

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Dominic Clayton a prisoner at HMP Lincoln on 16 January 2017

A report by the Prisons and Probation Ombudsman

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Dominic Clayton died on 16 January 2017 of multiple organ failure (related to mismanagement of his diabetes) in hospital while a prisoner at HMP Lincoln. He was 36 years old. We offer our condolences to Mr Clayton's family and friends.

Mr Clayton's care was not equivalent to that which he could have expected to receive in the community. His clinical needs were clear from the outset and apparent to the numerous clinical staff with whom he had dealings. It is not acceptable that his care was so badly mismanaged that he had to be sent to hospital and troubling that these failings were compounded by the prison's inefficient and confused emergency response procedures.

Nottingham Healthcare NHS Trust and the Governor will need to satisfy themselves that the failings identified in this case are addressed.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Elizabeth Moody
Acting Prisons and Probation Ombudsman

March 2018

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Summary

Events

1. On 10 January 2017, Mr Dominic Clayton was remanded to HMP Lincoln having committed offences while on bail. He was charged with trespass and theft.
2. Liaison staff at Lincoln Magistrates' Court alerted pharmacy staff at the prison that Mr Clayton would be transferred to Lincoln that day and that he was an insulin dependent diabetic. Lincoln pharmacy contacted his community GP surgery who faxed a repeat prescription for insulin (and other associated items) to the prison.
3. A prison GP received the repeat prescription and confirmed that the items on the prescription should be given to Mr Clayton. He did not make a note of this in the medical record because he believed that, as Mr Clayton had not yet arrived at Lincoln, he had no medical record (in fact Mr Clayton had been at Lincoln before and did have a record.)
4. Mr Clayton arrived at Lincoln. The reception nurse created a brand new medical record (not realising Mr Clayton already had a historical record). The doctor did not update the medical record about the prescription until the next day and could not remember what he had done to make sure staff were aware of the repeat prescription and that the medication was dispensed and administered to Mr Clayton.
5. Mr Clayton's community GP records have subsequently shown that he should have had four doses of insulin a day. He was at HMP Lincoln for almost 24 hours but staff only gave him one dose. Multiple members of staff saw Mr Clayton and recorded his need for insulin but they did not take sufficient action to ensure he received his medication.
6. A nurse conducted a medication in possession assessment and decided a specialist nurse should see Mr Clayton before being allowed his medication in possession.
7. Mr Clayton's condition deteriorated rapidly and on 11 January, a prison GP instructed staff to call an emergency ambulance. There was a significant delay between the GP giving the instruction to call an ambulance and one actually being called. The emergency service's nurse then had to call the prison five times in an attempt to get further information about the emergency before the ambulance could be dispatched.
8. In hospital, Mr Clayton had two heart attacks, suffered a perforated ulcer and multiple organ failure before doctors confirmed his death at 4.10pm on 16 January 2017.

Findings

9. The clinical reviewer found that the care Mr Clayton received at HMP Lincoln was not equivalent to that which he could have expected to receive in the community.

10. Despite early warning from the court liaison officer, staff only gave Mr Clayton one of the four insulin doses he needed. They did not create his medical record properly, record key occurrences promptly, give clear handovers, request GP records, consider the case for medication in possession adequately or have any mechanism for obtaining urgent out of hours prescriptions.
11. The emergency response was confused, lacked urgency and coordination and was not properly recorded by the control room.
12. Although the initial decision to restrain Mr Clayton when he was sent to hospital was reasonable, the prison failed to respond to his deteriorating condition and restraints were only removed at the request of nursing staff.
13. Managers did not hold a hot debrief for staff following Mr Clayton's death in accordance with PSI 64/2011.

