Circumstances surrounding the death of a man at Pilgrim Hospital in May 2006, whilst in the custody of HMP North Sea Camp

Report by the Prisons and Probation Ombudsman for England and Wales

February 2007

This is the report of an investigation into the circumstances of the death of man who died as the result of a stroke in Pilgrim Hospital, Boston, in May 2006. At this time he was in the custody of HMP North Sea Camp. He was 47 years of age.

I would like to extend my personal condolences to the man's family and to all those touched by his death.

Both my investigator and I would like to thank the Governor of North Sea Camp and his staff for their ready cooperation during this investigation. We are also grateful to the Governor of HMP Gartree and her healthcare staff for their assistance. (Gartree had agreed to take the man into their custody for a period of eight months after an earlier discharge from Pilgrim Hospital, as North Sea Camp is unable to provide 24-hour healthcare.)

As part of this investigation, East Lincolnshire Primary Care Trust carried out an excellent clinical review of the care the man received during his time in custody. I am also most grateful to them.

The man had not enjoyed good health for much of the last decade, but he had benefited from prompt medical treatment in most instances. This report concentrates on his last period of illness. I conclude that the care the man received was properly delivered both within the two prison healthcare facilities and in outside hospitals.

This investigation has drawn attention to the difficulties of providing appropriate care for low security prisoners with special medical needs. I make a total of seven recommendations, including two that identify good practice.

Stephen Shaw CBE
Prisons and Probation Ombudsman **February 2007**

CONTENTS **PAGE**

SUMMARY

The man was serving a life sentence. He had first come into custody in April 1984. By 2004, he had been reduced from a category A prisoner to category D, reflecting his significantly reduced risk to the public.

In February 1998, whilst at HMP Wellingborough, the man was diagnosed with high blood pressure and a congenital heart defect. He was moved from Wellingborough to HMP Bedford in January 2000. In 2001, he suffered a minor stroke and was treated at the local NHS hospital. He was returned to prison with an outpatient referral for a CT scan, but it is not clear from his records whether this took place.

In March 2002, the man was transferred to HMP Shepton Mallet. He had no major health concerns until 2003 when he returned to hospital with a further heart problem. This was kept under control with medication but did not require surgery.

On 4 July 2004, the man moved to HMP North Sea Camp, a lower security (category D) prison. Apart from an episode of anxiety in September 2004, he had no further medical complications until March 2005 when he suffered an extensive stroke leaving him physically disabled. He spent six months at Pilgrim Hospital, Boston, receiving rehabilitative care before returning to prison.

North Sea Camp felt that is was not practical for the man to return to them as their healthcare facilities could not meet his medical needs. It was not possible to find any other category D prison that could provide the level of care he required. Instead, he was transferred to HMP Gartree, a category B prison with 24-hour healthcare facilities, in September 2005.

At Gartree, the man was given an inpatient bed, occupational therapy and physiotherapy to aid his recovery. Although he physically benefited from his time at Gartree, he was unhappy with the restrictions on his freedom and wanted to return to North Sea Camp. In December 2005, the man's lifer manager and the head of healthcare at Gartree agreed that his recovery was sufficient for this to happen. Throughout January 2006, they looked to facilitate this move. However North Sea Camp, along with two other category D prisons, was not in a position to accept him due to his continuing medical needs.

In February 2006, the man fell and fractured his left hip. He was admitted to Kettering Hospital and returned to Gartree on 28 March. The man's mobility had improved and his medical needs reduced. Again, Gartree sought to move him back to North Sea Camp. This move took place on 7 April.

On arrival, healthcare and prison staff at North Sea Camp raised concerns about their ability to provide the level of care he required. However, within the limited facilities available, staff and prisoners assisted the man to the best of their ability and he coped well. Despite the initial struggle, he was happy to have returned.

Sadly, the man suffered a major haemorrhagic stroke on a day in May. He was taken to Pilgrim Hospital where, on consultation with neurosurgeons, the stroke was

deemed medically untreatable. He died in hospital at 6:50am on the following morning.

The clinical review of the man's care concludes that it is extremely unlikely that the transfer back to North Sea Camp contributed in any way to this second stroke and subsequent death. The care and support he received at both North Sea Camp and Gartree was appropriate, although record keeping and care plans on transfer between the prisons, both on the medical and custodial side, could have been managed better.

THE INVESTIGATION PROCESS

The investigation was opened at HMP North Sea Camp on 25 May 2006 by one of my investigators. She visited the prison with a representative from East Lincolnshire Primary Care Trust (PCT). All documentation relating to the man was made available.

After the initial visit, East Lincolnshire PCT identified a clinical reviewer to assess the care the man received whilst in custody.

