

**Investigation into the circumstances surrounding
the death of a man at
HMP Usk/Prescoed in January 2009**

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

December 2009

This is the report of an investigation into the circumstances of the sudden death of a man at Neville Hall Hospital, Abergavenny in January 2009. The man, a prisoner at HMP Usk, was 72 years old and had suffered from several chronic conditions. The post mortem found that he died from coronary artery thrombosis. An inquest into his death was held on 27 January 2009 and concluded that he died from natural causes.

He had remained in contact with some members of his family. I am also aware that staff and prisoners who knew him are saddened by his death. I would like to offer my sincere condolences to all those who knew him and have been affected by his death. I apologise for the lateness of this report.

My colleague conducted the investigation. An independent review of the man's clinical care was undertaken by the clinical reviewer, Review Manager Healthcare Inspectorate Wales. I am very grateful to her for her valuable contribution. I would also like to thank the Governor of HMP Usk and his staff for their cooperation. I am grateful to the prison liaison officer for his assistance. The family liaison officer and a member of the Independent Monitoring Board also made a very valuable contribution to the investigation.

I make six recommendations. Five relate to healthcare matters and were recommended by the clinical reviewer. The first two recommendations relate to the need to improve the quality, legibility and accuracy of prison healthcare clinical record keeping at Usk. The third recommendation asks that prisoners suffering from symptoms of hypertension are treated in accordance with the National Institute of Clinical Excellence guidelines. The fourth recommendation requires more detail to be provided in the event of requests for hospital tests. A fifth recommendation suggests improvement in communication between the prison and hospitals. The final recommendation is addressed to the Governor and concerns compliance with Prison Service Order 2710 in respect of holding debriefs following a death in custody.

My recommendations aside, I judge that the care the man received at Usk was appropriate.

The prison service have accepted four and partially accepted two of my recommendations and their response is documented on page 18 of my report.

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.

Jane Webb
Deputy Prisons and Probation Ombudsman

December 2009

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SUMMARY

In December 2004, the man was remanded into custody at HMP Gloucester. He underwent a routine reception healthcare screen interview that day. He told the healthcare worker that, in the past, he had depression, urine infections and acidity in his stomach. He had a forthcoming hospital appointment at the Ear, Nose and Throat Department at Gloucester Hospital. During an assessment with the doctor the following day, he was noted to have a false left eye sustained through an accidental injury in 1954.

He was sentenced to eight years imprisonment on 11 April 2005 and, in May, he transferred to HMP Usk. Healthcare staff at Usk made a thorough assessment of his physical health. They concluded that he suffered from high blood pressure, he did not have substance misuse issues or thoughts of self-harm, his diet was good and his family history showed that there was a risk of diabetes.

Throughout his sentence he had a variety of medical ailments and visited the healthcare department on a number of occasions. His blood pressure was regularly monitored. He was assessed as suffering from hearing loss and, following a referral by a consultant and after a lengthy wait, he was fitted with a hearing aid. Healthcare staff addressed his back problems by prescribing paracetamol, providing a bed board and obtaining permission for him to wear a surgical belt. He was well thought of by staff and worked well as a cleaner until he was retired by the prison.

On 25 October, he was admitted to Nevill Hall Hospital, Abergavenny with chest pain. Doctors diagnosed musculo-skeletal chest pain and discharged him the following day. During April and May 2006, he continued to be treated for urinary tract infections, dizzy spells, high blood pressure, an allergic reaction to amoxicillin, dermatitis (a skin condition), skin irritation to his left calf and a strained ankle.

In February 2007, he received bad news from his family. He was told that his estranged daughter had cancer. She died in September and he was very upset. Just before his daughter's death, he complained of vague chest pain and tightness to his chest. He was taken to hospital but tests showed he had not suffered a heart attack.

From October 2007 to mid February 2008, he attended healthcare for various medical complaints including problems with his right eye. In May, he again felt chest pain and went to hospital. The chest pain was not related to his heart and he returned to the prison. The clinical record said that an appointment for an exercise stress test was awaited to see if he had angina.