Recommendations

- The Head of Healthcare, working with Nottinghamshire Healthcare NHS Trust, should ensure that:
 - healthcare staff prescribe, dispense and administer medication without delay in line with professional standards of medicine management;
 - healthcare staff comply fully with the requirements for accurate and contemporaneous record keeping in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council;
 - staff take follow-up action, give clear verbal handovers and note SystemOne where action needs to be completed;
 - community GP records are routinely requested for all prisoners to ensure continuity of care;
 - medication in possession assessment processes are thorough and that staff record the rationale for their decisions; and
 - the service agreement with the out of hours' prescriptions service is fit for purpose, and put in place contingency plans for emergencies when the service cannot deliver.
- The Governor should review control room procedures and ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies as outlined in the local Medical Emergency Response Code Protocol, so that staff efficiently communicate the nature of a medical emergency, and there is no delay in calling, directing or discharging ambulances.
- The Governor should ensure that escort staff understand the importance of informing the prison of a change in a prisoner's medical condition so they can review the restraints status.
- The Governor should ensure that a debrief takes place after the death of a prisoner and that staff involved are appropriately supported.

The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP Lincoln informing them of the investigation and asking anyone with relevant information to contact her. One prisoner responded.
15. The investigator obtained copies of relevant extracts from Mr Clayton's prison and medical records. She interviewed 2 members of staff.
16. NHS England commissioned a clinical reviewer to review Mr Clayton's clinical care at the prison. The clinical reviewer also spoke to healthcare staff to gather further information.
17. We informed HM Coroner for Central Lincolnshire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
18. The investigator contacted Mr Clayton's mother, to explain the investigation and to ask if she had any matters they wanted the investigation to consider. She wanted to know how the prison had managed Mr Clayton's diabetes and how they had conducted the emergency response.
19. Mr Clayton's mother received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.
20. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Lincoln

21. HMP Lincoln houses up to 729 remand and convicted men. It serves the courts of Lincolnshire, Nottinghamshire and Humberside. It has four residential wings, which include a vulnerable prisoners' unit. Nottingham Healthcare NHS Trust provides health services and there is 24-hour nursing cover. There is no inpatient unit at Lincoln.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Lincoln was in January and February 2017. Inspectors reported that although some of the progress identified at the last inspection had been maintained, there had also been some deterioration.
23. They particularly praised the SPARC (Support for Prisoners after Remand or Conviction) initiative whereby a contact at Lincoln magistrates' court liaises with the prisoner and communicates any issues or needs to HMP Lincoln before the prisoner arrives there.
24. Prisoners were mostly positive about the quality of care they received from healthcare staff. Waiting times to see GPs were good at just over one week and 'on the day' urgent appointments were available if necessary. However, there was no cover at the weekends or in the evenings, which contributed to delays in giving new arrivals their medication. The pharmacy had an up to date medication in possession policy to ensure prisoners were assessed on reception but it was not always routinely reviewed to enable them to change their status.

Independent Monitoring Board

25. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to January 2017, the IMB reported that it had been a challenging year due to prison officer vacancies and sickness, which resulted in wing lock-downs and restricted regimes. They particularly identified issues with the building's fabric, the lack of CCTV, high use of New Psychotic Substances and levels of self-harm.

Previous deaths at HMP Lincoln

26. Since January 2015, there have been two previous deaths from natural causes at HMP Lincoln. We have previously made a recommendation about the importance of requesting community GP records for new prisoners.

Key Events

27. On 10 January 2017, Mr Dominic Clayton was remanded to HMP Lincoln having committed offences while on bail. He was charged with trespass and theft. It was noted at a very early stage that he was an insulin dependent Type 1 diabetic.
28. Type 1 diabetes is an autoimmune condition where the pancreas does not produce any insulin. Insulin is responsible for regulating blood glucose levels and deregulation can cause complications and fatalities. Individuals with diabetes have to ensure that they manually administer insulin into their system.
29. A practitioner from the SPARC project (Support for Prisoners After Remand or Conviction, an organisation funded by the prison to highlight the immediate needs of prisoners while they are still at court), spoke to Mr Clayton at Lincolnshire Magistrates' Court. Her police statement said that she telephoned HMP Lincoln pharmacy and told them he was on insulin.
30. The person she spoke to (there is no record who) told her that they had looked at Mr Clayton's historical records. (He had been in prison and at Lincoln before - the last period being between 8 April 2015 and 27 May 2015.) The prison pharmacy contacted Mr Clayton's community GP, and the surgery faxed a copy of Mr Clayton's repeat prescription to the prison. The prescription listed lantus (a long acting insulin which controls glucose levels between meals and overnight), novorapid flexpen (a fast-acting insulin to be taken before meals), omnican (insulin syringes), omnitest (blood glucose testing strips), mirtazapine (an antidepressant) and pregabalin (can be used for nerve pain, epilepsy and anxiety). There is no evidence that staff requested Mr Clayton's community GP records or assessed whether they were needed.
31. A prison GP said in his statement to the police that between 9.00am and 10.00am on 10 January, he opened Mr Clayton's 'prison record' but was unable to prescribe insulin because the record did not yet have a prison number. The head of healthcare told the investigator that the faxed repeat prescription from the community GP would have been taken to a prison GP. He ticked against lantus, mirtazapine, novorapid and pregabalin and wrote on the bottom of the prescription:

“*Please issue/administer patient all medication as per his repeat prescription as non IP (non In Possession).”
32. The Head of Healthcare's PA told the investigator that prescriptions are usually taken to the pharmacy hatch for them to dispense, but it is only open between 8.00am-9.00am and 4.00pm-5.00pm. The prison GP could not remember if he had given the prescription to a nurse or the pharmacy.
33. On his arrival at Lincoln, Mr Clayton was taken to the reception area and an officer started the booking-in process at 11.59am. The escorting officer passed to the officer a Suicide and Self Harm (SASH) form (designed to flag up any concerns about a prisoner to the receiving prison staff and completed by officers at the court). The form detailed an incident that took place on 8 January, at the police station, where Mr Clayton had grabbed some scissors in

a medical room and cut his own stomach. It noted that he had been very tearful and worried about his diabetic medication not being correct.

34. The officer asked Mr Clayton to provide personal details and asked a number of questions about his health and wellbeing. He told her that he had been taking subutex to help him with his drug issues and that he was an insulin dependent diabetic. He also told her that he intermittently used New Psychotic Substances (previously known as 'legal highs'). He was referred to the substance misuse team.
35. At 12.05pm, the reception nurse created a new SystmOne record for Mr Clayton but did not realise he had a pre-existing record. The reception nurse asked another nurse to check Mr Clayton's prison number who confirmed at 1.36 pm that a previous record existed. At 1.49pm, SystmOne generated a notification confirming that the two records would be merged overnight. Both records were available separately in the meantime.
36. The officer was concerned about Mr Clayton's presentation and wanted the duty nurse to see him but she was unavailable. She asked another nurse, Nurse A, to see him instead and he saw him at 12.20pm in a holding cell. The officer told the nurse that Mr Clayton was a Type 1 diabetic and needed insulin.
37. Nurse A thought Mr Clayton seemed fit and well. Mr Clayton asked him when he could have some pregabalin. (Pregabalin is a prescription drug used for a variety of reasons including pain relief, epilepsy, depression and anxiety. It can also be taken to increase the effect of illicit opiate-based drugs.) Nurse A told Mr Clayton a doctor would have to prescribe pregabalin if he agreed there was a need for it.
38. Nurse A was concerned about Mr Clayton's need for insulin and took his blood sugar level, which was '14.0mmol/L' (millimoles of blood sugar per litre). According to NICE guidelines a target range for someone with Type 1 diabetes would be 5-9mmol/L. He said in his statement to the police that the reading of 14 was 'slightly high but not worryingly so'. He said that Mr Clayton had arrived with some old medication and some diabetic treatment needles and he was aware that Mr Clayton's community GP had confirmed that his medication was novorapid.
39. Nurse A prescribed Mr Clayton insulin and supervised him self-administering a dose of 7 units. Mr Clayton seemed well apart from a light tremor in his left hand, and Nurse A was not concerned. Nurse A gave the reception nurse a verbal handover. Nurse A recorded his interaction with Mr Clayton at 12.25pm on 11 January and did not record any follow-up action. The officer recorded that she got Mr Clayton a hot drink with sugar in it and gave him some 'coco pops' cereal which he struggled to eat.
40. At 2.05pm, the Addaction substance misuse team saw Mr Clayton (standard procedure for prisoners who have declared previous substance misuse issues). She helped him complete the initial medicines in possession assessment and compacts for various drug treatments. She also conducted a urine test, which was positive for buprenorphine, benzodiazepine and opiates.