On reading through the man's medical record, it became clear that HMP Gartree had been responsible for the majority of his medical care during 2005. Given this, my investigator decided that it would be appropriate to interview staff at Gartree in addition to North Sea Camp. My investigator and the clinical reviewer held joint interviews at both prisons.

The clinical reviewer has produced an excellent and thorough report which can be found at Annex 1.

The man's family were contacted by one of my family liaison officers. Although his family were grateful for contact being made they did not want a visit from my office. They have raised no issues for further investigation or clarification.

At the time of issuing this report the Prison Service had not responded to the recommendations made.

HMP NORTH SEA CAMP and HMP GARTREE

HMP North Sea Camp is an adult male open prison, located on the outskirts of Boston, Lincolnshire that holds category D prisoners. Accommodation consists of single and multi-occupancy rooms in the North and South Units, and two-storey residential units with single rooms (the Harrison and Llewellin Units). Operational capacity for the prison is 306.

Since April 2005, healthcare at North Sea Camp has been commissioned by East Lincolnshire Primary Care Trust. The healthcare unit at North Sea Camp is equipped to provide basic primary care only and there are no inpatient facilities. Healthcare care facilities are available from 7:30am - 5pm Monday to Friday, and 8am - 11am at weekends. General practitioners from a local surgery provide clinics Monday - Friday.

The last full inspection by Her Majesty's Chief Inspector of Prisons (HMCIP) was in April 2004. The report found that healthcare services at this time were delivered in a poor environment, but the standard of service delivered to prisoners was good, clinically competent and respectful. Since the Inspector's report, there has been a change in healthcare management and a new healthcare unit has been built, improving both facilities and services.

North Sea Camp has had one other death from natural causes in the last two years. The investigation into this death made one recommendation that remains pertinent for this case. The recommendation asked the healthcare manager to remind staff of the importance of maintaining comprehensive medical records.

HMP Gartree is a category B prison located in Market Harborough, Leicestershire. The prison holds first and second stage life sentenced prisoners. Its operational capacity is 575.

Gartree provides 24 hour on-site healthcare, with inpatient facilities. There are six healthcare officers, six registered nurses and four GPs provided by an agency, all of whom come from the same outside practice. The doctors hold surgeries from 8am until midday, and provide telephone advice until 5pm each day. Out of hours cover is provided by a different agency. One member of the nursing team acts as disability liaison officer.

There are 14 inpatient beds, 12 of which are for prisoners who cannot be accommodated elsewhere. Prisoners located here do not participate in the standard prison regime, although they do spend the majority of the day unlocked.

The last HMCIP inspection took place in May 2005. The report found that nurse-led clinics and chronic disease management at Gartree were "under-developed", but that joint work with the PCT was well advanced following the transfer of the commissioning of healthcare to the PCT in April 2005.

KEY EVENTS

Events leading up to the man's death

In April 1984, the man was sentenced to life imprisonment for murder. At the time of sentencing he had already been in prison on remand for a period of 11 months. During the man's time in custody he was transferred regularly to different establishments. This is not unusual for prisoners serving long sentences.

In his earlier years in custody, there were no significant medical problems noted. However, on reception to HMP Wellingborough in June 1996, a first screen health check mentions that his mother had hypertension and had suffered two strokes.

On 9 February 1998, the man was admitted to Kettering Hospital from Wellingborough, after suffering severe headaches for two days. He also had a stiff neck and had been vomiting. He was diagnosed with high blood pressure. There are no blood pressure measurements in the man's medical notes prior to this admission to hospital. A chest x-ray revealed he had a congenital heart defect. Medication was prescribed to manage his condition (atenlol, amlodipine and lisinopril) and he was referred to a cardiologist. The man later underwent an operation to close the defect. The operation was successful and he was monitored closely by prison medical staff for the following six months.

The was transferred from Wellingborough to Bedford in January 2000. During September, he was referred to Bedford Hospital after episodes of dizziness and collapsing. This was attributed to an irregular heartbeat and his medications were reviewed.

On 11 November 2001, he returned to hospital having suffered a minor stroke. The man was returned to prison with an outpatient referral for a CT scan of his brain. The result of this scan cannot be found in his medical records; as a consequence, it is not clear whether he actually attended this appointment. However, his medical records do show that he continued to have his blood pressure monitored regularly.

In March 2002, the man moved from Bedford to Shepton Mallet. He had no major health concerns until 29 March 2003 when he was admitted to the Royal United Hospital, Bath, after suffering three weeks of increased shortness of breath, a productive cough and palpitations. He was diagnosed with left ventricular failure, secondary to an irregular heart beat (atrial fibrillation). This was managed with diuretics, lisinopril, digoxin and bisoprolol.

