

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at St Mary's
Hospital, Newport, in September 2012, while a
prisoner at HMP Isle of Wight**

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 a report into the death of a man in September 2012, at St Mary's Hospital, while in the custody at the Albany site of HMP Isle of Wight. A post-mortem showed that he died from a heart attack and coronary thrombosis. I offer my condolences to his family and friends.

The investigation was carried out by one of my investigators. A clinical reviewer was appointed to review the man's clinical care. The prison cooperated fully with this investigation.

The man had two long term conditions, diabetes and ischaemic heart disease. Although the clinical reviewer found some examples of a high level of attention and care, he also found some deficiencies in the management of these chronic conditions at Albany.

In the last days of his life, the man's health significantly deteriorated and he was admitted to the prison's inpatient unit. The night before he died, a nurse contacted the out of hours doctor because of concern about the man's condition. Some apparent miscommunication meant that the doctor was not fully aware of the seriousness of the concerns, and the man was not taken to hospital until the next morning, where he died shortly after. It is not possible to know whether an earlier admission would have affected the outcome.

While some aspects of the man's care were good, the clinical reviewer concludes that the lack of effective coordination of the management of his different chronic conditions and the delay in getting him to hospital on 12 September meant that the quality of care fell below what was expected.

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 was remanded into custody on 7 June 2007. He had a history of type 1 diabetes, heart disease, angina, high blood pressure, high cholesterol and depression and was prescribed medication.
2. On 30 September 2009, the man was sentenced to 14 years imprisonment and later transferred to HMP Isle of Wight, Albany site, on 17 November 2010. Because of his poor health the man had a great deal of contact with healthcare professionals throughout his time in custody.
3. After feeling unwell for two days, during which time he did not take his medication, the man was admitted to the prison's inpatient healthcare unit on the evening of 10 September 2012. During the night of 11-12 September, prison nurses checked on the man who was responsive but they could get no recordable blood pressure reading. The nurses contacted the on-call doctor but, because of a misunderstanding about the seriousness of his condition, the man was not transferred to hospital at that stage.
4. On the morning of the day the man died, at approximately 9.30am, a prison doctor was concerned about the man's condition and arranged for him to be taken by emergency ambulance to St Mary's Hospital. At 11.40am, he went into cardiac arrest at the hospital. Resuscitation attempts were unsuccessful and just after noon, he was pronounced dead. The post-mortem examination found that his death was caused by myocardial infarction (heart attack) and coronary thrombosis (blockage in the arteries that prevents the flow of blood).
5. We believe that the care and attention the man received at the Albany site of HMP Isle of Wight were not up to the standard expected in the community. The management of the man's long term conditions was not effectively coordinated and, with better communication between healthcare professionals he might have been referred to hospital sooner, though this might not have affected the outcome. We make recommendations about the management of prisoners with chronic health conditions and clinical record keeping.

THE INVESTIGATION PROCESS

6. The investigator visited HMP Isle of Wight, Albany site on 19 September 2012 and met the Governor, a member of the Independent Monitoring Board (IMB) and the Head of Healthcare. He obtained copies of relevant prison and healthcare records. The investigator subsequently interviewed seven members of staff. Notices about the investigation were issued to staff and prisoners inviting anyone with relevant information to contact the investigator. No one came forward.
7. A clinical reviewer was appointed to review the man's clinical care. The investigator and the clinical reviewer jointly conducted interviews.
8. The investigator contacted Her Majesty's Coroner to inform him of the investigation and request a copy of the post-mortem report. This report has been sent to the Coroner to assist his enquiries.
9. One of our family liaison officers contacted the man's ex-partner and his brother to inform them about the investigation and to invite them to ask any questions which they wished the investigation to cover. Neither had specific issues to raise.

HMP ISLE OF WIGHT

10. HMP Isle of Wight is an amalgamation of three prisons, Parkhurst, Camp Hill and Albany. The man lived at the Albany site which can hold up to 567 prisoners in seven cell blocks.
11. Health services at HMP Isle of Wight are commissioned and provided by the Isle of Wight PCT. An inpatient healthcare unit (IHU) was opened in October 2009 at the Albany site. It has 12 beds and caters for prisoners with a wide range of mental health, general medical, rehabilitative and health-related respite needs.