41. At 3.36pm, a nurse completed Mr Clayton's first night screen. She recorded that he had Type 1 diabetes and was receiving prescribed medication. She started an In Possession Risk Assessment for insulin and an epi-pen (an automatic insulin injector). She also noted he was on insulin, novorapid and lantus for his diabetes.
42. A nurse noted that Mr Clayton was able to demonstrate the correct technique for using and managing his epi-pen and had a current understanding of diabetes. She decided that Mr Clayton should not have his insulin in possession until a specialist diabetic nurse had assessed him. She was not available for interview by the investigator or the clinical reviewer.
43. At 4.00pm, Mr Clayton was sent to the First Night Centre on A wing. One of the officers conducting the two-part Cell Sharing Risk Assessment (CSRA) had noted that Mr Clayton was diabetic and was 'suffering at the moment'.
44. On 10 January, the duty governor authorised Mr Clayton to have a single cell. There was concern that other prisoners might take his diabetic needles for substance misuse (even though he was not allowed to have his medication in possession.) She recorded that the reason for her decision was because Mr Clayton was 'insulin dependent'.
45. Records show that Mr Clayton rang his cell bell at 4.25pm, 5.22pm, 7.28pm and 9.55pm. He also rang it at 3.22am and at 10.45am the following morning (11 January). Neither the First Night Centre's observation book nor the A wing general observation books record the reasons for Mr Clayton ringing the cell bell or staff responses.
46. At 7.03pm, a doctor from Addaction recorded on Mr Clayton's medical record that Mr Clayton was 'haemodynamically stable'. This term refers to blood circulation and the heart's pumping action. He also made a note about Mr Clayton's substance misuse, treatment and diabetes. He listed insulin among other medications but did not write a prescription for any insulin or record any follow up action. He made it clear that he had not seen Mr Clayton in person as there was an incident on the wing.
47. Nurse B said in her statement to the police that she visited Mr Clayton in his cell at approximately 3.30am on 11 January, after receiving a request from prison staff to see him, as he was not well. She thought he seemed physically okay but he told her he was due some insulin. Mr Clayton said that he felt sick and had not eaten anything. She noted that there was a plate of uneaten food in his cell. She told him to eat and drink something. She carried out basic observations which were in the normal range. His blood glucose levels were 15 Ommol/L, which she did not think an excessively high reading.
48. Nurse B said that although she thought Mr Clayton would benefit from insulin, she did not know that he had a prescription or that he had been given insulin because this information was not recorded in the medical notes. Nurse A's statement to police said he had spoken to Nurse B on the telephone and told her he had given Mr Clayton novorapid that day. Nurse B said she did not recall this conversation.

49. Nurse B asked Mr Clayton to provide a urine sample so she could test for ketones. Consistently high blood glucose levels can lead to a condition called diabetic ketoacidosis (DKA). This happens when a severe lack of insulin means the body cannot use glucose for energy, and the body starts to break down other body tissue as an alternative energy source. Ketones are the by-product of this process.
50. Nurse B rang the out-of-hours service at a hospital for an emergency prescription for insulin. She was told there was no nurse or doctor on duty who could prescribe it. Nurse B went back to see Mr Clayton at 5.00am but he was using the toilet and shouted that he was alright. She did not wait and collect a urine sample but told Mr Clayton to contact healthcare when he had produced one. Nurse B recorded her interactions with Mr Clayton on SystmOne and made an appointment for Mr Clayton to see a GP at 8.15am the next morning. She also sent a covering task to the administrative team to say that the GP might decide to see the patient as well.
51. Mr Clayton was added to the non face-to-face appointments ledger at 8.10am. The medical record appointments ledger shows two anonymous entries at 7.57am and 8.45am for non face-to-face appointments but both say that the GP 'may' wish to see Mr Clayton, as he was a Type 1 diabetic. A prison GP said he did not see these requests for a possible face-to-face appointment.
52. On 11 January, at 9.24am, a prison GP recorded in the medical records that he carried out a medical review. He noted that the plan was to 'confirm medications prescribed', which were listed as lantus, mirtazapine, novorapid, omnican, omnitest testing strips and pregabalin. He did not see Mr Clayton in person.
53. A member of the Addaction team filled in an interventions form to say that they went to see Mr Clayton in the first night centre. They recorded that they were unable to do their assessment because Mr Clayton was unwell. They saw him at his cell door and he complained that he had stomach pains because he had not had his diabetic medication. They recorded that they spoke to a member of healthcare staff (unnamed) who said that they were dealing with it.
54. An officer went to see Mr Clayton to carry out his basic custody screening report (a generalised risk assessment covering areas including education, relationships and healthcare). He came out of the cell to sit with her on the landing and she felt he was unwell as his face looked pained and he was sitting in a hunched position. He told her he felt 'bad' and had not had his insulin. He felt that there was a problem with his ketone levels. The officer took Mr Clayton back to his cell and returned to her office to input the results of his risk assessment, and phoned healthcare staff to go and see him. They told her that healthcare staff had already gone to see him.
55. A prisoner who subsequently wrote to the investigator said he saw Mr Clayton in his cell that morning, and he was unwell. Mr Clayton told him he had not had his insulin. The prisoner told the nurse who was giving out medication on the wing who said she was aware of Mr Clayton's needs and would deal with him when she had finished. The prisoner felt Mr Clayton needed his medication

