Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Duwayne Henry (aka Mr Duwayne Vidal), a prisoner at HMP Frankland, on 12 December 2019

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*

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 Duwayne Henry (who was also known as Mr Duwayne Vidal) died in hospital from diabetic ketoacidosis on 12 December 2019, while a prisoner at HMP Frankland. He was 38 years old. I offer my condolences to Mr Henry's family and friends.

On 10 December, Mr Henry told staff that he was suffering with abdominal pain and vomiting. His urine sample contained high levels of glucose and ketones, a sign of diabetic ketoacidosis, although Mr Henry had never been diagnosed with diabetes. A nurse called a hospital doctor for advice, who said Mr Henry should be sent in for further assessment. However, the prison did not call for an ambulance for almost seven hours. Mr Henry died in hospital two days later.

I am concerned about the long delay in arranging Mr Henry's transfer to hospital. I recognise that he was a category A prisoner and that his transfer to hospital therefore required careful consideration. However, in this case much of the delay was caused by a breakdown in communication between prison and healthcare staff. Important decisions taken about the timing of Mr Henry's transfer were not recorded and there was confusion about what had been agreed. Healthcare staff also failed to escalate their concerns about the delay to senior managers.

I cannot say whether the outcome might have been different for Mr Henry if he had been sent to hospital earlier.

I am also concerned that there was a delay in telling Mr Henry's family that he was seriously ill when his condition deteriorated in hospital.

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

Sue McAllister CB
Prisons and Probation Ombudsman **July 2021**

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Summary

Events

1. On 17 March 2015, Mr Duwayne Henry (who also used the name Duwayne Vidal) was sentenced to life imprisonment for sexual offences. He was moved to HMP Frankland on 29 March 2019.

2. He had asthma and depression, for which he was prescribed medication, but otherwise had little contact with healthcare at Frankland.

3. At around 1.30pm on 10 December, a nurse went to see Mr Henry in his cell because he had been complaining of abdominal pain and vomiting. The nurse found that Mr Henry had high levels of glucose and ketones in his urine, which can be a sign of diabetic ketoacidosis (a potentially life-threatening condition). The nurse sought advice from a senior nurse who advised that Mr Henry should be moved to the healthcare centre.

4. The senior nurse assessed him at around 2.30pm, and then consulted a hospital doctor who advised that Mr Henry should be sent to hospital for further investigation.

5. Mr Henry remained under observation in the healthcare centre while there were discussions with prison staff about arrangements for sending him to hospital. An ambulance was eventually called at 9.16pm. The ambulance arrived around 15 minutes later and it left the prison at around 10.20pm.

6. After he arrived at hospital, Mr Henry was diagnosed with diabetes. His condition deteriorated on the evening of 11 December, and hospital staff performed cardiopulmonary resuscitation (CPR) on him and placed him in an induced coma. In the early hours of 12 December, he had a heart attack and was resuscitated. He was pronounced dead at 1.25pm.

7. The post-mortem found he died of diabetic ketoacidosis.

Findings

8. Healthcare staff at Frankland saw Mr Henry promptly when he became unwell on 10 December, moved him appropriately to the prison's healthcare centre for assessment, correctly sought advice from the hospital, and monitored his condition closely.

9. However, there was a delay of almost seven hours before Mr Henry's transfer was agreed and an ambulance was called to take him to hospital. We agree with the clinical reviewer that this aspect of Mr Henry's healthcare care was not equivalent to the care Mr Henry could have expected to receive in the community.

10. We cannot say whether the outcome might have been different for Mr Henry if he had been taken to hospital earlier.

11. We recognise that Mr Henry was a category A prisoner (the highest security category) and that special consideration needs to be given to transferring

category A prisoners to hospital. However, we are concerned that the main reason for the long delay in this case was poor communication between prison and healthcare staff, and between healthcare staff within the healthcare team.