HM Inspector of Prisons (HMIP)

12. The last report published inspection report of HMP Isle of Wight followed an announced full inspection in May 2012. The report commented:

“Health services had improved considerably but there were still some difficulties for prisoners in accessing primary care services promptly, especially at Albany. Waits for routine GP appointments were sometimes too long and for the dentist were unacceptable. Management of long-term conditions was good and health promotion was developing. Good collaboration between the prison and health care commissioner and providers had enabled the development of telemedicine. Prescribing of ‘prized medications’ (tradable medication) was tightly controlled and administration of medicines was generally robust but there was no formal risk assessment for in-possession medication. Palliative care services were good. Mental health services had improved with the introduction of a primary mental health team.”

Independent Monitoring Board (IMB) report

13. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. The last report published by the IMB for HMP Isle of Wight, Albany site, for the period 1 January to 31 December 2011, noted that the main problem facing healthcare services was the ageing population and the number of hospital appointments cancelled by Saint Mary’s Hospital.

Previous deaths at the Albany site of HMP Isle of Wight.

14. The man’s death was the fifth attributed to natural causes to occur at the Albany site of HMP Isle of Wight in 2012. There are no significant similarities between the circumstances of the man’s death and the others.

KEY EVENTS

15. On 7 June 2007, the man was remanded into custody at HMP Hewell for serious offences. He was later convicted, and, on 30 September 2008, sentenced to 14 years imprisonment. The man had poor health with a history of type 1 diabetes, ischaemic heart disease, hypertension (high blood pressure), angina, high cholesterol and depression. He was a smoker but had no other history of substance misuse.
16. The man remained at Hewell until he transferred to HMP Birmingham on 8 October 2009. During his time at these two prisons the man's medical records show that he was prescribed: ramipril (for high blood pressure), atenolol (for heart disease), glyceryl trinitrate spray (for angina), simvastatin (for high cholesterol), isosorbide mononitrate (for angina), novomix (for diabetes), diltiazem (for high blood pressure), citalopram (an anti-depressant), tramadol (for moderate to severe pain), pregabalin (for neuropathic pain), nefopam (for moderate pain relief) and aspirin. The man's personal prison records show that he had adjusted well to prison life and was employed in the workshops. The man did not receive any visits, and he did not send or receive any letters or make any phone calls.
17. On 17 November 2010, the man transferred to HMP Isle of Wight, Albany site. When he arrived Nurse A conducted a health screen and recorded that the man suffered from heart disease, angina, diabetes and depression. The nurse recorded that the man smoked 15 cigarettes a day. He weighed 79kg (12st 10lb) and was 1.68m tall (5' 6"). The man's blood pressure was 144/92. (The normal range is 100/70 to 140/90. A blood pressure reading of greater than 140/90 is classed as high and a reading of 90/60 or below is classed as low.). Dr A, a prison doctor, saw the man and prescribed a continuation of his medication from Birmingham.
18. Between 18 November and 18 May 2011, the man had 31 separate appointments with healthcare staff including doctors, optician, chiropodist and nurses. While the man's medication and diabetes were reviewed regularly there were occasions where his blood pressure was not recorded. Dr B, a prison doctor, prescribed nortriptyline as an anti-depressant instead of citalopram.
19. On 19 May 2011, at 9.34pm, wing staff contacted healthcare as the man complained he felt unwell and then collapsed. Nurse B asked for an emergency ambulance, and ensured that paramedics were given details of the man's medication. He was taken to St Mary's Hospital, at Newport accompanied by two officers and restrained by an escort chain which the officers were authorised to remove for medical treatment.
20. The man remained in hospital overnight, but the next morning, 20 May, he discharged himself against medical advice. A consultant in the coronary care unit, completed a discharge summary which said the man's collapse was due to hypotension (low blood pressure) and bradycardia (slow pulse below 60 beats per minute) caused by his prescribed ramipril, diltiazem and atenolol. Tests conducted at the hospital showed that the man's heart sounds were normal and his chest and abdomen were clear. However, there was a first degree heart

block, which is a split-second delay in the time that it takes electrical pulses to move through to the heart.