sooner. Mr Clayton also spoke to the nurse but, according to the prisoner, he was not given any insulin.

56. At 10.00am, Mr Clayton saw Nurse C who recorded that Mr Clayton's blood glucose levels were 20, ketones high, blood pressure 150/70 (ideal is 120/80 so his reading was partially high) and his saturation levels (blood oxygen levels) were 100 percent. Mr Clayton told her he had vomited 17 times during the night and had an upset stomach. She spoke to a prison GP who advised that Mr Clayton should be transferred urgently to hospital. She made a retrospective entry about this conversation in the medical records at 10.11am. She noted that an emergency ambulance was required and one should be called via control room staff.
57. Neither prison records nor medical records clarify how this was done. The emergency service's records indicate that the first call was made at 10.26am by staff in the control room, at least 15 minutes after a prison GP had identified the situation as an emergency. The emergency services required further information and their operator arranged for one of their nurses to call the prison back to triage the call.
58. The nurse called the prison five times. Control room staff put her through to various telephone extensions where no one answered, so she had to leave a message. The emergency service's records indicate that they despatched an ambulance at 10.56am, which arrived seconds later (as the hospital is across the road). According to their records, the ambulance then left the prison at 11.18am.
59. When Mr Clayton arrived at hospital, the escorting officer described him as agitated, in a lot of pain and sweating an unnatural amount. Nurses took blood tests and said he would have to stay in hospital for 2-3 days. The hospital treated him for detoxifying for opiate addiction and diabetic ketoacidosis. At 5.05pm an officer described Mr Clayton's pain and distress as 'extreme'.
60. On 12 January at 12.25am, Mr Clayton vomited large amounts of blood. At 12.40am, an officer noted that he had removed restraints when nursing staff requested it and the prison were informed. Restraints were not reapplied at any point thereafter.
61. Mr Clayton was moved to the Intensive Care Unit and prison staff were advised to contact his family. An officer informed the night orderly officer and Mr Clayton's mother was on her way to the hospital by 2.00am.
62. Mr Clayton had had a cardiac arrest and over the following days suffered aspiration pneumonitis (a type of lung infection), a perforated duodenal ulcer (an ulcer in the small intestine), a further cardiac arrest and multiple organ failure. He was pronounced dead at 4.10pm on 16 January.
63. We were subsequently informed that the post mortem concluded that Mr Clayton's treatment at hospital deviated from standard practice and caused or contributed significantly to his death. These are not matters which fall within the remit of the PPO's investigation.

Contact with Clayton's family

64. At 2.00am on 12 January 2017, after being informed that Mr Clayton's condition was deteriorating, the prison appointed an officer as a family liaison officer. He attended the hospital at approximately 2.30am and introduced himself to Mr Clayton's mother. He offered advice and support over the next few days and after Mr Clayton died.
65. Mr Clayton's funeral was held on 9 March 2017. A prison manager and a member of the prison chaplaincy attended. The prison contributed to the funeral costs in line with national policy.