12. Healthcare staff failed to record discussions about the need for Mr Henry's transfer to hospital; no one in healthcare had responsibility for overseeing the transfer; and healthcare staff did not escalate their concerns to senior healthcare managers when the transfer was delayed.

13. Healthcare managers did not attend the multidisciplinary meeting to discuss the risk factors in sending Mr Henry to hospital. Although the prison's security department was well represented at the meeting, only one nurse attended from healthcare.

14. The minutes do not record the decisions reached at the meeting and there are conflicting accounts about what was agreed.

15. The prison did not contact Mr Henry's family until the early hours of 12 December. We consider that the family should have been contacted when his condition deteriorated on the evening of 11 December, if not before.

16. Several of the healthcare staff did not receive sufficient support following Mr Henry's death.

Recommendations

- The Head of Healthcare should ensure that there is a system of oversight to monitor the transfer of patients to hospital, with a clear escalation path where healthcare staff have concerns about delays.
- The Head of Healthcare should ensure that relevant clinical communications between healthcare staff are recorded in the prisoner's medical record.
- The Governor and Head of Healthcare should ensure that:
    - Appropriate senior healthcare staff attend key party meetings;
    - there is a clear record of what was agreed at key party meetings; and
    - decisions are clearly communicated to those who need to know.
- The Governor and the Head of Healthcare should establish a protocol for information sharing between the duty governor and a healthcare manager about prisoners requiring transfer to hospital.
- The Governor should ensure that staff notify a prisoner's next of kin as soon as possible when a prisoner becomes seriously ill.
- The Governor and Head of Healthcare should review the procedures for supporting staff after a major incident.

The Investigation Process

17. The investigator issued notices to staff and prisoners at HMP Frankland informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

18. The investigator obtained copies of the relevant extracts from Mr Henry's medical and prison records.

19. NHS England commissioned an independent clinical reviewer to review Mr Henry's clinical care at the prison.

20. They jointly interviewed healthcare and prison staff at Frankland on 21 January 2020.

21. We informed HM Coroner for County Durham and Darlington of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

22. One of the Ombudsman's family liaison officers contacted Mr Henry's next of kin to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Henry's next of kin responded on behalf of the family and provided a list of questions. In summary, the family wanted to know:

    - What healthcare did Mr Henry receive at Frankland?
    - Did Mr Henry appear unwell in the weeks/months before his death?
    - Who did Mr Henry speak to when he started to feel unwell in the days before his death?
    - Why was it decided that Mr Henry required medical care in hospital?
    - What treatment did he receive in prison when he became unwell?
    - Did Mr Henry have a heart attack in prison and was he unconscious when he went to hospital?
    - When was the ambulance called and when did it arrive?
    - Was there communication between prison healthcare and hospital staff?
    - Did Mr Henry have two heart attacks in hospital?
    - Why was the family not contacted earlier and told that Mr Henry was seriously ill?

23. Many of these questions have been answered by the clinical reviewer in her report and others are covered in this report. Further questions about the treatment Mr Henry received in hospital and his activities in prison are outside the remit of the PPO investigation and are matters for the hospital and the Prison Service to answer.

24. The initial report was shared with Mr Henry's next of kin. They responded and raised many points and additional questions that do not impact on the factual accuracy of this report, and these have been addressed through separate correspondence.

The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report. After consultation with HMPPS, two recommendations were slightly altered (recommendation two about the recording of communications between healthcare staff, and point one of recommendation three regarding healthcare staff attendance of key party meetings). Previously notified corrections to the transcript of the PPO's interview with a Custodial Manager which were overlooked, have now been made.

Background Information

HMP Frankland

25. HMP Frankland is a high security prison. It holds up to 852 men. There is 24-hour inpatient care. G4S Health Services (UK) provide general nursing services and substance misuse services. Spectrum Healthcare provides GP and pharmacy services.

