Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Baker a prisoner at HMP Garth on 3 January 2016

A report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

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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.

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

Mr David Baker died on 3 January 2016 at HMP Garth from abdominal bleeding caused by a ruptured aneurysm. He was 52 years old. I offer my condolences to Mr Baker's family and friends.

Mr Baker had a number of serious health problems and healthcare staff at Garth managed his conditions well. However, in mid-December 2015, there was a breakdown in Mr Baker's relationship with healthcare staff, after which he refused to collect or take any medication. There is nothing to suggest that Mr Baker did not have capacity to make such decisions about his treatment, although this was not documented. Nursing staff made efforts to encourage him to take his medication, but because of the risks, I consider they should have referred the matter to a GP or delivered some medication to his cell.

No one flagged up for night staff Mr Baker's medical risks. When he reported feeling unwell in the early hours of 3 January, I consider that prison staff should have sought advice from the on-call doctor, rather than relying on their unqualified assessment. Although it would not have affected the outcome for Mr Baker, I am also concerned that there were no first aid trained staff on duty at the prison.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **September 2016**

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Summary

Events

1. On 13 June 2006, Mr David Baker was sentenced to 24 years in prison for drugs offences. He had been at HMP Garth since 5 June 2015. Mr Baker had a number of serious and chronic medical problems, including kidney disease, high blood pressure and type 2 diabetes.

2. Healthcare staff monitored Mr Baker's medical conditions and referred him to appropriate specialists. In September, he missed a hospital appointment for a review of his kidney disease, because there were not enough prison staff to escort him. This was rearranged for 5 November.

3. In October, a prison GP arranged tests, which indicated Mr Baker's renal function had worsened. On 27 October, the GP discussed the test results with the hospital renal team who decided that as Mr Baker's clinical observations, including his blood pressure, were within normal limits, he did not need to be admitted to hospital at the time.

4. Doctors adjusted Mr Baker's medication and nurses monitored his blood pressure, though he often refused to have this taken. On 5 November, Mr Baker attended the renal appointment and had further tests later in the month. A letter of 2 December, from a hospital renal consultant indicated that he needed to discuss the results urgently. There is no record of whether this happened.

5. On 15 December, Mr Baker had a disagreement with a healthcare assistant at the wing medication hatch, who said she had felt threatened and intimidated by his behaviour. An officer gave Mr Baker an official behaviour warning, which he refused to accept. Later that day, Mr Baker handed in all his medication and refused to have any further interaction with healthcare staff or listen to advice about the risks of not taking his medication.

6. Afterwards, Mr Baker submitted a number of complaints about his treatment and said that healthcare staff refused to bring his medication to him in his cell. Various members of staff, including the Head of Healthcare, tried to resolve the impasse, without success, but no one referred him to a GP.

7. At 3.37am on 3 January 2016, Mr Baker told a night patrol officer that he felt unwell, had coughed up blood and needed to see a member of healthcare staff. There are no healthcare staff on duty at Garth at night and the night manager decided that Mr Baker should wait to see a nurse when they came on duty later that morning. In the meantime, prison staff would monitor him.

8. At 5.55am, the night patrol officer could not get a response from Mr Baker and the night manager and other officers attended. They went into the cell and found Mr Baker in a slumped position with no signs of life. The night manager radioed a medical emergency and the staff tried to resuscitate Mr Baker.

9. At 6,30am, paramedics arrived and, shortly afterwards, recorded that Mr Baker had died. A post-mortem examination found the cause of death was abdominal bleeding caused by a ruptured splenic artery.

Findings

10. Prison healthcare staff managed Mr Baker's chronic medical conditions effectively and referred him to appropriate secondary care. The clinical reviewer considered that Mr Baker's care at Garth was equivalent to that he could have expected to receive in the community. Until the breakdown in the relationship between Mr Baker and healthcare staff in the last few weeks of his life, his interaction with healthcare staff appeared to have been good. While nursing staff made reasonable efforts to encourage Mr Baker to take his medication, because of the risks involved, we consider that they should have referred the matter to a GP, who might have been able to mediate the situation.

11. The investigation identified a need for some improvements in medical record keeping. Mr Baker attended a number of hospital appointments, which were either not recorded in his medical record or had only limited details. There was nothing to confirm whether healthcare staff saw Mr Baker before he left to go to hospital or when he returned and there was no information from the hospital about his condition or treatment.