He continued to experience dizzy spells relating to high blood pressure. A prisoner who shared his dormitory said that he recalled a few days before his death, he had suffered dizzy spells and healthcare had treated him promptly.

In December 2008, he walked to healthcare from his dormitory as he, again, had chest pain. He went to hospital as an emergency and his condition deteriorated. The hospital advised the prison to contact his family as he was unlikely to survive. He was placed on a life support machine but was unable to breathe unaided. At 4.45pm the following day, the life support machine was switched off and he died in the presence of his family.

The Family Liaison Officer spoke with his sister. She invited the family to attend the memorial service at the prison and to speak to staff and prisoners who knew him. The family were very appreciative of how they were treated by the prison and spoke well of the Family Liaison Officer.

My investigation has made five recommendations relating to healthcare matters and another recommendation regarding the failure of the prison to hold a hot debrief in accordance with Prison Service Order 2710. I conclude that, in spite of these recommendations, the man received good care.

THE INVESTIGATION PROCESS

1. The Ombudsman was notified of the man's death in January 2009. Terms of reference and notices were issued to staff and prisoners at Usk telling them that an investigation would be taking place, and inviting those who wished to see the investigator to make themselves known. The investigator requested copies of his core record, clinical record, and other records relevant to his time in custody and his death.
2. The investigator also contacted HM Coroner to inform him of the nature and scope of my investigation. The Coroner told her that the man had died from coronary artery thrombosis. An inquest was held on 27 January 2009 and a verdict of death by natural causes was recorded.
3. The investigator visited Usk in May 2009. She met and spoke at length with staff and prisoners who knew the man. She visited the healthcare centre and saw the wing and cell where he was located before he died.
4. A clinical review of the man's clinical care was commissioned from Healthcare Inspectorate Wales (HIW). The clinical review was conducted by the clinical reviewer, Review Manager, HIW and appears as an annex to this report.
5. One of the Ombudsman's Family Liaison Officers spoke with the man's sisters. They did not raise any concerns regarding his care at the prison. While they were shocked at his sudden death, they said that other close family members had suffered from heart problems.

HMP USK/PRESCOED

6. HMP Usk is a category C closed prison for prisoners convicted of a sexual offence or offences, or who have a sexual element in their offending history. On arrival into prison, prisoners are risk assessed and given a category based on their offence and the risk that they pose to the public should they escape. There are four levels of category: A, B, C and D, with category A prisoners being the most dangerous. Category C prisoners are those who cannot be trusted in open prison conditions but who would not have the ability or resources to make a determined escape. Usk is located in Monmouthshire and is joined with HMP Prescoed, an open prison, although both prisons are located separately. It has a maximum capacity of 256 prisoners.
11. Accommodation is provided in three double storey wings in a combination of single and double cells and two dormitories. In May 2003, the Comber Unit opened on D wing (where the man was located) and provides ground floor accommodation for 20 prisoners.
12. HM Chief Inspector of Prisons made a short unannounced inspection in early March 2008. She described both Usk and Prescoed as “good prisons” overall with educational and vocational opportunities in both prisons judged as “impressive”.
13. She criticised healthcare accommodation. (Building improvements were awaited at the time her inspection was conducted.) Healthcare is provided by permanent nursing staff. A doctor attends the prison three days per week to deliver primary health care to prisoners. Out of hours medical help is provided by an on-call system after 4.30pm weekdays and at weekends.
14. The investigator spoke with a member of the Independent Monitoring Board¹ who told her that the prison was well run under a recently appointed governor. She added that the Board received very few complaints regarding healthcare. She described healthcare as very good especially as the population of Usk were older than that of Prescoed and had higher health needs.
15. This is the fifth death through natural causes at Usk that the Ombudsman’s office has investigated.

¹ The Independent Monitoring Board members monitor the day-to-day life in their local prison and ensure that proper standards of care and decency are maintained. Prisoners can complain to them using confidential access, they visit the prison regularly and require responses from Governors on any points raised by prisoners. The Board is required to produce an annual report on the prison to the Secretary of State, highlighting good practice and flagging up areas of concern.