HM Inspectorate of Prisons

26. HMIP carried out an unannounced inspection of Frankland in January 2020. Inspectors noted that a comprehensive health needs analysis had been updated in 2018, which had informed the new health services contract due to start in April 2020. In the HMIP survey, only 38% of prisoners said that the quality of the GP service was good, against the comparator of 65%, and only 41% against 57% said the overall quality of health care was good. Health complaints were found to be poorly managed, which exacerbated prisoners' negative perceptions of health services. Inspectors found that health staffing had increased since the last inspection but not all vacancies had been filled, and prisoner access to health services was acceptable.

Care Quality Commission (CQC)

27. The CQC inspected the healthcare services provided by G4S Health Services (UK) at Frankland in January 2019 and judged that G4S was in breach of CQC regulations. As a result, they issued a Requirement Notice under section 60 of the Health and Social Care Act 2008.

28. The CQC carried out a further inspection in November 2019. They found that improvements had been made and the provider was no longer in breach of the regulations. In particular, they found that:

- Competency assessments for healthcare staff responsible for the safe handling of medicines were in place.
- Patient involvement in care planning had improved.
- Staff were sufficiently trained to carry out their duties.
- Systems to support good governance at local level were appropriately embedded across the service.

Independent Monitoring Board

29. 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 30 November 2018, the IMB noted the appointment of a new Head of Healthcare who had set up a programme to tackle shortcomings in the healthcare provision at Frankland identified by the CQC.

Previous deaths at HMP Frankland

30. Mr Henry was the eighth prisoner to die at Frankland since December 2017. Of the previous deaths, one was self-inflicted and six were from natural causes. There are no similarities between the investigation findings in Mr Henry's case and the findings in the previous investigations at Frankland.

Key Events

31. On 17 March 2015, Mr Duwayne Henry was sentenced to life imprisonment for sexual offences.

32. In 2016, Mr Henry changed his name by deed poll to Duwayne Vidal. However, prison Governors have discretion over whether or not to accept a prisoner's change of name while he is in prison. There is no record that Mr Henry's change of name was recognised and he continued to be known as Duwayne Henry in prison. We have, therefore, used that name in this report.

33. Mr Henry spent time in several prisons before he was moved to HMP Frankland on 29 March 2019.

34. Mr Henry had asthma and depression, for which he was prescribed medication. Other than this, he had very little contact with healthcare staff at Frankland until December 2019.

35. Over the weekend of 7/8 December, Mr Henry told an officer that he thought he might have indigestion. The officer advised him to see a nurse for medication, but there is no record of Mr Henry approaching healthcare staff about this. On 9 December, officers carried out a routine cell search in Mr Henry's cell. Although one of the officers involved said that Mr Henry was a little irritable about this, he did not recall him saying that he felt unwell.

Events of 10 December 2019

36. At around 9.00am on 10 December, Mr Henry went to see a nurse in the healthcare centre. He told a nurse that he was feeling unwell and he had seen blood in his urine. The nurse asked him to return at lunchtime with a urine sample so that it could be tested.

37. Mr Henry did not return with the sample. A nurse went to see him on the wing at around 1.30pm after wing staff called asking for a nurse to see him. The nurse found Mr Henry rolling around in bed in some discomfort and Mr Henry told him that he had abdominal pain, had been vomiting and felt generally weak. The nurse carried out tests on his urine and found high readings for glucose, blood and ketones. (Ketones are a type of chemical produced by the liver when it breaks down fats. A high level of ketones in the urine can be a sign of diabetic ketoacidosis, a potentially life-threatening condition where ketones build up in the blood and make it acidic.) He reported his concern about this to an advanced nurse practitioner, who told him to bring Mr Henry to the healthcare centre for observation.

38. Prison staff took Mr Henry to the healthcare centre in a wheelchair because he was unable to walk due to his abdominal pain. At around 2.30pm, the advanced nurse practitioner assessed him. He recorded that Mr Henry looked very weak and unwell and that he said he had not eaten for four days and had vomiting and loose stools. Mr Henry had a recorded blood sugar level of 14.5mmols. (A normal blood sugar level for a healthy individual is between 4 to 5.4mmols. High sugar levels are potentially dangerous and can lead to other complications.)