12. In the early hours of 3 January, Mr Baker repeatedly told prison staff that he felt ill and had been coughing blood. Staff did not identify any immediate signs, which would indicate a medical emergency. However, we are concerned that no one consulted the out of hours service for professional advice from qualified clinicians. Although this would not have altered the outcome for Mr Baker, we are concerned that there were no first aid trained staff on duty on the night of 3 January.

Recommendations

- The Head of Healthcare should ensure that prisoners who decline to take critical medication for serious conditions have a care plan to encourage their compliance including an assessment of mental capacity and are referred for a GP review.

- The Head of Healthcare should develop a protocol with the Lancashire Teaching Hospitals NHS Foundation Trust to ensure appropriate information is shared after a prisoner returns from hospital and that a member of healthcare staff assesses prisoners when they come back and records relevant information in their medical records.

- The Governor and Head of Healthcare should ensure that night staff are properly briefed about prisoners with health concerns and medical risks and that night staff appropriately seek advice from the out of hours service when there are any doubts about the seriousness of a prisoner's condition.

- The Governor should ensure that there are sufficient first aid trained staff on duty at all times who are able to administer basic life support in an emergency.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Garth informing them of the investigation and asking anyone with relevant information to contact him. Four prisoners responded.

14. The investigator visited Garth on 7 January 2016. He obtained copies of relevant extracts from Mr Baker’s prison and medical records and interviewed a member of staff and two prisoners. On 9 February, he interviewed five members of staff and three prisoners at Garth.

15. NHS England commissioned a clinical reviewer to review Mr Baker’s clinical care at the prison.

16. We informed HM Coroner for Preston and West Lancashire District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report. This investigation was suspended pending the results of the post-mortem examination. We regret the consequent delay in issuing this report.

17. One of the Ombudsman’s family liaison officers contacted Mr Baker’s ex-partner and daughter to explain the investigation process and to ask if they had any matters they wanted the investigation to consider. His ex-partner wanted information about what happened on the morning of 3 January and about the staffing arrangements. She asked for clarification about his diagnoses, his medication, and whether the prison had refused him access to medication or to a GP. She also asked for details of any missed hospital appointments.

18. Mr Baker’s ex-partner received a copy of the initial report. She did not make any comments.

19. We shared the initial report with the Prison Service. There were no factual inaccuracies.

Background Information

HMP Garth

20. HMP Garth holds up to 846 men, many serving indeterminate sentences for public protection, life sentences, or other long sentences. Lancashire Care Foundation Trust provides health services. Nurses are on duty between 7.00am and 9.00pm every day. Chorley Medics provide an out of hours service. GP clinics are held every day, normally from 9.00am to 1.00pm with occasional clinics from 1.00pm to 5.00pm. There is no inpatient unit.

HM Inspectorate of Prisons

21. The most recent inspection of Garth was in January 2015. Inspectors noted that a senior nurse led the healthcare team effectively. Significant staffing shortages had limited the service's ability to provide a full range of services, particularly for long-term conditions, but this was improving. Overall, healthcare provision was adequate, although waiting times for most primary care clinics were too long. Prisoners waited too long for external hospital appointments. Pharmacy services were reasonable but administration of medication was poorly supervised, with too many opportunities to divert medication.

Independent Monitoring Board

22. 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 November 2015, the IMB reported that a system of triage was used when the prison could not escort prisoners to routine hospital appointments, but considered that this could have serious consequences. They noted that waiting times had not improved for non-urgent GP appointments, though the appointment of two agency doctors would help to address the problem.

Previous deaths at HMP Garth

23. Mr Baker was the first prisoner to die from natural causes at Garth since 2010.

Key Events

24. On 13 June 2006, Mr David Baker was convicted of conspiracy to supply controlled drugs and sentenced to 24 years in prison. He spent time in a number of prisons before moving to Garth on 15 June 2015.

25. Mr Baker had a history of chronic kidney disease and high blood pressure. At his initial health assessment at Garth, he told a nurse that he also had type 2 diabetes, carpel tunnel syndrome (pain, numbness and tingling in the hand), back pain and sciatica. Mr Baker said he had recently stopped taking medication for depression. The nurse referred Mr Baker to the prison GP.