KEY FINDINGS

1. On 14 December 2004, the man was remanded to HMP Gloucester having been charged with a sexual offence. On the same day, he underwent a first reception health screen interview with a member of the healthcare staff. He gave his home address and the name of his community doctor. He said he had not been homeless in the past year and confirmed that this was his first time in prison.
2. The man told the healthcare worker that he had seen a doctor for depression in the few months before he came into prison. He also said that he had a hospital appointment two days later on 16 December at the Ear, Nose and Throat department of Gloucester Hospital.
3. The healthcare worker noted that the man had been prescribed Zoton² medication. He said that he had a problem with spicy food and suffered from urine infections and related matters but no other health issues were recorded. He said he not received medication for mental health problems and had not tried to harm himself. He asked to see a doctor about his physical health.
4. The man saw the doctor the following day. The doctor recorded that he suffered from reflux oesophagitis³ and queried whether he had undergone operations for vagotomy⁴, pyluoplasty⁵ and pharyngeal pouch⁶. The man told the doctor that he was sharing a cell with a prisoner who had similar health problems. He also recorded that the man did not have thoughts of harming himself.
5. As the man had a variety of medical complaints, he visited the healthcare department several times during the first three months of 2005. He also had a history of hearing loss and was referred to a consultant. An Ear, Nose and Throat (ENT) Registrar assessed the man on 24 February. Following that appointment, the ENT Registrar wrote to the Senior Medical Officer at Gloucester prison on 1 March to explain that he was arranging for the Audiology Department to fit the man with a hearing aid.
6. On 11 April, the man was sentenced to eight years imprisonment at Gloucester Crown Court. An entry in his clinical record shows that he told healthcare staff that he would cope with his sentence but that he needed something to help him sleep that night.

² Zoton is prescribed for the relief of symptoms caused by a duodenal ulcer

³ Reflux oesophagitis is when acid from the stomach leaks up into the gullet. This can cause heartburn and other symptoms

⁴ Vagotomy is the surgical cutting of the vagus nerve to reduce acid secretion in the stomach

⁵ This term does not match any known medical condition and is probably spelled incorrectly

⁶ The clinical reviewer in her review explains a pharyngeal pouch as a 'weakening in the wall of the throat which can cause a pocket to form in which food can get caught'.

7. A month later, on 12 May, the man transferred to HMP Usk. The Reception Screening for Prisoners on Transfer form gives similar information to that of the first reception health screen at Gloucester. The man added that he had had an operation on his bladder but did not give a date. He said he did not wish to see a doctor. He underwent a number of health assessments. He was assessed as having high blood pressure and an action plan was put in place to monitor this until the doctor's review. He said that he was reducing his smoking levels. His cholesterol level was tested and results were awaited. His diet was good and he did not take drugs or drink to excess. The healthcare worker checked his family health history and it was noted that his father and brother suffered from CVA/TIA⁷ and his mother and sister were diabetic.
8. A few days later, the man signed a consent form giving healthcare staff permission to apply to the ENT department of Gloucestershire Hospital for his medical records. A letter from Gloucestershire Hospital Legal Services Department dated 31 May shows that the hospital complied with the request.
9. An entry dated 18 May in the wing history sheet said that the man had been working as a cleaner in the programmes department but was asked to leave over a difficulty with programmes staff. However, this did not reflect upon the fact that "his work as a cleaner was first class" and, as he was elderly, he retired.
10. Healthcare received a letter dated 30 June from the Audiology Department at Gloucestershire Hospital telling them that the current waiting time for an appointment (for a hearing aid) was 12 to 18 months.
11. In September, the man told healthcare staff that he had a bad back for which he was prescribed paracetamol and a bed board was requested. The prison doctor sent a memorandum to wing staff saying that the man had permission to wear a surgical belt on medical grounds. He would be able to have the belt in his possession following clearance from the security department.
12. A discharge summary dated 8 November 2005 from Nevill Hall Hospital, said that the man had been admitted on 25 October and discharged the next day. He was diagnosed with musculo-skeletal chest pain. He had been taken to hospital because he had suffered two episodes of sharp central chest pain. Tests showed that he had not suffered a heart attack and he was given pain relief. (There is no corresponding entry in the clinical record to confirm that he was taken to hospital with chest pain.) On 29 October, an entry in the clinical record suggested that he might have a chest infection. He was given amoxicillin (an antibiotic similar to penicillin) and omeprazole for acid reflux.
13. The man was treated for a variety of health complaints during April and May 2006. They included urinary tract infections, dizzy spells, high blood pressure, an allergic reaction to amoxicillin, dermatitis (a skin condition), skin irritation to his left calf and a