39. He then telephoned the Surgical Registrar at a University Hospital to discuss Mr Henry's symptoms. The registrar suspected that Mr Henry may have cholecystitis (inflammation of the gallbladder) and advised that he should be brought to A&E so a scan could be done. He asked for blood tests to be taken so that they could be sent to the hospital for further analysis before Mr Henry arrived there.

40. In a statement written after Mr Henry's death, the advanced nurse practitioner said that he tried to tell the nurse in charge, of the clinical findings and the advice from the Surgical Registrar for Mr Henry to attend A&E, but she was in a meeting with the clinical lead and there was no other senior person for him to handover to. He said that he spoke to a nurse and advised him that Mr Henry needed to go to hospital "and to request an ambulance for within one hour". At interview, however, he said he had told two nurses that Mr Henry needed to go to hospital.

41. The advanced nurse practitioner recorded in Mr Henry's medical notes, "Nursing staff to monitor in health care until transport arranged." He did not record who he had told about this in the health record and he said at interview that this was a verbal handover. He then returned to his normal work.

42. The nurse in charge said at interview that she was not told that Mr Henry needed to go to hospital and that she did not know this until later. The clinical lead said at interview that the advanced nurse practitioner told her that Mr Henry needed to go out and that she asked a nurse to begin the paperwork and take it to the Security Department.

43. It is not clear who told prison staff that Mr Henry needed to go to hospital.

44. At 3.05pm, a nurse documented in Mr Henry's medical record that he had been unable to obtain a blood sample from Mr Henry due to poor venous access. He noted that Mr Henry had vomited and was excessively thirsty (a known symptom of high blood sugars). He also noted that Mr Henry was waiting in healthcare to be transported to A&E for further investigations.

The key party meeting

45. At around 3.45pm, the prison held a multi-disciplinary 'key party meeting' to discuss the risks of sending Mr Henry to hospital. (Mr Henry was a category A prisoner, the highest security category. Category A prisoners are deemed to pose the most risk to the public, police or national security should they escape.) The duty governor chaired the meeting. Three representatives from the prison's security department also attended.

46. The advanced nurse practitioner said that it would have been normal practice for the clinical lead or the nurse in charge to attend the key party meeting. However, they were in a meeting so he was asked to go. He said he did not know that Mr Henry was a category A prisoner until shortly before the meeting.

47. The nurse in charge said that she did not attend the meeting because she was in a meeting with the Head of Healthcare at the time. The clinical lead said she did not attend because she was not told the meeting was taking place.

48. The minutes of the meeting were recorded on a template form. This notes that the *'reason for the emergency escort'* was "acute abdomen pain, could be blockage in bile tube, surgical reg states needs seeing". Below this is written in different hand-writing "query cholecystitis (inflammation of the gallbladder / blocked bile duct)? gastroenteritis".

49. The form records that the *'consequences of not sending the prisoner to hospital'* were that he could develop sepsis (a life-threatening condition). Against the question *'could treatment be deferred and if so for how long?'*, it was recorded "ketones are high and needs seeing ASAP, would not recommend deferring treatment". Against the question *'could a specialist attend the hospital?'*, it was recorded "unable to get correct personnel in, bloods have been taken and awaiting results". (This question appears to be a mistake on the template form – we assume it should read *'could a specialist attend the prison?'*)

50. The minutes of the key party meeting do not record the decisions taken.

51. The duty governor told the investigator that the decision made at the meeting was to keep Mr Henry in the healthcare centre until 8.00am the following morning while they waited for the blood test results, although any information from healthcare about deterioration in his condition would result in an earlier transfer. The duty governor said that he understood that Mr Henry could be suffering from a range of conditions from gastroenteritis (which could be treated in the prison) to more serious conditions and that the blood tests would show what the problem was.