21. The consultant in the coronary care unit recorded that the medical team at the hospital had wanted the man to stay in hospital for further tests and assessment, but he refused. The doctor prescribed bisoprolol (for cardiovascular disease) to replace the ramipril, diltiazem and atenolol. His other medication remained unchanged. The doctor requested that the man be monitored once he was back at the prison. The man arrived back at the prison at 12.30pm and was admitted to the inpatient healthcare unit (IHU) where he was monitored by nursing staff.
22. On the evening of 21 May, Nurse C spoke to Dr C, an on call duty doctor, to seek advice as the man had requested additional insulin. The doctor advised that the man was not to be given any insulin until the following day.
23. On 23 May, Dr B reviewed the man's medication without seeing him and made no changes to the prescribed medication. The man was then discharged from the IHU and returned to his wing.
24. From 24 May 2011 to 25 March 2012, the man had 40 further appointments with healthcare staff. These included regular blood tests and diabetic screening. Doctor B added candesartan (for treatment of high blood pressure) to the man's prescribed medication as the man's blood pressure was consistently recorded as 158/99 or higher (above normal limits). During this same period the man declined to attend doctor's appointments four times. Wing staff made regular entries in the man's electronic case notes, which recorded that he was polite and respectful and enjoyed his work as a menu orderly and his educational courses.
25. On 26 March, the man returned all his medication and diabetic monitoring equipment to Nurse D saying he was not getting any benefit from the medication. The nurse recorded that the man looked very ill and booked an urgent appointment for him to see the doctor.
26. Dr D saw the man later that morning. The man described a wave-like pain that started in the bottom of his legs making it difficult for him to walk and sleep. He also said he felt depressed. The doctor discussed admitting the man to the IHU for a period of assessment.
27. The man was admitted to the IHU on 31 March for a pain assessment. His blood pressure was recorded as 160/116 (above normal limits). For the next 48 hours he was assessed and monitored by healthcare staff. The man complained that the pain in his legs affected his sleep, though Nurse E recorded that he had slept for long periods. On the evening of 1 April, Dr B authorised one night's dose of tramadol and zopiclone (for insomnia).
28. On 2 April, Dr D noted that the man suffered pain in both legs which was not related to walking or exercise. The doctor diagnosed this as a symptom of diabetic neuropathy (damage to the nerves that causes sensations such as pain) and prescribed buprenorphine transdermal patches (semi-synthetic opioid slow release medication through the skin for moderate to acute pain) with one patch to be applied every 96 hours. The doctor also referred the man for

assessment and tests at the hospital. The man was discharged from the IHU and returned to the wing.

29. During April, the man attended scheduled reviews for his pain relief, diabetes and heart condition. It is recorded that the man had good control of his diabetes, was still smoking despite being given advice to stop, and his blood pressure was high, at 166/110 on 3 April, and 149/110 on 10 April.
30. In April, the man suffered with gastroenteritis and was prescribed prochlorperazine (for vomiting and diarrhoea) for five days. At the end of May, the man reported suffering from constipation. At a diabetic review on 29 May, Nurse F noted that the vomiting and constipation could cause a loss of diabetic control.

June 2012

31. On 8 June, the man told Dr D he was experiencing persistent constipation but was content with the prescribed pain relief medication. The doctor prescribed senna for his constipation and referred the man to be seen by the mental health team because of his ongoing depression.
32. The man attended the pain clinic at St Mary's Hospital on 18 June. Dr E, an associate specialist in anaesthetics and pain management, agreed with Dr D's diagnosis of diabetic neuropathy. Dr E prescribed duloxetine (for diabetic neuropathy), 60mg once a day, in addition to the buprenorphine patches, which the prison doctors could reduce if the man responded well to the new medication.
33. On 19 June, Nurse G conducted a mental health assessment and recorded that the man was very tearful and his physical health was not good. She noted that the man said he was pleased with the care provided by the prison, had a good relationship with staff and fellow prisoners, enjoyed the educational courses and art work in his cell. The man expressed remorse for his offences, and said he did not think he should ever be released. The nurse taught him some breathing relaxation exercises and arranged to see him a week later.
34. Later that afternoon Dr B recorded the man's blood pressure as 160/90 (above normal limits) and noted that his blood pressure needed to be strictly controlled between 120-130/80. He increased the dose of candesartan from 4mg to 12mg and ordered a review in six weeks. The doctor also diagnosed that the man suffered from proteinuria (excess protein in urine most commonly caused by diabetes).
35. On 21 June, Dr D increased the man's oral pain relief (duloxetine) and stopped the prescription of buprenorphine patches as they were causing a skin irritation.
36. The man chose not to attend appointments with the chiropodist on 22 June and to have blood tests on 28 June.