⁷ CVA/TIA is a cerebral vascular accident (stroke related); TIA is a temporary ischaemic accident (heart related)

strained ankle. In July, healthcare staff submitted a Special Diet Request form to the catering department to advise them that he could not tolerate onions or spicy food and had been advised to choose non-spicy food items from the menus.

14. The man received an appointment to have his hearing aid fitted on 1 September 2006. A handwritten note on the letter said “no staff” and “transferred to Gwent”. It is not clear what this means or whether the appointment took place.
15. An entry dated 1 December 2006 on the man’s wing history sheet says that he continued to conform to the prison rules and regime and had completed the Enhanced Thinking Skills course. On 29 November, he moved to the quieter Comber Unit. He continued to do well and wing staff found him “very positive and upbeat about his future.” He was making plans for his release including considering where he wanted live. He was also a Listener⁸.
16. The wing history sheet says that on 7 February 2007 the man received a visit from his sisters and they had given him bad news about his daughter having treatment for cancer. An officer noted that the man was worried and upset and he advised him to speak to the prison chaplain. The officer also told wing staff and the Orderly Officer⁹ of the man’s situation. He attended healthcare on 9 February as he was unable to sleep. He was prescribed Zimovane¹⁰ for three nights to help him sleep.
17. The clinical reviewer noted that the man lost a piece of his hearing aid on 3 July and needed to return to the hospital for a repair. He was advised by the hospital to attend the drop-in clinic. On 9 August, healthcare contacted the Nevill Hall Hospital to ask if the man had been to hospital and the matter was passed back to ensure an appointment was made.
18. The man’s blood pressure was checked regularly throughout September and October 2007. The prison doctor reviewed the man on the night of 15 September because he complained of vague chest pain and tightness to his chest. His blood pressure and temperature were taken and he was given oxygen. The prison doctor contacted the hospital accident and emergency department, however there is no evidence that the man was sent to hospital for further tests or treatment.
19. On 22 September, the man told an officer that he had learned that his daughter had died. It is not clear how he knew or who had told him. The funeral had taken place the previous day, before he became aware of his daughter’s death. The man was seen to be quite upset and the chaplain and the orderly officer were told.
20. An entry in the wing history sheet dated 1 December 2007 says that the man had been allocated a probation officer. This would suggest that the parole process had

⁸ A Listener is a trusted prisoner who listens and assists other prisoners when they are in crisis. They work on a one to one basis day or night. They are vetted and trained by the Samaritan organisation who supervise the Listeners Scheme.

⁹ The Orderly Officer is the discipline officer who is in charge of the day to day running of the prison wings.

¹⁰ Zimovane ;The clinical reviewer defines this as treatment for insomnia

started. This is confirmed in the next entry dated 14 June 2008 when the parole dossier¹¹ was completed.