52. At 4.29pm, the advanced nurse practitioner recorded in Mr Henry's medical record that he had attended the key party meeting and informed prison staff of the clinical findings, that the hospital registrar had advised that Mr Henry needed an ultrasound scan for possible cholecystitis, and that Mr Henry needed further assessment in A&E. He told the investigator that he was repeatedly asked at the key party meeting whether Mr Henry's transfer could wait until the next day and he said it could not.

53. The advanced nurse practitioner said at interview that he understood from the meeting that Mr Henry would be taken to hospital. He said there had been discussion at the meeting about taking Mr Henry to hospital in the category A van, which he would have been happy with as Mr Henry was mobile and it might have been quicker than calling an ambulance.

54. The advanced nurse practitioner told the investigator that when he attended the meeting he did not know that a nurse had attempted to take blood samples at about 3.00pm but had not been successful. He also said that the blood tests were not necessary for Mr Henry to go to A&E but he had thought they would be helpful for the hospital in investigating his condition.

55. Healthcare staff told the investigator that they understood that Mr Henry was to be taken to hospital and that they should monitor him while transport was arranged.

56. The advanced nurse practitioner and the lead nurse saw Mr Henry around 5.00pm and observed him through his cell observation panel. They were both

surprised by how relatively well he was. He was trying to get his television to work and asked for his normal medication. Both nurses then left the prison at the end of their shift.

6.30pm to 9.16pm

57. At around 6.30pm, a nurse telephoned a Custodial Manager (CM), the orderly officer who was responsible for the running of the prison, to find out when Mr Henry was going to hospital. She said that she had been told that the prison was waiting for the results of the blood tests which had been sent to the hospital. The nurse that it had not been possible to take Mr Henry's blood. A nurse also spoke to the CM on the telephone and told her that he had tried and failed to take a blood sample (probably due to Mr Henry being dehydrated).

58. The CM telephoned the duty governor to let him know that no blood had been taken. The duty governor said that he had been told at the key party meeting that a blood sample had been sent out for analysis.

59. At around 7.00pm, a nurse telephoned a CM who had taken over as the night orderly officer. The nurse was concerned that Mr Henry had still not left the prison to go to hospital. He said that a blood sample had not been taken from him.

60. The CM asked the duty governor to contact healthcare staff to clarify the situation. At around 7.15pm, the duty governor telephoned a member of healthcare staff and obtained Mr Henry's NHS number. He then telephoned the hospital pathology laboratory who told him that no blood sample had been received.

61. At 8.00pm, a nurse came on duty. He was given a handover and told about the confusion around Mr Henry's transfer to hospital. He noted that he would clarify this with the night orderly officer.

62. The duty governor went to the healthcare centre at around 8.45pm and told a nurse that the plan was to keep Mr Henry under observation through the night and send him to hospital early the next morning. The nurse told him that Mr Henry's situation was very serious and could not be delayed until the next day or it was likely that he would go into a diabetic coma and die. He noted that Mr Henry was generally unwell, lethargic and sleepy. His eyes were sunken, his skin and lips dry and he was clearly severely dehydrated. His extremities were cold to touch.

63. Healthcare staff continued to monitor Mr Henry, as they had done throughout the afternoon. While his observations mostly remained in the normal range, his blood sugar level rose sharply after 8.30pm from 16.8mmols to 31mmols at 9.00pm.

64. At 9.45pm, a Health Care Assistant recorded retrospectively that Mr Henry had a National Early Warning (NEWS2) score of 5 (indicating a medium clinical risk in need of an urgent response from clinicians) and that the blood sugar monitor was no longer able to monitor his blood sugar levels as they were too high.

65. An ambulance was called at 9.16pm and arrived at the prison at 9.29pm. The ambulance left the prison at 10.19pm. The ambulance crew recorded that Mr Henry was “comfortable and stable” and was talking. Mr Henry was restrained and accompanied by three prison officers.

66. Later that night, the hospital told prison healthcare staff that Mr Henry had been diagnosed with diabetes and had been admitted to a ward where he was expected to stay for at least three days.