Support for prisoners and staff

66. After Mr Clayton's death, managers did not debrief the staff involved to ensure they had the opportunity to discuss any issues arising, or to offer support.
67. The prison posted notices informing other prisoners of Mr Clayton's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Clayton's death.

Post-mortem report

68. The coroner provided a copy of the post-mortem report which gave the cause of death as 1a) multi-organ failure, 1b) cardiac arrest, 1c) diabetic ketoacidosis and 2) perforated duodenal ulcer.

Findings

69. The clinical reviewer concluded that the care Mr Clayton received at HMP Lincoln was not equivalent to that which he could have expected to receive in the community. The post-mortem report also concluded that Mr Clayton's treatment at a hospital was inappropriate and caused or significantly contributed to his death.
70. HMP Lincoln's uncoordinated and disjointed approach to managing Mr Clayton's condition led to him developing diabetic ketoacidosis and, avoidably, being taken to hospital.
71. The investigation identified a number of concerns - staff not using SystemOne effectively, not delivering follow-up care, not requesting community GP records, inadequate medication in possession assessments, and unacceptable out of hours arrangements for prescriptions.
72. Mr Clayton's regime was one treatment of lantus per day and novorapid before meals. In order to maintain a steady glucose level, Mr Clayton should have had 28 injections a week (one lantus and three novorapid per day). The liaison point at court contacted HMP Lincoln's pharmacy and alerted them to the fact that Mr Clayton needed insulin. The pharmacy contacted Mr Clayton's GP and arranged for a prison GP to deal with the repeat prescription.
73. It is unacceptable that within less than 24 hours, a minimum of 14 members of staff recorded that Mr Clayton needed insulin and yet he only received one of the four doses he needed. We make the following recommendation:

The Head of Healthcare, working with Nottinghamshire Healthcare NHS Trust, should ensure that healthcare staff prescribe, dispense and administer medication without delay in line with professional standards of medicine management.
74. There is no evidence of what a prison GP did to ensure that staff were aware of the repeat prescription or to follow it up. He told the investigator that he probably gave it to the pharmacist or a nurse. He did not note the medical record about the prescription later that day even though a new medical record was available. He updated Mr Clayton's medical record the next day.
75. When Mr Clayton arrived at prison, the reception nurse created a new medical record because he could not find Mr Clayton's historical record. A colleague later located the historical record and the computer system began merging the old and new notes – a process, which would not be completed until the next day, although both records were available in the meantime for updating.
76. Nurse A saw Mr Clayton at 12.20pm. Mr Clayton told him he was diabetic and Nurse A got him one dose of novorapid and watched him self administer it. He said he gave the reception nurse a verbal handover. He did not record his interaction with Mr Clayton until 12.25pm the next day and did not record any follow up action that was needed.

77. Nurse B saw Mr Clayton at approximately 3.30pm on 11 January. She said in her police statement that she wanted to test Mr Clayton's urine in order to detect any ketones and gauge what care he needed. However, when she went to see him one and a half hours later, she did not question whether he had produced a sample and did not follow this up.
78. Although a prison GP was aware that he had to review Mr Clayton's medication, he did so without seeing him, as is fairly normal practice. He said that he did not see Nurse B's notes to consider whether it was necessary to see him face-to-face. We make the following recommendations:

The Head of Healthcare working with Nottinghamshire Healthcare NHS Trust should ensure that all healthcare staff comply fully with the requirements for accurate and contemporaneous record keeping in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.

The Head of Healthcare should ensure that staff take follow-up action, give clear verbal handovers and note SystmOne where action needs to be completed

79. PSO 3050 "Continuity of Health Care for Prisoners" states that "Efforts should be made to retrieve any information required from a prisoner's GP or other relevant service he/she has recently been in contact with."
80. Healthcare staff at Lincoln do not request GP records as a matter of course when a prisoner comes into custody. The Head of Healthcare's PA, said that staff assess the need for the GP records on a case by case basis and only request them if it is deemed necessary. There is no evidence that staff assessed whether it was necessary to obtain Mr Clayton's GP records or that they requested them.
81. Although the court liaison point and pharmacy staff were quick to identify Mr Clayton's medical needs, and obtain a repeat prescription from the community GP, it is best practice to get the whole record. It is not the first time we have had to make this recommendation to HMP Lincoln and we make the following recommendation again:

The Head of Healthcare working with Nottinghamshire Healthcare NHS Trust should ensure that community GP records are routinely requested for all prisoners to ensure continuity of care in line with PSO 3050.