21. From October 2007 to mid February 2008, the man went to healthcare on 9 occasions for various medical conditions including urine infections. He had stopped smoking. The clinical record shows that on 20 February, he had a further urine infection caused by urethral stricture. (The clinical reviewer has described this as a narrowing in the urinary tract.) On the same day, he returned to healthcare complaining of problems with his right eye, pain behind his ear, blurred vision and dizziness. Healthcare staff contacted the prison doctor (who had seen him earlier that day) and he prescribed co-codamol.¹² The prison doctor advised healthcare staff to review this should he suffer from shortness of breath. An electrocardiogram (ECG) was used to monitor his heart and result was normal.
22. The man continued to attend healthcare for blood pressure reviews and to deal with his acid reflux condition. The clinical record shows that on 14 May he complained of feeling “chest pressure”, breathlessness and pain in the back of his neck. However, he did not complain of pain in his jaw or down his arm which might have suggested a heart attack. Blood was taken for tests and he went to hospital for further tests, returning to the prison the following day. (There is no record of the outcome of the blood tests.)
23. The hospital found that the man’s chest pain was not related to his heart. However, an appointment for an exercise stress test was arranged to see if he had angina. There is no recorded information about this appointment. The hospital discharge letter said that he was investigated for “cardiac chest pain” and his tests were normal. Therefore, the hospital discharged him back to the care of the prison with no follow up arranged. The investigator was unable to clarify the entry relating to the exercise stress test as the member of staff who recorded it was on long term sick leave. Therefore, the appointment for the test remains unexplained. He was advised not to take any exercise and to “have a quiet week”. A healthcare review was set for the following week.
24. Throughout May and June, the man felt unwell. Healthcare staff continued to monitor his blood pressure and manage his various symptoms including dizziness and dermatitis.
25. Healthcare staff were called to the gym on 18 July because the man felt unwell. His blood pressure was raised and he “appeared very anxious”. They told him to go back and rest in his cell and they would check up on him later in the morning. This is no entry in the clinical record to confirm whether they did so.

¹¹ The parole dossier is a bundle of reports from internal and external probation officers, wing staff, healthcare and other prison professionals involved in the man’s sentence. This is then submitted by the prison parole clerk to the Parole Board of England and Wales for their consideration as to whether he could be released on licence into the community.

¹² An analgesic used for pain relief.

26. No further entries are made in the clinical record until 29 August when the man's blood pressure was taken and no problems were identified. In September, he continued to have difficulty with acid reflux and blood was taken for his annual hypertensive check (high blood pressure). During October, his ear problems were identified and treated appropriately.
27. A fellow prisoner remembered that the man had complained of experiencing pins and needles and a numbness in his leg a few days before his collapse. He was sitting in his chair in the dormitory he shared with the prisoner, but he felt unwell and had to lay on the bed. The prisoner recalled that "two or three times, he [the man] had little turns and felt faint" and healthcare "checked him out".

Events in December

47. The prisoner who shared a dormitory with the man told the investigator that before the man went to work that morning, he was stitching a tapestry rug and that he was getting on well with it. At 10.00am, the prisoner noticed that he was standing at the sink, in pain and with his arms out holding on to the sink. The man left the dormitory two minutes later.
48. The investigator spoke with a second prisoner who also shared the dormitory with the man. He was waiting in healthcare in the morning to see healthcare staff when he saw the man walk in clutching his chest. A prisoner banged on the nurses' door to ask for help. The nurses took him into the room. There was no doctor there at the time because the doctor only visited the prison three days each week.
49. The clinical record shows that nursing staff saw the man at 10.10am and he had chest pain. He was given an ECG and the reading said there was an abnormality with his heart. Oxygen was given and an emergency ambulance was called at 10.17am. A paramedic arrived at 10.42am and the ambulance arrived at 11.00am.
50. A risk assessment for the man's attendance at hospital was completed by healthcare and security staff. It concluded that he was not a security risk and there was no evidence in the past that he had tried to escape from custody. The security assessment was that he should be accompanied by two officers and placed in a single handcuff linked by a chain to one escorting prison officer. This was to be used on the journey to the hospital and on return to the prison.