26. Later that day, another nurse assessed that Mr Baker was suitable to keep stocks of all his medication in his cell to administer as necessary, with the exception of tramadol. (Tramadol is an opiate-based pain relief medication that is often traded and misused in prisons, so prisoners are not allowed to keep it in their possession.)

27. On 16 June, a prison GP examined Mr Baker, noted his medical history and diagnosed arthritis and glomerulonephritis (severe kidney disease). The GP noted that Mr Baker took medication to control his blood pressure and tramadol for pain. He referred him to orthopaedic services at the Royal Preston Hospital.

28. On 22 June, a mental health nurse assessed Mr Baker who said he had had previous contact with mental health services when he had experienced problems sleeping. Mr Baker said that he had stopped taking medication in July 2014 and the nurse was satisfied that Mr Baker did not need support from the mental health team at the time.

29. On 25 June, a prison GP reviewed Mr Baker's medical history and recorded an established diagnosis of membranoproliferative nephritis (a kidney disorder that involves inflammation and changes to kidney cells). He noted his previous hospital care at Nottingham Renal Unit and referred him to the Renal Unit at hospital. The hospital arranged an appointment for 10 September.

30. Healthcare staff monitored Mr Baker for his various medical conditions and took blood tests. He attended specialist appointments for carpel tunnel syndrome and the arthritis in his back and knees. He went to the wing medication hatch each day to collect his tramadol.

31. On 18 July, at the medication hatch, Mr Baker told a nurse he felt his blood glucose was high. He went to the healthcare centre for observation and tests, and the results were within the normal range. Healthcare staff saw Mr Baker regularly to administer medication and to test his blood.

32. On 10 September, Mr Baker did not attend his scheduled appointment at the renal unit, as there were insufficient prison staff to escort him. A new appointment was arranged for 5 November.

33. On 3 October, Mr Baker told a nurse he had experienced pain in his chest for four days. He went to the prison's healthcare centre for examination but did not appear to be in pain and spoke only about his other conditions. His vital signs

were normal. An electrocardiogram (ECG) showed his heart rhythm was normal and there were no other cardiac concerns.

34. On 7 October, a prison GP reviewed Mr Baker and noted he was generally well but his urine was 'frothy' (an indication of potential high levels of protein in the urine, consistent with his renal condition). The GP arranged liver function and blood tests. The results were abnormal but consistent with Mr Baker's condition. The GP arranged further tests and a further review a week later.

35. On 27 October, the GP considered Mr Baker's recent blood test results, which indicated his renal function had worsened. The GP spoke to the on-call renal registrar about whether to send Mr Baker to hospital. The registrar advised that, as Mr Baker's blood pressure and general clinical observations were within the normal range, admission to hospital was unnecessary.

36. On 5 November, Mr Baker attended hospital for the re-arranged appointment with a renal consultant. (This hospital appointment was not recorded in his medical record.) The next day, a locum GP received a message from Mr Baker's consultant advising him to prescribe doxazosin (for high blood pressure) and to record Mr Baker's blood pressure in a week's time. Mr Baker had a target blood pressure of 130/80, to prevent pressure on his renal function.

37. A letter from Mr Baker's consultant, dated 9 November, outlined the progressive nature of Mr Baker's renal disease. It noted that Mr Baker had oedema (swelling to the lower limbs caused by fluid retention) and that he needed doxazosin and sodium bicarbonate (used to control acidity in the body). A doctor prescribed sodium bicarbonate.

38. On 9 November, Mr Baker attended the healthcare centre to have his blood pressure recorded, but refused to wait and left before the nurse could take it. On 11 November, a prison GP saw Mr Baker and recorded that he had a below target blood pressure of 108/72.

39. On 17 November, Mr Baker attended hospital for a renal biopsy and liver ultrasound. Again, this appointment was not recorded in his medical record. A letter from Mr Baker's consultant dated 2 December, noted he was trying to arrange an urgent appointment with Mr Baker to discuss the results of the tests. It did not give any further information and it is not clear whether Mr Baker attended an appointment with his renal consultant, but on 25 November, he was prescribed alfacalcidol (a vitamin D to treat severe renal failure). There was no record of who made this decision.