Events of 11 and 12 December

67. On the morning of 11 December, hospital staff told the prison that Mr Henry had been moved to the Intensive Care Unit as he had been confused overnight and his blood sugars had risen to 51.7mmols.

68. The bed watch officers recorded that Mr Henry remained conscious through the day and received treatment and food and drink. At 6.00pm, a bedwatch officer reported to the prison that Mr Henry had become a bit more unwell about ten minutes previously. He appeared to have been unconscious for a while and nurses took action to stabilise him.

69. In the hour after 7.00pm, Mr Henry’s condition deteriorated. He had low blood pressure and following increasing shortness of breath, he was given cardiopulmonary resuscitation (CPR) for eight minutes. Following this, hospital doctors put Mr Henry into an induced coma and intubated him (a tube put down his windpipe to make it easier to get air in and out of the lungs).

70. At 9.00pm, a nurse recorded in Mr Henry’s medical notes that he had been informed by the night orderly officer that Mr Henry had had a cardiac arrest and had been resuscitated and placed in an induced coma. (The night orderly officer had been told this by the bedwatch staff on the basis that Mr Henry had been given CPR.)

71. There were no further reports of any worsening of Mr Henry’s condition until the early hours of the next day.

72. At 11.55pm, when a nurse took off Mr Henry’s socks, two sim cards were found hidden in them.

73. In the early hours of 12 December, the prison was told that Mr Henry had also been diagnosed with pancreatitis (inflammation of the pancreas). On 12 December at 2.25am, a doctor told the bedwatch staff that Mr Henry’s condition was deteriorating and it would be appropriate to consider contacting his family. Around this time Mr Henry had a heart attack and was resuscitated.

74. Mr Henry’s condition continued to decline through the morning of 12 December. At 3.45am, he was put on dialysis because his kidneys were failing. At 6.00am, the hospital told the prison healthcare staff that Mr Henry was in a critical condition and that his family had been informed.

75. At 9.15am, bedwatch staff were told by a nurse that he was no longer responding to any medication. Mr Henry was pronounced dead at 1.25pm.

Contact with Mr Henry's next of kin

76. Mr Henry's prison records listed his next of kin. A CM who was appointed as the prison's family liaison officer (FLO), spoke to Mr Henry's next of kin on the telephone shortly before 4.00am on 12 December and told them of Mr Henry's condition. She also spoke to Mr Henry's other next of kin at around 5.30am, after she had contacted the prison.

77. Mr Henry's first next of kin arrived at the hospital at around 9.30am, with other members of his family. His other next of kin arrived around noon with another family member. Other relatives arrived at the hospital later in the day. They were with Mr Henry when he died.

78. A CM maintained telephone and email contact with Mr Henry's next of kin in the days following his death and passed on questions they raised to the coroner and the PPO.

79. The prison contributed towards Mr Henry's funeral in line with national guidance.

Support for prisoners and staff

80. Notices to staff and prisoners informing them of Mr Henry's death were issued on 13 December. They explained where people could get support if they had been affected by his death.

81. At interview, it was evident that some members of staff had been significantly affected by Mr Henry's death. One member of prison staff had not received the support that they needed, but explained that this was due to unusual circumstances at that time rather than indicative of a general problem. However, several members of the healthcare staff said that they had not received support following Mr Henry's death.

Post-mortem report

82. The post-mortem examination concluded that Mr Henry died from diabetic ketoacidosis.

83. The pathologist noted that it appeared to be a new diagnosis of type 1 diabetes (a chronic condition where the pancreas produces little or no insulin), and said that it is not at all uncommon for someone of Mr Henry's age to develop type 1 diabetes.

84. He noted that Mr Henry also had cerebral oedema (build-up of fluid around the brain), cerebral ischaemia (reduced blood supply to the brain) and acute pancreatitis, which he considered had arisen as complications of the diabetic ketoacidosis.

Findings

Clinical care

85. Apart from asthma and depression, for which he received medication, Mr Henry had very few health problems prior to his death.