July

37. Nurse G saw the man again on 2 July, and recorded that the man was much calmer and not tearful. The man told the nurse that he had found the breathing exercises very helpful. The nurse arranged a further appointment.
38. On 17 July, the man told Dr D he was experiencing increased pain in his legs. The man was on the maximum amount of duloxetine. The doctor discussed the man's pain management with his colleagues and decided to prescribe a 200mg dose of tramadol for two to three weeks and then to replace this with MXL (morphine sulphate capsules– an opioid pain relief).
39. At a review on 27 July, the man told Dr D that the tramadol was not effective in reducing his pain. The doctor increased the dose from 200mg to 300mg to be reviewed a week later.
40. On 30 July, Nurse G reviewed the man. He said the relaxation techniques were still helping him.

August

41. On 3 August, the man told Dr D the increased tramadol had not helped. The doctor prescribed 30mg MXL and planned a further review. The next day the man did not attend his appointment for a diabetic review.
42. At his pain relief review with Dr D on 10 August, the man said that his pain was now under control but he was suffering from constipation. The doctor prescribed senna.
43. On 24 August, the man told Dr D he was experiencing increased pain in his legs during the night. The doctor admitted the man to the IHU so that his pain management could be monitored. The man's blood pressure was recorded as 155/101 (above normal limits). The doctor prescribed 10mg MST continus tablets (prolonged release opioid pain relief) and oramorph (morphine sulphate oral solution for severe pain) for any breakthrough pain. The man remained in the IHU for the next four days. He was closely monitored by nurses and given oramorph three times during this period. The doctor discharged the man back to the wing on 28 August, and prescribed 60mg MXL to replace MST.
44. Dr D reviewed the man on 31 August. The doctor recorded that the MXL helped the man with his pain relief. The man's blood pressure was recorded as 151/91 (above normal limits) and the doctor noted that this was "reasonably ok". He planned to review it later in the year, but further medication could be prescribed if necessary.

September

45. At 7.00 pm on 10 September, wing staff contacted healthcare staff as the man had told them he was in pain and he looked unwell. Nurse H assessed him in the healthcare centre and recorded that the man looked very pale. The man told the nurse that he had been vomiting for two days and had not taken any of his medication, but had not told anyone. The nurse admitted him to the IHU

and requested an out of hours doctor to come and see him. The nurse recorded the man's blood pressure as 110/85 (within normal limits).

46. Dr A, the on-call doctor, arrived at the prison at 9.00pm. The man told the doctor that he had originally been constipated but now complained of a tender abdomen. The doctor recorded that the man's abdomen was soft, he was not dehydrated but there was evidence of ketones (an acid remaining when the body burns its own fat due to a lack of insulin) in his urine and on his breath. The doctor recommended that the man remain in the IHU and be given insulin, senna and pain relief.
47. Nurse I monitored the man overnight and recorded that the man had not been given any insulin as there was none in his medication that came with him from the wing and there was no stock available in healthcare. The nurse also recorded that the man was fine during the night.
48. Dr D saw the man at 10.20am on 11 September. The man told the doctor that he did not want to take morphine anymore as it made him constipated. He said that he had stopped vomiting and wanted to go back to the wing. The doctor recorded that the man looked pale and unwell and should be monitored as an inpatient for another day. Nurse J recorded that during the rest of the day the man declined food and fluids despite encouragement from staff. He took all his medication including insulin.
49. During the early hours of 12 September, Nurse I and Nurse B tried to take the man's blood pressure but were unable to obtain a readable blood pressure or pulse. Nurse I contacted Dr F, the on call doctor, who advised that the man should be observed through the night. The nurses checked on the man as directed. The man was responsive when the nurses spoke to him, but he had no recordable blood pressure reading or pulse when the nurses used both a manual and automatic recording machine.
50. At approximately 9.30am that morning Dr D saw the man who said he had no chest pain or shortness of breath but had experienced dark diarrhoea for four days. The doctor was unable to obtain a blood pressure reading or pulse and requested an emergency ambulance to take the man to hospital.
51. Paramedics arrived in minutes and the man was taken to St Mary's Hospital. A risk assessment was completed which authorised the man to be accompanied to hospital by two officers but no restraints were used. Hospital records show that the man went into cardiac arrest at 11.40am, resuscitation was attempted but at 12.02pm a hospital doctor confirmed that the man had died.