On 4 July 2004, he was transferred from Shepton Mallet to North Sea Camp following a lowering of his security category to category D (the lowest level).

On reception, he was referred by the prison medical officer to a cardiologist at the local hospital (Pilgrim Hospital) as he continued to have shortness of breath and an irregular heartbeat. On 3 September, the man complained of stress and not coping. He was prescribed diazepam to treat his anxiety.

On 15 March 2005, the man was found lying on his bed, disorientated and agitated. His left-side was weak and his speech slurred. He was diagnosed as having suffered a stroke and taken by ambulance to Pilgrim Hospital. The stroke left him with physical disabilities and he required both rehabilitative and medical care. He received daily physiotherapy and regular occupational therapy. During his stay in the hospital, the man developed a deep vein thrombosis despite medication to stop his blood from clotting.

On 29 July, he was assessed by the hospital physiotherapist. The report noted that he still had weakness in his left leg, spasticity in his left arm, impaired balance and attention, and he was unable to 'dual task'. He could walk short distances with the aid of a stick, but lacked confidence after his leg gave way on several occasions. He was unable to fully use his left arm. It was recommended that he receive daily physiotherapy and that on discharge this should continue on a twice weekly basis.

The man's general medical condition slowly improved during his first month in hospital. His discharge from hospital was delayed by the lack of available prison accommodation to ensure the necessary level of health and social care, coupled with access to appropriate rehabilitation.

Whilst in hospital he was seen by a consultant psychiatrist. The consultant diagnosed a re-adjustment disorder, as a result of his stroke. The man felt his condition was a further form of imprisonment. There was no evidence of depression or any other psychiatric illness, but he was prescribed for the long-term an anti-depressant (sertraline) to improve his mood.

On 2 August, the hospital notified North Sea Camp that the man was medically fit for discharge. Discussions took place between Pilgrim Hospital, Rushcliffe Primary Care Trust, the East Midlands Regional Prison Nurse Advisor and North Sea Camp to find the most appropriate place for him on release. It was decided that a return to North Sea Camp would not be suitable, as the layout and infrastructure could not meet the man's needs. Some alternatives within the community were explored, however not extensively. A placement was sought on the hospital wing at HMP Norwich. However, he did not fall into the admission criteria for the older persons unit and could not be accepted at Norwich as a result.

Instead it was recommended that a prison with suitable healthcare facilities be identified. The East Midlands Regional Prison Advisor contacted the Head of Healthcare at HMP Gartree to see if they could accept the man. HMP Gartree is the only category B lifer prison in the East Midlands Region that has in-patient beds. He was transferred there on 2 September.

The Head of Healthcare had concerns about accepting the man because a category B prison is not an appropriate environment for a category D prisoner. A return to a high security prison can be disappointing and frustrating. It is also problematic from an administrative point of view, as it can then be a long process moving the prisoner back to a category D establishment. Despite this, Gartree agreed to accept the man.

He was discharged from hospital and taken to Gartree on 2 September 2005. On reception, he was assessed by the healthcare team, including by an occupational therapist. It was noted that further assessment would be necessary to determine what aids he might need to assist with daily living. This took place on 7 October and the man was provided a comprehensive programme of physiotherapy and occupational therapy.

There were a number of instances where the man struggled with his disability and he fell. On both 19 and 20 September, there are records to say that he had fallen in his room. A further fall is noted on 1 October when officers found him having fallen whilst trying to adjust his television. Healthcare staff were summoned as he had hit his head on a locker. Although there were no apparent injuries and he seemed coherent, he was monitored during the night and it was recommended that he be seen by the GP when they next attended.

On 19 October, the occupational therapy in-reach team assessed the man. It was noted that it took him 35-40 minutes to dress himself. Although he did not have a problem with eating independently, he did struggle with the toileting facilities and this had led to a fall. It was recommended that a rail be fitted in his cell to help.

(As expected, the man was having difficulty adjusting to being in a higher security prison. He disliked the weekends, as prior to his stroke he would have been permitted to have town visits.)

The man fell again during the night on 3 November. At 2:40am, staff heard a loud noise from his cell. He had fallen over, hitting his head and hurting his hand on making his way back from the toilet as there was no light on. The man was given paracetamol and observed for the rest of the night. No further problems were reported.

On 9 December, it was noted by healthcare staff that he was “low in mood”. Staff opened a self-harm at risk document (F2052SH), to closely monitor him. (Under D2052SH procedures, the concerns that arise from the initial assessment are recorded and staff monitor the prisoner until it is decided they are no longer at risk.) In his case, the F2052SH was closed four days later following a noted improvement in his mood and an increase in his anti-depressant medication.