40. On 15 December, Mr Baker went to the medication hatch to take his tramadol. A nurse was dispensing medication and a healthcare assistant was helping and checking that prisoners took their medication as directed. The healthcare assistant told the investigator that Mr Baker tapped her hand through the hatch with his identity card. Mr Baker said he wanted to go to hospital, as he hated the prison. He then stared at her and asked her if she felt threatened.

41. The healthcare assistant said she felt threatened and intimidated by Mr Baker's behaviour. She reported the incident and an officer spoke to Mr Baker about it. Mr Baker strongly denied it and refused to accept a warning from her, issued as

part of the prison's strategy for challenging and managing anti-social behaviour. He said that he would not go to the hatch to collect his tramadol any longer. Later that day, he handed in all of his blood pressure and cholesterol medication to the medication hatch. Healthcare staff advised him against this, but, after 15 December, Mr Baker refused to engage with prison healthcare staff.

42. On 24 December, on the advice of a consultant, a GP prescribed mycophenolate mofetil (an immunosuppressant, usually used to reduce the risk of rejection after organ transplants but also used to reduce inflammation in patients with Mr Baker's condition). A letter dated 24 December, from the consultant indicated that he had discussed the risks of the medication with Mr Baker, who had agreed to try it, as his renal function was deteriorating.

43. On 25 December, a healthcare assistant telephoned prison staff on Mr Baker's wing and asked an officer to send Mr Baker to collect the medication, that the GP had issued that day, including the mycophenolate mofetil. Mr Baker refused. The healthcare assistant asked the officer to contact the healthcare unit if Mr Baker changed his mind. As Mr Baker refused to have any contact with healthcare staff, he never received this additional medication.

44. Nurses frequently tried to speak to Mr Baker to advise him of the risks of not taking his medication, but he consistently refused to see or speak to them. However, there is no record that they referred him to a GP or sought a GP's advice.

45. On 26 December, Mr Baker asked an officer to contact healthcare staff about his medication. Mr Baker told him that he did not feel able to collect it, but healthcare staff had refused to deliver it or to allow anyone to collect it on his behalf. The officer spoke to a healthcare assistant, who said that Mr Baker had to collect his medication himself. The officer noted Mr Baker had swollen legs and Mr Baker told him that he had been passing blood.

46. Later that day, the healthcare assistant telephoned the wing and asked an officer to bring Mr Baker to collect his medication. An officer spoke to Mr Baker but he refused and said his feet were not fit for walking. The officer noted that staff had seen Mr Baker walking around the wing throughout the day without any apparent problem.

47. On 27 and 28 December, Mr Baker refused to attend the medication hatch although officers offered to accompany him and healthcare staff tried to advise him about the risks of not taking his medication.

48. On 29 and 30 December, Mr Baker submitted complaints that healthcare staff had not given him medication issued in hospital and that they were racist. On 30 December, when a healthcare assistant called the wing to ask him to bring him for his medication, officers said that Mr Baker had told them he 'would rather die' than collect his medication.

49. On 31 December, a healthcare manager wrote to Mr Baker in response to his complaints. In her letter, she referred to a meeting arranged for 21 December with the Head of Healthcare and a lead nurse to discuss his concerns, which he

had refused to attend. She explained why he could not keep some medication in possession and he had to collect his medication in person. She said that the swelling in his legs was most likely caused because he had stopped taking his medication. She advised him to resume taking it and come to the healthcare centre to be examined. Again, there is no record that anyone referred the matter to a GP.

50. On 2 January 2016, Mr Baker told a Supervising Officer (SO) that healthcare staff would not allow him to keep his medication in his cell and had banned him from attending the treatment hatch. The SO contacted healthcare staff to try to resolve Mr Baker's problems. A healthcare assistant outlined the earlier incident and reiterated that Mr Baker could only obtain his medication from the medication hatch, and only if a prison officer accompanied him. The SO offered to go with Mr Baker to the treatment hatch to get his medication, but he would not go. Mr Baker insisted that he had mobility problems and said that he intended to resolve the problem through legal channels.

3 January 2016

51. At 3.37am on 3 January 2016, the night patrol officer (an operational support grade) responded almost immediately when Mr Baker rang his cell bell. Mr Baker told her that he felt ill, had coughed up some blood, and needed to see someone from the healthcare team. She explained that healthcare staff were not on duty during the night, but she would contact the night manager. She noted Mr Baker did not appear to be in any pain and there was no evidence of any blood.