Contact with the man's family

52. The man's ex-partner and his children lived in Lincolnshire and the prison arranged for the family liaison from HMP North Sea Camp to break the news of his death that afternoon. The man's ex-partner wanted no other contact or involvement with the funeral, but told the family liaison from HMP North Sea Camp that the man had a brother.

53. The prison's family liaison officer contacted the man's brother through the West Mercia Police. His brother also said he wanted no involvement. The prison then arranged and paid for the man's funeral.

Support for staff and prisoners

54. The member of staff, responsible for the incident at the Albany site, offered support to the two officers who had escorted the man to hospital. Prisoners were offered support from the chaplaincy, IMB or the Samaritans. All prisoners being monitored as at risk of suicide and self-harm were reviewed.

ISSUES

Clinical Care

55. The man had a history of ischaemic heart disease and diabetes. He smoked against advice and offers to help him stop. Despite a high level of healthcare involvement with the man and examples of some good care, the clinical reviewer, the clinical reviewer concluded that some aspects of the man's clinical care fell below expected standards.
56. There was some evidence of careful thought and care. In particular, the man's chronic pain was taken seriously, and carefully investigated. His medications were regularly reviewed and altered to try and improve his symptoms. The clinical reviewer notes that stronger medication is prone to causing more side effects, but attempts were made to minimise them.
57. There was also evidence that the man received annual diabetic retinopathy screening and flu vaccinations in line with previous recommendations the clinical reviewer had made.
58. The man's compliance with taking his medication was erratic and medication is important in the management of both ischaemic heart disease and diabetes. The clinical reviewer notes that the man returned all his medication and diabetic monitoring equipment to the medication hatch on 26 March 2012 when he said nothing was helping him. The clinical reviewer commented:

“The control of his raised blood pressure was poor. Very high levels were documented on many occasions, often with no comment or actions proposed. When it was documented that he had protein in his urine and should have tight control of his blood pressure, this was not pursued and raised levels remained uncorrected.

“ ... When blood pressures were recorded as part of diabetic checks and found to be high, no actions were recorded to address these observations or inform clinicians at the next appointment

“ ... The management of his diabetes was also suboptimal. Later, it became clear that he was not using his insulin pen correctly in terms of dosage and frequency. He was also poorly advised to stop taking his insulin when in IHU in May 2011 by GPs.

59. While there was evidence of regular interaction, there was not enough evidence of a coordinated and integrated approach to managing the man's complex and chronic health problems. We therefore make the following recommendations:

The Head of Healthcare should ensure that, in accordance with relevant NICE guidelines, prisoners who have complex and chronic health problems have a coordinated single case management plan, which is regularly reviewed and updated, and followed by all staff.

The Head of Healthcare should ensure that all healthcare staff follow appropriate clinical requests and documented treatment plans when

taking blood pressure. All results must be promptly acted upon and recorded to allow timely documented clinical decisions.

The man's last 48 hours

60. The clinical reviewer comments on the man's admission to IHU:

"In his final illness, the man presented in the evening [of 10 September] after having being ill for two days. He was seen promptly that evening. He was transferred to IHU and was assessed by the duty doctor. His symptoms were thought to be due to side effects of the strong pain killers he was prescribed. The man was keen to return to the wing but was persuaded to stay in IHU. He remained mobile and lucid despite having a very low blood pressure.