The man was deeply frustrated by his disability and by being held in a closed prison. He wanted to return to a category D establishment to continue with his resettlement programme. His lifer manager recommended that he be transferred back to category D establishment, preferably North Sea Camp. He was making good progress and the healthcare manager agreed that he was fit for transfer. A care plan was put together and a mini case conference was arranged for after the Christmas period to discuss next steps.

On 10 and 11 January 2006, an administrative officer in the custody department at Gartree contacted category D establishments to see whether they would accept the man on transfer. North Sea Camp was reluctant to take the man back on two grounds. One was for a security reason – he had sent what was seen as an inappropriate letter to his former lifer manager. The second was for healthcare

reasons. The healthcare manager felt that the layout and infrastructure of the prison was not suitable. He thought it would be more appropriate for the man to remain at an establishment with 24-hour healthcare. Due to this reluctance, the administrative officer contacted two other establishments, HMP Kirkham and HMP Sudbury. Both Kirkham and Sudbury declined to accept the man on the grounds that his medical needs could not be met by their healthcare units. He was to remain at Gartree for the foreseeable future.

On 31 January, a further occupational therapy assessment was conducted by the in-reach team. The assessment noted that the man:

- was able to sit and rise from the toilet slowly without aids
- was able to sit and rise from bed
- still had difficulty in folding clothes, but was able to dress independently
- had no evidence of depression.

At 9pm on 5 February, the man was found on the floor of his cell having fallen whilst attempting to use the toilet. He was assisted back to his bed. During the night he was incontinent of urine and his bed was changed. The next morning he complained of difficulty in putting weight on his leg. He was taken to Kettering Hospital where he was diagnosed with a fractured left hip. The prison was advised that he would have to remain in hospital for at least five days.

The man remained in hospital and was appropriately released on temporary licence for the duration of his stay. This meant he required no escort staff, but prison staff visited him regularly to ensure that he was complying with the conditions of his licence and to offer support. The man's brother also visited.

By 27 February, his condition had improved and he only required minimal assistance. The hospital recommended that a local NHS rehabilitation place be found for him to continue his care. The Head of Healthcare at Gartree made several enquiries, but no place was available locally. (The man was still registered as a patient in East Lincolnshire and no funding was available to find him a place in within the Melton, Rutland and Harborough Primary Care Trust.) North Sea Camp was again contacted to see if they would accept him after he was discharged from hospital.

On 17 March, a letter was sent from Kettering Hospital to the Head of Healthcre regarding the man's discharge information. It stated:

- that the man was able to walk up to 100m with tripod stick
- he could transfer independently from bed to chair and vice versa
- he required a chair with arms and a seat height of approximately 19 inches
- his bed height needed to be approximately 23 inches
- that he should be given co-codomol painkillers if needed.

He was discharged from hospital and taken back to Gartree on 28 March. During the period of return to Gartree, his blood clotting levels (INR) were checked four times. On deciding the man was fit for transfer, the prison's medical officer advised that his medications continue and that his INR levels be checked in four weeks time.

Further discussions were held between Gartree and North Sea Camp about the man's moving back. The security issue was again raised but it was nonetheless agreed that he could return to North Sea Camp. My investigator spoke with the lifer manager at North Sea Camp regarding how they came to overturn their original decision not to receive him back. The Lifer Manager was unsure of who made the final decision to accept him back, and it is of concern that there is no documentation available from either prison to explain the rationale behind the decision making. The Head of Healthcare at North Sea Camp said that he was not consulted. He was told that the man might return, but not given formal notification.

The man was transferred back to North Sea Camp on 7 April. On reception he was assessed by healthcare. Only his tripod stick and medications were brought with him. A nurse noted that the man was not fit for "type 1 healthcare" and that he needed "type 3". (There are four types of healthcare in prisons:

- type 1 - daytime cover, generally by part time staff (no inpatient facilities)
- type 2 – daytime/ 24-hour cover, generally by full time staff (no inpatient facilities)
- type 3 – health care centre has 24-hour nurse cover, usually with inpatient facilities
- type 4 – as type 3, but also serves as a national or regional assessment centre, used by other prisoners.)

Given the nurse's assessment, it was suggested that a request for transfer to somewhere more suitable for the man be made. There is no record of this request.

A needs assessment was conducted in April. It was noted that the man could walk moderate distances, but struggled with heavy doors. He was able to manage his hygiene needs independently and was happy to take his own medication. The man was worried that he would have difficulty coping at North Sea Camp, but was happy he had returned to open conditions.

The man was housed in the Llewellin Unit on the ground floor. His room was sufficiently spacious to get a wheelchair in and out, but no special aids were fitted in his room. However, the Head of Healthcare and fellow prisoners state that he was able to manage reasonably well without any aids.