52. The night patrol officer telephoned the night manager, who said she would check Mr Baker's records and the night duty handover record from healthcare staff, then call her back. The night manager noted that there was nothing about Mr Baker on the handover record. She checked his prison record and noted that there were reports he had threatened staff.

53. The night manager called the night patrol officer back and said that healthcare staff had not identified any concerns about Mr Baker in their handover record. The night patrol officer reiterated that Mr Baker looked fine, was able to talk to her and that there was no evidence he had coughed up blood. The night manager told the night patrol officer to monitor Mr Baker and tell him that he could see healthcare staff in the morning. When the night patrol officer explained this to him, Mr Baker said he still felt ill and something had burst in his stomach. He said he thought he could be dead in the morning. She told Mr Baker to ring his cell bell again if he did not feel better in the next ten to fifteen minutes.

54. At 4.18am, Mr Baker rang his cell bell and the night patrol officer responded immediately. He said that he still felt unwell and had coughed up blood. She noted that Mr Baker talked normally and again she could not see any evidence of blood. She went back to the wing office and phoned the night manager, who said she would attend. The night manager then radioed other officers and asked them to meet her at Mr Baker's cell.

55. At approximately 4.30am, staff arrived at Mr Baker's cell. Officer A spoke to Mr Baker through the observation panel in the cell door and Mr Baker again said he did not feel well and had coughed up blood. The officer could not see any sign of blood around Mr Baker's face or in the cell. Mr Baker said that he wanted to go to hospital or to see a nurse. The officer explained that there were no nurses on duty during the night but a nurse would be able to see him in a couple of hours. The officer said that Mr Baker was very calm and did not appear to be in pain.

56. The night manager decided that it did not appear to be an emergency requiring Mr Baker to go to hospital immediately. Instead, she would ask nurses to assess him when they arrived later that morning. She agreed with the officers that they would stay on the wing to support the night patrol officer if Mr Baker continued to ring his cell bell. They agreed they would check Mr Baker again in about half an hour.

57. At approximately 5.00am, Officer A checked Mr Baker again by opening the observation panel but did not speak to him. He said Mr Baker was sitting on the edge of the bed, moving his arms and looking straight ahead. The officer said he did not look like he was in pain. He went back to the wing office and told the night patrol officer to continue to monitor Mr Baker. The officers then left the wing.

58. At approximately 5.55am, the night patrol officer went back to check Mr Baker again. She said Mr Baker was on the bed but obscured by a cupboard and she could only see his feet, which she thought were an unusual colour. She called Mr Baker and banged on his cell door. When he did not respond she went back to the wing office, phoned the control room and informed the night manager, who said she would attend. The night manager then radioed the other officers and asked them to go back to Mr Baker's cell.

59. The night manager and Officer B arrived on the wing shortly after 6.00am and went to Mr Baker's cell with the night patrol officer. They opened the observation panel and tried to rouse Mr Baker from outside the cell but still go no response. After about a minute, they went back to the wing office and met two other officers who arrived a few minutes later.

60. At 6.06am, they all went back to Mr Baker's cell and spent almost a further minute trying to rouse him from outside, then decided to open the cell. Officer A went in first. He said Mr Baker was on the bed, slumped against a cupboard, with his feet hanging over the side of the bed. He could not find a pulse or any other sign of life. Another officer put her hand on Mr Baker's head, which she said felt cool. The officers put Mr Baker into the recovery position and the night manager radioed a code blue medical emergency (used to indicate circumstances such as when a prisoner is unresponsive, not breathing, or has problems breathing). The control room called an ambulance immediately.

61. The night patrol officer brought a defibrillator from the wing office. The officers placed Mr Baker on his back and attached the defibrillator pads to his chest. The defibrillator found no shockable heart rhythm and the staff followed the instructions given by the defibrillator to begin cardiopulmonary resuscitation, which they continued until shortly before 6.30am, when paramedics arrived.

The paramedics took over emergency treatment but shortly afterwards recorded that Mr Baker had died.

Contact with Mr Baker's family

62. Mr Baker had named his 17 year old daughter as his next of kin. The prison appointed an officer as their family liaison officer. At 11.15am, the officer and a senior prison manager went to the address they had for Mr Baker's daughter to inform her of his death. When they arrived, they learnt that she had moved and were given her new address.