Events at the hospital

51. The man's journey and events after he arrived at Nevill Hall Hospital are recorded in the Prisoner Escort Record form (PER). The ambulance left the prison a few minutes after 11.00am and arrived at Nevill Hall Hospital at 11.30am. Paramedics handed him to hospital care at 11.35am and medical staff asked for the handcuffs to be removed at 11.41am. The prison staff immediately complied.
52. At 11.45am, the man was "rushed to Crash Room". The Nursing Sister asked the bedwatch officers¹³ to tell his relatives that he was gravely ill. An officer, one of the officers on bedwatch duty, telephoned the prison and asked a senior officer to contact the man's family.
53. Around 45 minutes later, the Nursing Sister told the Bedwatch officer that the man's condition had deteriorated and he was being put onto a life support machine. The man's sister and brother-in-law arrived at the hospital at 3.41pm and spoke with medical staff.
54. The nursing staff told the bedwatch officers that, if the man went into cardiac arrest again, he would not be resuscitated. The bedwatch officers kept the prison informed of his condition throughout the night.
55. In January 2009 nurses told the bedwatch officers that they were waiting for instructions from the consultant to withdraw medication and turn off the life support machine to see if the man could breathe on his own. The bedwatch officers gave this information to the prison.
56. At 11.30am, the man's family returned and they were joined by other family members at midday. The bedwatch officers telephoned the Governor at 1.20pm to tell him that the life support machine would be switched off when all the family were present. The chaplain also visited during this time. The family were consulted before the machine was switched off at 4.45pm and the man died in the presence of his family.

Events after the man's death

57. The investigator spoke with the prison's family liaison officer. She said that she was not on duty when the prison contacted her after the man's death but she was 'on call' as a family liaison officer. She understood from the Governor that the man's sisters were away from home. She contacted them the following day and, together with the chaplain, she visited them at home in Gloucester.

¹³ A Bedwatch Officer is a prison officer who accompanies prisoners when they go to hospital and remains with them at all times.

58. The prison's family liaison officer returned the man's property to his sisters during the visit. One of his sisters told my family liaison officer that the prison "have been very good". She said she could not fault either the chaplain or the prison's family liaison officer whom she thought had been "especially good" as she had taken a lot of pressure from the family. The prison had offered to pay for the funeral and the family had accepted. The family were invited to a memorial service at the prison and were asked if they wished to have the opportunity to speak to staff and prisoners. The man's sister spoke highly of staff and said that they were always treated well when they visited him every month.
59. The prisoner who shared a dormitory with the man was surprised at his death and said a wing officer had kept prisoners informed of his condition. The Governor told my investigator that staff on D wing were aware that the man had gone to hospital. He said that prisoners were told individually of his death. He spoke on the telephone to one of the man's sisters who lived in Germany and was shocked at the news.
60. There is no evidence that a hot debrief¹⁴ for staff was held as required by Prison Service Order 2710, Following a Death in Custody. The Death in Custody Action Plan says that the two prisoners who knew the man were identified as those who might need counselling as they shared a dormitory with him and knew him well. The Governor said that the prison's family liaison officer contacted the bedwatch officers and offered them support, although they did not take up the offer.

¹⁴ A hot debrief is a meeting held by management for staff involved in a serious incident. It is an opportunity to share learning, review procedures and provide support for staff who need it.

ISSUES

The clinical review

61. The clinical review was undertaken by a clinical reviewer, Review Manager, Healthcare Inspectorate Wales. Her review is based on the man's prison clinical record, reports and letters from other healthcare professionals and records of interviews with prison staff. She makes a number of recommendations which I endorse and, in some instances, recast.

Record keeping

62. The clinical reviewer has judged that the clinical records were generally in good order. However, some entries were illegible, unsigned and with abbreviations used throughout. I endorse her finding. An entry in the clinical record dated 15 May 2008 says that the man awaited an appointment for an exercise stress test. There is no evidence in any other healthcare record of such an appointment and whether it took place and healthcare staff were unable to explain it to the investigator.
63. There were periods within the record where, in the clinical reviewer's opinion, it was not clear what care and treatment the man was receiving including admissions and visits to hospital in relation to his hearing aid.

The Head of Healthcare should ensure that all healthcare staff are reminded of the requirements to keep accurate, legible, signed records in accordance with Nursing and Midwifery Council Guidelines and that abbreviations should not be used.

The Head of Healthcare should ensure that all dates of admission to hospital and attendance at clinics are recorded, including the reason for them.