86. Over the weekend of 7/8 December, he told a prison officer that he thought he had indigestion and was advised to see healthcare. We found no evidence to suggest that Mr Henry had approached healthcare staff to report any problems until the morning of 10 December.

87. The clinical reviewer found that healthcare staff saw Mr Henry promptly when he became unwell on 10 December, and appropriately moved him to the healthcare centre for assessment. They correctly sought advice from the hospital and monitored his condition closely.

88. However, the reviewer found that communication issues led to a delay in Mr Henry being sent to hospital. She considered that this was not equivalent to the standard of care that he could have expected to receive in the community. She could not say whether the outcome might have been different for Mr Henry if he had been sent to hospital earlier.

Lack of oversight of hospital transfer by senior healthcare staff

89. The clinical reviewer found that individual nurses did their best to raise their concerns with prison staff about the delay in sending Mr Henry to hospital, but that senior healthcare staff – the nurse in charge, the clinical lead or the head of healthcare – were not involved in the discussions and no one was responsible for monitoring his transfer to hospital. There did not appear to be a route for healthcare staff to escalate their concerns to healthcare managers. We make the following recommendation:

The Head of Healthcare should ensure that there is a system of oversight to monitor the transfer of patients to hospital, with a clear escalation path where healthcare staff have concerns about delays.

Clinical record keeping

90. The clinical reviewer noted that healthcare staff conducted frequent observations on Mr Henry and reported clinical findings to relevant staff, but some of this information was reported verbally and not recorded. As a result, some of the recommendations made by healthcare staff were not acted upon and there is no evidence in the medical record that the recommendations were made.

91. The advanced nurse practitioner said that, after he spoke to the Surgical Registrar, he told the nurse in charge that day that Mr Henry needed to be taken to hospital by ambulance. He said the clinical lead was also there at the time. He did not note this in Mr Henry's medical record. The nurse in charge said at interview that she could not recall advanced nurse practitioner telling her this and that she did not know until later that Mr Henry needed to go to hospital. We make the following recommendation:

The Head of Healthcare should ensure that relevant clinical communications between their staff are recorded in the prisoner's medical record.

Key party meeting on 10 December

92. Mr Henry was a category A prisoner and therefore subject to special considerations prior to any movement outside the prison. These are set out in Prison Service Instruction (PSI) 09/2013, *Management and Security of Category A Prisoners – External Movement,* which says:

> *"Category A prisoners must leave the prison for medical treatment only when the doctor or other suitable clinician assesses that treatment cannot be deferred or provided in any other prison.* Medical staff should be asked to certify in general terms why the external movement is necessary." [Italics indicate mandatory actions.]

93. At Frankland, the risk associated with the movement of category A prisoners outside the prison is considered at a "key party meeting". This is composed of various personnel, including wing, security and healthcare staff. The duty governor chaired the key party meeting to discuss Mr Henry's transfer to hospital and the advanced nurse practitioner was the sole healthcare representative.

94. We understand that taking a category A prisoner out to hospital raises significant security issues and should only take place when clinically essential. That means that the clinical issues must be properly discussed and understood. We are concerned that there was only one nurse present at the key party meeting and that more senior members of healthcare staff did not attend.

95. The discussion at the meeting was recorded on a template form which provided very little space for recording the details. However, the form records clearly that the Surgical Registrar at the hospital had said Mr Henry needed to be seen; that he could develop sepsis if he was not taken to hospital; that his ketones were high and he needed to be seen ASAP; and that the advanced nurse practitioner would not recommend deferring treatment. All of this points to the need to take Mr Henry to hospital as a matter of urgency.

96. The only points to the contrary recorded on the form were that the results of blood tests were awaited (although this was recorded in response to the question about whether a specialist could attend the prison and no conclusion was drawn from it) and a note in different hand-writing that Mr Henry might have an inflamed gall bladder, a blocked bile duct or gastroenteritis. It is not clear who entered this note, nor whether it was entered during the meeting or afterwards.