The man struggled with getting to the toilet facilities. He had difficulty pushing the heavy fire door whilst walking with his stick and this prevented him from getting to the toilet quickly. Prior to this being recognised, he resorted to urinating in the wastepaper bin in his room. On acknowledging his difficulty, officers and fellow prisoners tried to assist the man by either holding or leaving the fire door propped open.

At North Sea Camp, the man was seen on a daily basis by healthcare staff. He was taken by wheelchair everyday, except Sunday, to the healthcare unit. He was assisted to a bath by the healthcare manager three times a week. His medications were dispensed daily and, according to healthcare staff, his INR levels and blood pressure were checked regularly. However, these checks are not recorded in his

medical records. The man appeared to be relatively fit and well. After a minor period of adjustment, he had begun to get used to his change in ability and lifestyle.

On a day in May at 6:30pm, a prisoner on Llewellin Unit heard a groaning noise. Initially he thought nothing of it, but approximately 10 minutes later another prisoner came to tell him that he had seen the man lying on his bed foaming at the mouth. The first prisoner immediately went to the man's room and found him lying on the side of the bed. The man looked as if he had been vomiting and one arm was twitching. He tried to get a response from the man. The first prisoner asked the other prisoner to get help and to ask staff to summon an ambulance. A third prisoner helped the first prisoner move the man into the recovery position. The first prisoner held the man's hand until a Senior Officer and an Officer arrived at about 6:45pm.

On arrival, the Senior Officer noted that the man was foaming at the mouth and had "terrible pallor". The Senior Officer immediately notified the Orderly Officer of the emergency, and then radioed the gate to summon an ambulance. The Orderly Officer arrived shortly after being informed.

The ambulance arrived at 6:52pm. The paramedics administered oxygen and prepared the man for transfer to hospital. The Orderly Officer organised a temporary release licence and contacted the Duty Governor to let him know that the man was being taken to Pilgrim Hospital. The local police were also informed, as the man was going unescorted. The ambulance left the establishment at 7:09pm.

At 9:45pm, a Staff Nurse from Pilgrim Hospital requested that the prison notify the man's next of kin as his condition was critical. The man's father was informed by a Principal Officer at 10:15pm.

The prison contacted the hospital at 12:45am to receive an update on the man's condition. They were informed that he had deteriorated and that his family had been told what was happening. Sadly, the man passed away early the following morning.

Events following his death

The prison was notified of the man's death at 7:45am on the following morning and arrangements were made to immediately notify the family.

In accordance with the local contingency plans for a death in custody, the man's room was sealed at 8:00am. The Head of Healthcare and the Governor were told shortly after at 8:07am. Those staff who attended to the man the previous evening were asked to provide statements. The local police were notified at 8:40am. A hot debrief with all staff concerned was held at the same time (this gave staff and opportunity to discuss what had happened and where, if at all there were lessons to be learnt). Counselling and support was offered to staff and prisoners affected by the man's death.

A Principal Officer was nominated to act as family liaison officer. A few days after the man's death, the Governor and family liaison officer visited his family at their home. During their visit they returned the man's belongings and discussed the family's preference for the type of funeral and where it should be held. It was

decided that the funeral would be held in Boston and that he would be cremated. The Governor offered to cover the cost of the service and cremation, and said that he would make the arrangements and advise the family of the date.

The Governor wrote to the man's parents with information of organisations that can offer support to family and friends following the death in custody of a relative. A further letter was sent a few days later to inform them of the date for the funeral. He asked that they discuss any arrangements they wished to be incorporated into the service with the chaplain at North Sea Camp.

The funeral took place on at Boston Crematorium. The chaplaincies from both HMP Gartree and North Sea Camp spoke at the service held for the man. Prisoners at both establishments were given the opportunity to contribute through identifying an appropriate piece of music to be played during the service. Those who knew him well were able to attend the service. The man's family also attended.

ISSUES

Clinical Review

The clinical review was undertaken by East Lincolnshire Primary Care Trust (PCT). The clinical reviewer has been a full time GP Principal since 1989 and is also the Clinical Director for a Pre-hospital Emergency Care Scheme. She sits on a number of PCT committees, including the Clinical Governance Forum. I summarise her findings below.

Summary

The man died at Boston Pilgrim Hospital in May 2006, while a prisoner at HMP North Sea Camp. He suffered a major haemorrhagic stroke the day before he died which resulted in collapse, loss of consciousness and convulsions. This stroke was deemed medically untreatable after consultation with the regional neurosurgeons. He was therefore managed conservatively, with death occurring within 24 hours of admission.

Prior to this terminal event, he had suffered an extensive stroke in March 2005, which left him severely physically disabled. In February 2006, he fell and fractured his left hip for which he underwent internal fixation.