63. The officer and the senior prison manager went to the new address and informed Mr Baker's daughter and her mother, Mr Baker's ex-partner, that Mr Baker had died. They offered condolences and ongoing support.

64. Mr Baker's funeral was on 2 February 2016. The prison contributed towards the cost in line with national policy.

Support for prisoners and staff

65. A governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. He reminded everyone of the services provided by the staff care team and the employee assistance programme.

66. The prison posted notices informing staff and prisoners of Mr Baker's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Baker's death.

Post-mortem report

67. A post-mortem examination concluded that Mr Baker died from an intra-abdominal haemorrhage (abdominal bleeding) caused by a ruptured splenic artery aneurysm (the splenic artery is the blood vessel supplying oxygenated blood to the spleen).

Findings

Clinical care

68. Mr Baker had complex medical needs and took a range of medication to manage his conditions. He needed consultant-led care to manage his renal condition. Before the incident at the medication hatch on 15 December 2015, the interaction between Mr Baker and healthcare staff had been good. He had been appropriately referred to secondary hospital care when necessary and healthcare staff monitored him regularly.

69. Mr Baker missed one renal review in September because there were insufficient prison staff to escort him to the appointment, but the appointment was re-arranged for the beginning of November. While it is regrettable that this appointment was cancelled, we are satisfied that this had no bearing on Mr Baker's death.

70. Mr Baker was given a warning under the prison's anti-social behaviour policy after allegedly being threatening and abusive towards the healthcare assistant at the medication hatch, after which he returned all his medication, including that prescribed to control his blood pressure. High blood pressure is a known risk in causing aneurysms to rupture. Mr Baker was warned that he was placing himself at risk by not taking his medication.

71. We are satisfied from the evidence available that the healthcare assistant had good reason to feel threatened and that it was reasonable to warn Mr Baker about his behaviour. It is apparent from Mr Baker's prison record that he had a history of being abusive and threatening to staff, including healthcare staff. The year before, at his previous prison, he had handed in all his medication after an altercation with a pharmacy technician, but later began taking them again.

72. After he handed his medication in, Mr Baker complained that he was unable to get to the medication hatch because of increased mobility problems. The Head of Healthcare told us the Mr Baker was fit enough to take the very short walk to the medication hatch to collect his medication each day. She said it was an unnecessary risk to take his medication to him, particularly as he had made threats towards healthcare staff. A senior prison manager had agreed that a prison officer would accompany Mr Baker to the medication hatch to collect his medication.

73. There was nothing in Mr Baker's clinical record to suggest he lacked capacity to make decisions about his care and treatment. It was his decision to hand his medication in, he was warned of the risks of not taking it, and staff encouraged him to attend the medication hatch to resume taking it again. In this respect, Mr Baker's care was equivalent to that he could have expected in the community.

74. Healthcare staff did attempt to encourage Mr Baker to continue taking his medication and we acknowledge that he could be very difficult to manage, had been hostile and threatening towards healthcare staff, and seems to have been unwilling to cooperate with attempts to resolve the situation. However, we are concerned that despite the acknowledged risk of Mr Baker not taking his medication, no one sought advice from GPs or referred him to a GP to discuss

the implications. This included when he did not receive additional medication prescribed on 24 December, at the request of his renal consultant. Mr Baker's grievance appears to have been with nursing staff rather than doctors and it is possible that a GP intervention might have helped resolve the apparent impasse.

75. For perhaps understandable reasons, healthcare staff appear to have taken an entrenched position of requiring Mr Baker to attend the medication hatch to collect all of his medication, when previously he had kept a week's supply of his blood pressure medication and other medication in his cell. In view of the risks to his health, it is difficult to understand why it was not possible for a member of healthcare staff escorted by an officer, to deliver a supply of this medication to his cell, once he had shown some signs that he was willing to take it again. Ultimately the decision whether or not to take his medication was Mr Baker's responsibility but we consider that healthcare staff should at least have referred the problem to a GP. We make the following recommendation:

The Head of Healthcare should ensure that prisoners who decline to take critical medication for serious conditions have a care plan to encourage their compliance including an assessment of mental capacity and are referred for a GP review.

Recording hospital appointments

76. Between October and December, Mr Baker attended a number of hospital appointments but there were no corresponding entries in his medical record although for one appointment in November, there was a detailed follow-up letter from the consultant. On two further occasions, on 22 and 24 December 2015, the medical records just noted 'hospital'. There was nothing in the record to indicate that healthcare staff saw him when he got back from his appointments and they did not record any information from the hospital about his treatment or medication.