Hypertension management

64. The clinical reviewer has identified that although the man's blood pressure was repeatedly measured as higher than normal, he was not given any hypertensive medication. She considers this unusual considering the symptoms he displayed including dizziness, generally feeling unwell, tiredness and chest pain.

The Head of Healthcare should ensure that prisoners suffering from indications of hypertension are treated appropriately according to the National Institute of Clinical Excellence Guidance – Hypertension: Management of Hypertension in Adults Primary Care.

65. The clinical reviewer found that tests and investigations into the man's health were ordered and the prison doctor was waiting for the results. However, it was not clear

from the records what some of these tests were, whether they were undertaken, what the results were or if treatment started.

The Head of Healthcare should ensure that medical staff properly record the circumstances and details of tests as well as the outcome and any treatment.

66. The clinical reviewer is concerned that the man had to wait over a month to get his hearing aid fixed when the hospital had said that he could go to any drop-in clinic Monday to Friday between 9.00am and midday. The clinical reviewer has judged that this had been arranged but the records are not clear.

The Head of Healthcare should improve communication between the prison and hospitals in arranging appointments.

67. There is no evidence that a formal hot debrief¹⁵ was held for all the staff who were involved in the man's care and the events leading up to and following his death. A hot debrief is a requirement of Prison Service Order (PSO) 2710 and should follow every death in custody. Paragraph 5.3 of the PSO says that there must always be a hot debrief immediately after the incident and provision should be made in the local contingency plans. A senior member of staff must act as debriefer and a duty care team member must also attend.

The Governor should ensure that formal hot debriefs take place in accordance with PSO 2710 and are documented.

Conclusion

68. The man was an older prisoner. During his four years in prison, he reported and was diagnosed with a number of ailments, including chest pain. Hospital and prison tests revealed no heart abnormalities but he was treated for other conditions. His condition suddenly deteriorated in December 2008 and an ECG showed an abnormality of his heart. He was admitted to hospital where he died the following day.

69. My recommendations aside, I judge that the medical care the man received for the conditions he disclosed to healthcare staff was comparable to that which he would have received in the community.

RECOMMENDATIONS

1. **The Head of Healthcare should ensure that all healthcare staff are reminded of the requirements to keep accurate, legible, signed records in accordance with Nursing and Midwifery Council Guidelines and that abbreviations should not be used.**

Accepted. All nursing staff have been reminded of the need for accurate recording, which is also legible and not abbreviated.

2. **The Head of Healthcare should ensure that all dates of admission to hospital and attendance at clinics are recorded, including the reason for them.**

Accepted. Nurses have been reminded to record admissions to hospital in the HC record. Attendance at out patient clinics is already recorded on the outpatient's appointment sheet.

3. **The Head of Healthcare should ensure that prisoners suffering from indications of hypertension are treated appropriately according to the National Institute of Clinical Excellence Guidance – Hypertension: Management of Hypertension in Adults Primary Care.**

Accepted. Nurses are fully aware that any patients showing indication of hypertension are referred for assessment to the GP who then makes his clinical assessment of the most appropriate treatment.

4. **The Head of Healthcare should ensure that medical staff properly record the circumstances and details of requested tests as well as the outcome and any treatment.**

Accepted. The GP has been informed of the need for such records. Correct recording should greatly improve with the introduction of the Prison Health Information Technology (PHIT).

5. **The Head of Healthcare should improve communication between the prison and hospitals in arranging appointments.**

Partially Accepted. The clinical reviewer has indicated that, "The clinical reviewer has judged that this had been arranged but the records are not clear." This appears to be a recording issue and not a need to improve communication between the prison and hospitals. Nonetheless evidence of such communication will be retained.

6. **The Governor should ensure that formal hot debriefs take place in accordance with PSO 2710 and are documented.**

Partially Accepted. Staff on duty at the time of the man's death were all briefed by the Senior Officer on duty. The two escorting staff that were in attendance at the hospital at the time of death were contacted by the establishment Care Team and offered support but both declined.

All prisoners located on D wing were spoken to personally and informed of the man's death. However, contingency plans will be reviewed to ensure when the 'hot debrief' takes place it is recorded.