escorting prisoners to hospital, and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes into account factors such as the prisoner's health and mobility. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of

escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion regarding the prisoner's ability to escape must be considered as part of the assessment process.

87. When he was taken to hospital on the morning of 10 February, the man was restrained by an escort chain, although he was seriously ill, unconscious at the time and required treatment during the journey. The duty governor said that when he made the decision to restrain him, he was not aware that he was unconscious. Had he known this, he might have made a different decision. There is a requirement for risk assessments to take into account medical opinion, but there is no information about his health on the risk assessment form and it is clear that this was not done. We also note that the risk assessment indicates that he was considered low risk, was awaiting confirmation of category D status, and was on the enhanced level of the incentives and earned privileges scheme. This would call into question whether restraints would have been necessary even if he had have been conscious. It is reassuring that the restraints were removed soon after he arrived in hospital, but this was at the request of hospital staff. We do not consider a properly balanced initial risk assessment was made.

The Governor of Highpoint should ensure that risk assessments for prisoners being taken to hospital fully take into account the prisoner's health and circumstances and are based on the actual risk the prisoner presents at the time.

RECOMMENDATIONS

1. The Heads of Healthcare at Hewell, Oakwood and Highpoint should ensure that where a complex medical history is indicated, all relevant information should be sought and obtained from agencies involved in the prisoner's care and a care plan formulated to ensure all identified needs are met.

2. The Heads of Healthcare at Oakwood and Highpoint should ensure that prisoners receive medication as prescribed.

3. The Governor of Highpoint should ensure that when a cell door is unlocked, officers satisfy themselves of the safety and wellbeing of the prisoner and that there are no immediate issues that need attention.

4. The Governor of Highpoint should ensure that all staff are aware that they should request an ambulance immediately in an emergency without waiting for healthcare staff to attend and that one is called automatically when an emergency code is called.

5. The Governor of Highpoint should ensure that risk assessments for prisoners being taken to hospital fully take into account the prisoner's health and circumstances and are based on the actual risk the prisoner presents at the time.

ACTION PLAN: The Man – HMP Highpoint

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Heads of Healthcare at Hewell, Oakwood and Highpoint should ensure that where a complex medical history is indicated, all relevant information should be sought and obtained from agencies involved in the prisoner's care and a care plan formulated to ensure all identified needs are met.	Accepted	**Hewell:** It is already established practice to call for records for those patients with complex histories in circumstances where those agencies can be identified and contacted. It does require the support of the patient (e.g. being able to remember their GP/other health care providers' name and location). Action will be taken to remind all staff that, in cases where the patient has a complex presentation, that community records should be obtained. **Oakwood:** All prisoners received on transfer who have a history of complex medical needs will have their previous care organisations contacted where no information exists in their clinical record to indicate their history and proposed plan of care. This will be undertaken through contact with GP and other relevant services. **Highpoint:** A meeting has been arranged by Care UK with Senior Managers, Clinical Governance and the Lead GP for 27 August 2013 to discuss the outcomes and recommendations from this clinical review. Subsequently the local Clinical Governance and Service Delivery Group will work through the recommendations so these can put in to practice within our service delivery. This work will be reviewed by NHS England through contract monitoring.	30 September 2013 30 September 2013 Dates for work to be completed to be provided following the meeting on 27 August.	
2	The Heads of Healthcare at Oakwood and Highpoint should	Accepted	**Oakwood:** Prisoners at HMP Oakwood will have medication prescribed, ordered and administered in	30 September 2013	

	ensure that prisoners receive medication as prescribed.		a timely manner. **Highpoint:** Since the death of the man, significant changes have been implemented within the pharmacy service which includes the pharmacy gaining registration with the General Pharmaceutical Society and the service being led by a permanently employed Pharmacist. The issues raised will be also be discussed at the 27 August meeting by Care UK and again put into practice and monitored through the local Clinical Governance, Service Delivery Group and Medicines, Management Group. This work will be reviewed by NHS England through contract monitoring.	Dates for work to be completed to be provided following the meeting on 27 August	
3	The Governor of Highpoint should ensure that when a cell door is unlocked, officers satisfy themselves of the safety and wellbeing of the prisoner and that there are no immediate issues that need attention.	Accepted	Staff will be reminded, via a notice to staff, of the requirement to check the well being and safety of prisoners when unlocking cell doors. This message will also be promoted through the weekly staff briefings.	16 August 2013	
4	The Governor of Highpoint should ensure that all staff are aware that they should request an ambulance immediately in an emergency without waiting for healthcare staff to attend and that one is called automatically when an emergency code is called.	Accepted	Staff will be reminded, via a notice to staff, of the requirement to request an ambulance immediately in an emergency without waiting for healthcare to attend. This message will also be promoted through the weekly staff briefings.	16 August 2013	
5	The Governor of Highpoint should ensure that risk assessments for prisoners being taken to hospital fully take into account the prisoner's health and circumstances and are based on the actual risk the prisoner presents at the time.	Accepted	The existing risk assessment is to be amended to include a checklist bullet point to ensure the prisoners "Current Medical Condition" is reviewed and assessed.	23 August 2013	