The man had a history of hypertension, atrial fibrillation and mild heart failure. He was also diagnosed with a heart defect which was treated by insertion of an intra-atrial prosthesis and was, at the time of death, taking oral anti-coagulation medication. He gave a social history of smoking and had a family history of hypertension, stroke and type two diabetes. All of these factors would significantly increase his risk of suffering both a first and repeated strokes.

During his time as an in-patient at Boston Pilgrim Hospital and Kettering General Hospital, he received appropriate care and rehabilitation for his stroke and fractured hip. The medical care received following his second, fatal stroke was also appropriate and conformed with national guidelines.

There was some difficulty in securing prison accommodation that could provide the necessary level of rehabilitation and medical care following the man's first stroke. This caused a significant delay in his discharge from hospital and resulted in the need for him to be admitted to a higher security prison than was warranted by his category D status. While this caused him a degree of unhappiness and frustration, he did receive the necessary rehabilitation and was able, ultimately, to return to North Sea Camp.

There were concerns voiced by North Sea Camp at the time that the man was transferred there but, with assistance, he appears to have coped well with his disability. It is extremely unlikely that this transfer and the lack of type 3 health care contributed in any way to the development of his second stroke and his subsequent death.

Key findings and conclusions in the clinical review

The man had multiple risk factors for development of a stroke, namely long term hypertension (high blood pressure), smoking history, atrial fibrillation, an intra-cardiac prosthesis and a family history of hypertension and stroke. These risk factors appear to have been appropriately managed both within the prison and by secondary care.

Following his first stroke, he was statistically at a 30 per cent risk of developing a further stroke. Risk of recurrent stroke may be reduced by active management of risk factors – control of blood pressure, smoking cessation and anticoagulation in the presence of atrial fibrillation.

The man's blood pressure was at times erratic, as indicated by recorded measurements in his prison medical records. His blood pressure was extremely elevated on admission following his second, fatal stroke. This may have occurred prior to or as a result of his stroke, with the associated increase in intracranial pressure secondary to brain haemorrhage. If his blood pressure was elevated in the period before his stroke, this would have contributed to the severity of intracranial haemorrhage. Healthcare staff at HMP North Sea Camp have reported that his blood pressure was measured and did not give rise to concern. Unfortunately, there are no measurements documented in the medical record to confirm this.

The man was offered assistance with smoking cessation on several occasions, both within the prison and in secondary care. Unfortunately, he was reported as not being motivated to quit and continued his smoking habit.

He was appropriately anti-coagulated following his first stroke and this therapy was continued and regularly monitored. Despite this, he developed thrombus on the prosthesis that had been surgically inserted into his heart. The pathologist undertaking post mortem examination concluded that this was likely to be the site of an embolic thrombus that caused his second stroke. During his in-patient stay following his first stroke, the man developed a deep vein thrombosis (DVT) despite adequate anti-coagulation. It is therefore possible that he had a degree of resistance to anti-coagulation. This could have been managed by maintaining his INR at a higher level, but this would then have been associated with a higher risk of haemorrhage.

The man received appropriate rehabilitation following his first stroke. He had intensive physiotherapy and occupational therapy during his protracted stay in secondary care. This was continued at a lower level at HMP Gartree. He was provided with all necessary physical aids while at Gartree. His functional level was significantly improved when he was transferred from Gartee to North Sea Camp.

During his stay at Gartree, his mental state and mood were affected by the high level of security that he was subjected to. This was not appropriate for his category D status, but was necessary as Gartree was the only prison available with type 3 health care at the time of discharge from hospital.

Following transfer to North Sea Camp, concern was expressed about the lack of healthcare facilities necessary to manage the man's ongoing needs. Despite this, he appears to have coped very well with his disability and received a high level of assistance and support from health care staff and other prisoners. He is reported as being very happy following his transfer and was due to start town visits.

The health care facilities at North Sea Camp are equivalent to those expected of a well organised primary care provider. The healthcare team were enthusiastic and well motivated. Documentation was poor with a notable lack of blood pressure recordings and GP consultations.

Overall, the man received appropriate management for his medical problems according to national guidelines. Although there are clear deficiencies in the provision of medical services for complex medical problems within the Prison Service, these do not appear to have contributed to his death.

Conclusion

The standard of documentation in the prison medical records varied significantly between sites. There should be standardisation of record keeping ensuring that minimum standards are maintained and that appropriate healthcare is provided when prisoners are transferred.

The Department of Health, in conjunction with Primary Care Trusts, should reinforce the standardisation of patient record keeping, ensuring that minimum standards for entries are maintained.

Continuity of care when prisoners transfer between prisons should be ensured by both verbal and written handover, including details of past history, current medical problems and ongoing needs, details of medication and a clear statement of the input that is required to maintain physical and mental wellbeing.