97. We are concerned that the duty governor did not understand that Mr Henry needed to be taken to hospital as a matter of urgency and believed that it was acceptable to wait until the following morning. He was also under the misapprehension that the blood tests (which had not in fact been taken) were key to determining how serious Mr Henry's condition was. We cannot say whether these misunderstandings arose because the advanced nurse practitioner failed to explain the clinical issues clearly at the meeting, or because the duty governor was overly focussed on security issues.

98. There is nowhere on the template form to record the decision taken at the key party meeting and there is no record elsewhere of the decision that was reached.

99. It is a cause for serious concern that the decision reached at the key party meeting was not recorded anywhere. As a result, the duty governor and the advanced nurse practitioner apparently left the meeting with a very different understanding of what had been agreed about the need for and the timing of Mr Henry's transfer to hospital. We consider that the outcome of this important meeting should have been clearly recorded and communicated to those who needed to know.

100. We make the following recommendations:

The Governor and Head of Healthcare should ensure that:

- **Appropriate senior healthcare staff attend key party meetings;**
- **there is a clear record of what was discussed and agreed and the reason for the decision; and**
- **decisions are clearly communicated to those who need to know.**

The Governor and the Head of Healthcare should establish a protocol for information sharing between the duty governor and a healthcare manager in respect of prisoners requiring transfer to hospital.

Informing Mr Henry's next of kin

101. Mr Henry was admitted to hospital on the evening of 10 December. His family were not informed that he was unwell until shortly before 4.00am on 12 December, the day of his death. The family have asked why they were not told about his critical condition earlier.

102. Prison Rule 22 says:

> "If a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of mental disorder, the governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed".

103. However, in the section on 'Hospital liaison and procedures', PSI 09/2013 says:

> *"Liaison between the prison and the Category A prisoner's family should not normally occur, however where contact is considered it must be balanced against the security risks that this would create*."

104. When Mr Henry was taken to hospital on 10 December, he was fully conscious and did not appear to be in imminent danger. He was admitted to a standard ward and the prison was told that he would be discharged in a few days. Although he was taken to hospital by emergency ambulance, we are satisfied that the seriousness of his condition was not apparent and that, given his category A status, there was no reason why his next of kin should have been informed at this point.

105. Early on 11 December, Mr Henry was moved to the Intensive Care Unit. We recognise that Mr Henry remained conscious during the day and ate some food at 5.25pm, and that hospital staff gave no indication to the bedwatch staff at the hospital that Mr Henry was seriously unwell. However, admission to an Intensive Care Unit does indicate that a patient is seriously ill and we think that the prison should have considered informing his family at this point.

106. Mr Henry's condition deteriorated in the early evening of 11 December. Between 7.00pm and 8.00pm, hospital staff performed CPR and placed Mr Henry in an induced coma. It was now clear that Mr Henry was seriously ill and we consider that his next of kin should have been informed at this point.

107. The duty governor for the evening of 11 December was asked why the next of kin were not informed until the next day. He said that with hindsight it would have been preferable to notify them earlier, but although he knew Mr Henry was ill, he thought he was relatively stable. He said that telling the next of kin had to be balanced with security considerations where category A prisoners are concerned. He also said it was the prison's practice to take the lead from the hospital staff and they did not suggest contacting Mr Henry's relatives until the early hours of 12 December.

108. Although we accept that contacting the families of Category A prisoners in hospital requires careful consideration, we consider that the prison should have contacted Mr Henry's family earlier than they did and certainly when Mr Henry was placed in an induced coma on the evening of 11 December.

109. We make the following recommendation:

The Governor should ensure that staff notify a prisoner's next of kin as soon as possible when a prisoner becomes seriously ill.

Support for staff

110. Several of the healthcare staff at interview said that they felt unsupported following Mr Henry's death. We make the following recommendation:

The Governor and Head of Healthcare should review the procedures for supporting staff after a major incident.

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