"On his first night in the IHU, the man did not receive any insulin as there was no stock overnight and his own supply did not come with him from the wing. The following day (11 September), the man declined food and fluid but accepted his insulin. His blood sugar was not tested overnight...[this meant there was] a significant risk of the man having a very low blood sugar, which could have made him acutely unwell"

61. The clinical reviewer also notes that the man's condition deteriorated on his second evening in the IHU. His blood pressure could not be recorded by either automatic or manual blood pressure machines. The clinical reviewer comments that "it is clear that there was a degree of miscommunication between the nurse and the duty doctor". The duty doctor, Dr F, said his assumption, from his conversation with the night nurse, was that only one attempt had been made to obtain the man's blood pressure. Nurse I, however, thought he had explained the different ways in which he and Nurse B had attempted to take the man's blood pressure.
62. It is also apparent from interviews that there were different interpretations of Dr F's instruction that the night nurses should monitor the man overnight, and what action should be taken if his observations continued to be of concern.
63. Dr F said at interview that when he was telephoned he requested a further check of the man's blood pressure. The doctor said his expectation was that the nurses would check on the man at least hourly and if the man still had no recordable blood pressure he expected the nurse to contact him again immediately. At interview, Nurse I said that his understanding of Dr F's advice was to monitor the man through the night and to contact the doctor again if there was deterioration in the man's condition.
64. The clinical reviewer concludes that this miscommunication meant that the significance of the failure to record the man's blood pressure was "not appreciated by either party". In addition the clinical said that "No entries were made on his observation chart; no MEWS (early warning) score was completed."
65. The clinical reviewer commented:

“As is often the case in younger patients, the man remained lucid and able to walk as his system compensated for his illness. He then suddenly decompensated and became rapidly worse. He was sent to hospital in extremis and died just over an hour later.”

66. Had communication between the night nurses and Dr F been better, it is possible that the doctor would have advised admitting the man to hospital during the night. The nurses could have decided to send the man to hospital if an emergency admission was considered necessary, but believed they were following Dr F’s advice to monitor and he did not suggest hospital admission. While an earlier hospital admission might not have altered the outcome, it would have enabled an acute specialist assessment at an earlier stage. There is no record that either the nurse or the out of hours doctor considered whether immediate hospital assessment and treatment was necessary.

The Head of Healthcare should ensure that whenever there is concern about a prisoner’s condition at night, admission to hospital should be considered, discussed and documented. Where there are grave concerns about the immediate health of a prisoner an ambulance should be called.

Liaison with the man’s family

67. Because of the distance involved, the prison followed national guidance and contacted HMP North Sea Camp to ask their family liaison officer, to inform the man’s family of his death. This meant that the news was given face to face in a timely manner, by a trained member of Prison Service staff. Further efforts were made to contact the man’s brother. While his family did not wish to have any further contact with the prison about the man’s funeral we are satisfied that the prison informed his family of his death appropriately.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that, in accordance with relevant NICE guidelines, prisoners who have complex and chronic health problems have a coordinated single case management plan, which is regularly reviewed and updated, and followed by all staff.

Accepted

Care planning for complex patients has been part of our plans going forward but has been held up by the recent tendering process and commissioning decisions. A template for personalised care planning has been embedded in the SystmOne clinical system and is starting to be trialled in the Parkhurst site.

A community matron role to support case management for complex patients has been planned but is dependent on the service model put in place once the service moves to a different provider later this year.

2. The Head of Healthcare should review the process for taking blood pressure levels and to ensure that all healthcare staff follow appropriate clinical requests and documented treatment plans. All results must be promptly acted upon and recorded so that timely documented clinical decisions can be made.

Accepted

Current Hypertension flow charts to be reviewed and updated to ensure they are inline with the Care Pathway for Hypertension as specified in the NICE Clinical Guideline 127. Local adaptation will specify the recording of blood pressures onto systm1 and highlight additional points of when a GP appointment is needed.

3. The Head of Healthcare should ensure that whenever there is concern about a prisoner's condition at night, admission to hospital should be considered, discussed and documented. Where there are grave concerns about a prisoner's immediate health an ambulance should be called.

Accepted

Since the death of the man an updated Adult Observation Policy incorporating Modified Early Warning Score – MEWS has been ratified within the Trust dated 17/12/2012. This policy makes specific reference to prisoners located in the inpatient unit at HMP IOW and the appropriate escalation process according to MEWS result. This policy is to be circulated to all IHU nursing staff.

The Joint Memorandum of Understanding for Access to Healthcare in Prison Sites Out of Hours will be updated and will include the recording of MEWS onto Systm1 and subsequent actions taken.