The Department of Health, in conjunction with Primary Care Trusts, should consider implementing a standard handover for medical needs when prisoners are transferred between prisons. This should be in written format, in addition to any verbal handover, and note any ongoing needs, details of medication and a statement of input required to maintain physical and mental wellbeing.

GP input into the management of chronic disease appears to be limited within the Prison Service and in this case was below the standards required for the General Medical Service Quality and Outcomes Framework. These standards should be applied to all GPs who are awarded the contract for provision of prison medical services by Primary Care Trusts.

East Lincolnshire Primary Care Trust should work closely with the Governor at North Sea Camp to instruct GPs to ensure patient record keeping is in line with standards required for GMS Quality and Outcomes Framework.

All prisons, regardless of their security classification, should be capable of managing prisoners with complex health needs and physical or learning disability.

General issues considered during the investigation

Transfer from hospital back to prison

During the period after the man's first stroke in March 2005, his medical needs were believed to exceed the level of care a category D establishment could provide. Alternative accommodation was required and he was transferred from Pilgrim Hospital to HMP Gartree, as it was the only prison within a reasonable area with in-patient beds and 24-hour care. Unfortunately, on moving to HMP Gartree the man was treated as a category B prisoner. This meant that he was unable to continue with his resettlement programme as a category D prisoner which includes town and family visits. His freedom was restricted. This deeply frustrated the man and affected his mood on occasion. On discussing the man's situation with staff at both HMP Gartree and North Sea Camp, it was clear to my investigator that he was not happy with this change in circumstances and desperately wanted to return to a category D establishment, preferably North Sea Camp.

On 11 January 2006, the custody unit at HMP Gartree wrote to three category D prisons asking that they consider accepting the man on transfer. He no longer required 24 hour healthcare, but did need long-term physiotherapy and occupational therapy. All three, including North Sea Camp, turned down the request due to the lack of availability of physiotherapy and occupational therapy.

The Prison Service should ensure that prisoners' progression through the security categories is not compromised as a result of perceived health needs. This would be in line with the recommendation made by the Chief Inspector of Prison in her thematic review of older prisoners in England and Wales:

"The National Offender Management Service, in conjunction with the Department of Health, should develop a national strategy for older and less able prisoners that conforms to the requirements of the Disability Discrimination Act and the National Service Framework for Older People."

In North Sea Camp's case, there was a further issue if the man returned to the establishment. His previous lifer manager had received inappropriate correspondence from him during his time at HMP Gartree. This had been noted in the man's security file and a decision made that he should not return to North Sea Camp. Due to lack of documentation from either prison, it is unclear how the decision that he could in fact return to the establishment was reached. It appears that North Sea Camp reluctantly agreed to take him back.

The Governors at both HMP Gartree and North Sea Camp should ensure that staff record all decisions taken and the rationale, when discussing the transfer of prisoners, particularly when security and medical needs are in question.

Needs assessment

On return to North Sea Camp in April 2006, the man was allocated a room on the ground floor of the Llewellin Unit. This was good practice. The room was large enough for wheelchair access, but no additional aids were fitted to assist

mobilisation. Although the Head of Healthcare and fellow prisoners state that the man was able to manage without them, he did have mobility problems as demonstrated by the fact he used his wastepaper bin when he could not get to the toilet in time. Propping open the fire door for ease of access to the toilet area was neither a good nor adequate long-term solution, as this is a clear breach of health and safety regulations.

Other than assistance with mobility, a fellow prisoner noted during interview that the man was "fiercely independent" and did not ask for help. On occasions where he did require assistance, he received a great deal of help and support from prisoners and staff.

There was considerable discussion between the lifer manager at North Sea Camp and Prison Service Headquarters about the need to find an establishment that could meet the man's needs. The local decision was that his needs could not be effectively managed at North Sea Camp as the layout, location and construction of the prison is not conducive to prisoners with such medical and physical needs. During interview, the Head of Healthcare mentioned that a request to transfer the man to somewhere more suitable had been made. There is no record of this request.

A comprehensive needs assessment was conducted on 10 April. This concluded that the man would require further occupational therapy and physiotherapy input. Despite these concerns, no occupational therapy assessment took place. My investigator raised this with the Head of Healthcare at North Sea Camp. The Head said that he was "unsure of what North Sea Camp could have done to improve the facilities available to the man," given their limited resources.

I do not feel that this is sufficient reason for not having organised a follow-up occupational therapy assessment. The clinical review refers to the National Clinical Guidelines for Stroke, which stipulate that:

- The need for special equipment should be assessed on an individual basis; once provided the value and need for equipment should be evaluated on a regular basis.