77. The Head of Healthcare told us that the local hospitals were poor at providing information and also said that escort staff did not ensure that prisoners saw a member of healthcare staff when they returned from hospital appointments. This meant that not all relevant information was recorded and compromised effective continuity of care. We make the following recommendations:

The Head of Healthcare should develop a protocol with the Lancashire Teaching Hospitals NHS Foundation Trust to ensure appropriate information is shared after a prisoner returns from hospital and that a member of healthcare staff assesses prisoners when they come back and records relevant information in their medical records.

Staff response on 3 January

78. On 27 October 2015, after a trial period, Garth removed night nurse cover and replaced it with an out of hours' nurse and GP service. When healthcare staff were withdrawn at night, the Head of Healthcare introduced a policy requiring a lead nurse to complete a daily handover document for the prison's night manager with details of prisoners with medical issues, prisoners who might ask

to go to hospital inappropriately and prisoners who had not received medication, which might lead to a detrimental effect on their health or behaviour. It also outlined options for emergency, non-urgent and urgent but non-emergency care.

79. Mr Baker did not appear on the handover document and none of the staff who dealt with him on 3 January had any previous knowledge of him or of his medical history. Although healthcare staff had identified that he might be at risk because he was not taking his medication, no information about him was noted in the handover document.

80. The night manager told us that as there was no information about Mr Baker on the handover sheet and as no one could see any blood after Mr Baker said he had been coughing up blood, she did not consider there was a need for him to go to hospital immediately. None of the staff went into the cell to assess Mr Baker and no one considered calling the out of hours GP service for advice at any time after Mr Baker reported being unwell. The staff did not have any access to his medical record and had no information about his clinical history.

81. We consider that prison staff who have no medical training are unqualified to make such assessments. We recognise that when Mr Baker reported being unwell and asked to go to hospital, there was little to indicate to a lay person without any knowledge of his clinical history that this was a medical emergency. However, at minimum the staff should have called the out of hours service for advice, or asked a clinician to attend the prison to assess Mr Baker. We make the following recommendation:

The Governor and Head of Healthcare should ensure that night staff are properly briefed about prisoners with health concerns and medical risks and that night staff appropriately seek advice from the out of hours service when there are any doubts about the seriousness of a prisoner's condition.

Emergency response

82. At 5.55am, when Mr Baker did not respond, the night patrol officer did not immediately regard it as an emergency or a life-threatening situation. She did not radio an emergency medical code but instead telephoned the night manager. The night manager and Officer B arrived quickly but, despite not getting a response from Mr Baker, they did not go into his cell or radio an emergency code. Instead, they waited until 6.06am, when two other officers arrived.

83. PSI 24/2011 'Nights Function' says that staff have a duty of care to prisoners, to themselves and other staff. The preservation of life must take precedence over usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, then cells may be unlocked without the authority of the night orderly officer and an individual member of staff can enter the cell on their own. However, prison staff are not expected to take action that they feel would put themselves or others in danger, and should first make every effort to get a verbal response from the prisoner. What they observe and any knowledge of the prisoner should be used to make a dynamic risk assessment of the situation.

84. The night manager told us that she had looked at Mr Baker's security and prison records and had security concerns about Mr Baker, particularly about threats he had made to staff. She therefore did not consider it safe to open Mr Baker's cell until she had a sufficient number of 'control and restraint' trained officers present. While we consider that it ought to have been possible to open Mr Baker's cell five minutes earlier, when there were three staff present, we accept that she made a risk assessment based on the information she had at the time.

85. The cause of death meant that it was highly unlikely that anything could have been done to save Mr Baker, once he had collapsed. However, we were concerned to find that there were no first aid trained staff on duty in the prison, even though 24-hour nurse cover had been withdrawn some months earlier. Health and Safety regulations require all workplaces to have first-aid trained staff and we consider that the risks inherent in prisons, including the risk of suicide and self-harm, means that this is particularly important that prisons have sufficient first aid trained staff on duty at all times. We make the following recommendation:

The Governor should ensure that there are sufficient first aid trained staff on duty at all times who are able to administer basic life support in an emergency.

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