82. The nurse who completed Mr Clayton's first night screen recorded that he took insulin for Type 1 diabetes and conducted a medication in possession assessment. She did not allow Mr Clayton to have his own medication but did not record or justify the reasons for her decision. Mr Clayton self-medicated in the community and Nurse A had already witnessed him doing so that day. We make the following recommendation:

The Head of Healthcare, working with Nottinghamshire Healthcare NHS Trust, should ensure that medication in possession assessment processes are thorough and that staff record the rationale for their decisions.

83. Nurse B phoned the out-of-hours service at a hospital for an emergency prescription of insulin in the early hours of 11 January. The out-of-hours service did not have anyone available to write prescriptions and Nurse B seems to have left the matter for a prison GP to address in the morning. We make the following recommendation:

The Head of Healthcare, working with Nottinghamshire Healthcare NHS Trust, should ensure the service agreement with the out of hours' prescriptions service is fit for purpose and put in place contingency plans for emergencies when the service cannot deliver.

The emergency response

84. There was an avoidable delay in calling an emergency ambulance following a prison GP's decision, which a nurse recorded at 10.11 am, and breakdowns in communication which led to further avoidable delay.
85. Nurse C has left the prison and the bank nursing service, so we have not been able establish what happened after she was told to call an emergency ambulance. The control room made the first call to the emergency services at 10.26am.
86. The control room was not able to connect the emergency service's nurse to the healthcare department even after five attempts and the nurse had to leave a message on an answer machine. This is not acceptable.
87. The prison's control room log did not record its initial call or the subsequent five calls from the emergency services to the prison. We make the following recommendation:

The Governor should review control room procedures and ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies as outlined in the local Medical Emergency Response Code Protocol so that staff efficiently communicate the nature of a medical emergency, and there is no delay in calling, directing or discharging ambulances.

Restraints

88. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. 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 takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

89. On 11 January, a prison manager authorised that Mr Clayton be restrained by an escort chain (an escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). The medical assessment was unsigned and did not object to the use of restraints. It authorised the restraints to be removed for treatment only. It also noted that Mr Clayton's mobility was not impaired. The security assessment deemed all risks as medium.
90. At 00.40am an officer noted that he had removed restraints when nursing staff requested it and he informed the prison. Restraints were not reapplied at any point after this. It was approximately twelve hours after an officer first described Mr Clayton as being in pain that staff removed restraints. The records do not show that either officer contacted the prison to discuss the appropriateness of restraints. We consider that managers should have had the opportunity to reconsider the restraint arrangements earlier given Mr Clayton's deteriorating condition.
91. Although one of the escorting officers was new and the other officer was on loan from another prison, given the officers' written descriptions of Mr Clayton's sustained pain level, it is reasonable to have expected them to alert the duty governor to the situation. We make the following recommendation:

The Governor should ensure that escort staff understand the importance of informing the prison of a change in a prisoner's medical condition so they can review the restraints status.

Hot debrief

92. Chapter 12 of the Prison Service Instruction (PSI) 64/2011 directs that: 'In line with PSI 08/2010 Post Incident Care a 'Hot Debrief' must be held immediately after all deaths in custody. A senior manager of staff must act as the de-briefer and a member of the care team must attend. All staff directly involved in the incident, including Healthcare staff, should be invited. It may be useful to keep a record of those who attend. Governors/Directors are reminded that staff affected by a death in custody may require support at any time and on more than one occasion, including during police and PPO investigations, and during the completion of the inquest.'
93. Lincoln did not hold a hot debrief after Mr Clayton's death. There is no record of an opportunity for the staff involved in Mr Clayton's care before he went to hospital, or those staff who escorted him, to discuss the circumstances of his death. The PSI explicitly states that a hot debrief should be held after all deaths in custody. We make the following recommendation:

The Governor should ensure that a debrief takes place after the death of a prisoner and that staff involved are appropriately supported.

**Prisons &
Probation**

Ombudsman
Independent Investigations