- Patients should be supplied as soon as possible with all the aids, adaptations and equipment they need.

In addition to this, Prison Service Order 2855, 'Management of Prisoners with Physical, Sensory or Mental Disabilities,' states that establishments have a duty to take reasonable steps to provide auxiliary aids if it would make it easier for prisoners with disabilities to make use of services and accommodation.

North Sea Camp did not fully meet either of these requirements in not providing a fuller assessment of the man's needs.

Policy for managing prisoners with disabilities

My investigator asked the Governor of North Sea Camp if the prison has a policy for managing prisoners with disabilities. She was referred to Chapter 2, Standard 2 'Person-centred Care' in the National Service Framework for Older People. (The National Service Framework for Older People places duties upon social service and healthcare providers in relation to the assessment and support of those in need of special care. This guidance is further supported by Prison Service Orders (PSO 2855 and PSO 8010, chapter 6) and legislation in the form of the Disability Discrimination Act (DDA).)

I am concerned about using a framework for older people to meet the needs of those with disability needs. It is not the case that all people with a disability are elderly, and they should not be treated as such. Indeed, the man was only 47 years old when he returned to North Sea Camp.

Conclusion

Although it is clear that the man's needs were considerably reduced by the time of his return to North Sea Camp, he still had limited mobility and struggled with some aspects of his accommodation. This is not something that would have affected the outcome, but an occupational assessment would have made sure that the man's basic living requirements were as accessible to him as possible.

Despite concerns about his move back to North Sea Camp, everyone my investigator spoke with during the course of her investigation stressed that the man was happy to return to the prison. He had been deeply frustrated by both his reduction in mobility and his placement at Gartree. The Head of healthcare at Gartree said that the man felt he was "being punished, because he was infirm". His lifer manager at Gartree echoed this sentiment and said that the man was "keen to get back to a category D establishment".

I believe that staff at both establishments had the man's medical and personal needs in mind whilst trying to establish the best way to manage him. Prisons are principally designed for young, able-bodied prisoners, yet increasingly hold a minority of prisoners who are either elderly or infirm. I commend the compassionate care and support that healthcare staff at both HMP Gartree and HMP North Sea Camp gave to him during the last nine months of his life.

The Governors of Gartree and North Sea Camp should commend their healthcare staff for the compassionate care and support given to the man during his rehabilitation.

With regard to the occasion of the man's final, fatal stroke, I wish to single out his fellow prisoner for his swift and compassionate conduct. The Senior Officer who attended the incident stated during interview that the prisoner responded correctly by placing the man in the recovery position and offering comfort and support until medical help arrived. I appreciate that it was a distressing situation for the prisoner, and wish also to commend his actions.

The Governor of North Sea Camp should formally thank the prisoner for his swift and compassionate action taken on attending to the man who died.

Overall, I believe that the man's case highlights the need for the Prison Service, in partnership with the Department of Health, to develop a national strategy to enable less able prisoners to be managed and appropriately supported in all categories of prison. While I appreciate the cost implications, I do not believe it is appropriate for category D prisoners to be transferred to higher security establishments in order to have their long term medical needs provided for. Moving back to a higher security prison once a prisoner has progressed to an open prison causes unnecessary frustration and upset.

RECOMMENDATIONS

Clinical

- **The Department of Health, in conjunction with Primary Care Trusts, should reinforce the standardisation of patient record keeping, ensuring that minimum standards for entries are maintained.**

- **The Department of Health, in conjunction with Primary Care Trusts, should consider implementing a standard handover for medical needs when prisoners are transferred between prisons. This should be in written format, in addition to any verbal handover, and note any ongoing needs, details of medication and a statement of input required to maintain physical and mental wellbeing.**

- **East Lincolnshire Primary Care Trust work closely with the Governor at North Sea Camp to instruct GPs to ensure patient record keeping is in line with standards required for GMS Quality and Outcomes Framework.**

General

- **The Prison Service should ensure that prisoners' progression through the security categories is not compromised as a result of perceived health needs. This would be in line with the recommendation made by the Chief Inspector of Prison in her thematic review of older prisoners in England and Wales:**

  "The National Offender Management Service, in conjunction with the Department of Health, should develop a national strategy for older and less able prisoners that conforms to the requirements of the Disability Discrimination Act and the National Service Framework for older people."

- **The Governors at both HMP Gartree and North Sea Camp should ensure that staff record all decisions taken and the rationale, when discussing the transfer of prisoners, particularly when security and medical needs are in question.**

- **The Governors of Gartree and North Sea Camp should commend their healthcare staff for the compassionate care and support given to the man during his rehabilitation.**

- **The Governor of North Sea Camp should formally thank the prisoner for his swift and compassionate action taken on attending to the man who died.**