



Investigation report

Management of chronic health conditions in prisons

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Theme:

Long-term conditions, Access to care

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Executive summary

The reference event

Martin, a 43-year-old man, was being held at a Category B local prison(1) . Martin had epilepsy since childhood, and at the time was taking the anti-epilepsy medicine Tegretol (carbamazepine) Prolonged Release (400mg) twice a day. He was also taking other types of medication for different conditions.

Martin was assessed as suitable for transfer to a Category C prison and placed on a transfer list. He would be moved the next day (Friday). On Friday morning, after the necessary procedures had been carried out, he was taken to the Category C prison, where he arrived at 11:35 hours. Later in the day, a nurse in the healthcare department assessed Martin's health. At 15:02 hours she noted in Martin's electronic health record that he had been transferred without any medication. She sent a message to the healthcare provider's doctors, via the prison's computerised healthcare system, which said, 'Please could you prescribe all this mans [sic] meds - not arrived with any meds - we will arrange a delivery tomorrow.'

The prison's general practitioner (GP) was absent due to illness and there was no one else available on site who could prescribe the medication. The duty manager for the healthcare provider, who was a GP, carried out the task remotely. She electronically prescribed Martin's medication at 19:16 hours on Friday evening; however, the prescription for epilepsy medication was omitted.

The following morning (Saturday) a nurse realised that Martin's epilepsy medication had not been prescribed, so she sent another message asking for this to be done. However, the medication was not a standard item held in stock and the prison did not have any at the time. This meant that a signed prescription form was needed so that staff could acquire it from the local pharmacy. There was no authorised prescriber available until Monday, so it was not possible to get the medication until then.

At 15:01 hours on Sunday Martin had two epileptic seizures in his cell, followed by two smaller seizures that took place while an ambulance crew were tending to him. He was taken to the local emergency department (ED) where he was assessed and given Tegretol. Martin spent the next three hours in the ED; he was then taken back to the prison.

On Monday Martin's prescription was signed and his medication acquired. Since then he has received it twice daily.

The national investigation

The Healthcare Safety Investigation Branch (HSIB) identified the risk of a lack of continuity of healthcare for prisoners with long-term chronic health conditions, who were being transferred within the prison system; the reference event highlighted this risk. Following initial information-gathering and evaluation of the safety issues against the HSIB criteria for investigation, HSIB's Chief Investigator authorised a national safety investigation.

The investigation reviewed the entire event, from the start of Martin's internment through to the moment where his medication was acquired by the Category C prison. The investigation followed the pathway of care and the processes that were involved, including the healthcare aspects and the operational side of the prison, to understand the decisions made. The human factors that may influence decision-making at all levels throughout the transfer process were considered, along with the complexity of the environment and the system in which staff work.

This investigation focused on the routine transfer of prisoners around the prison system. The scope of the investigation included the communication of healthcare and prison information between different environments and locations, and the inspection of prison transfer processes by the Care Quality Commission (CQC) and Her Majesty's Inspectorate of Prisons (HMIP). The investigation identified opportunities and remedies that could be applied across the system to reduce the risk to prisoners being transferred between prisons within the prison system and to those being released into the community.

(1) Local prisons house prisoners who are taken directly from court in the local area after being put on remand or given a custodial sentence.

Findings

- Prison healthcare departments where there is only one authorised prescriber on site, particularly during core hours when transfers occur, create single points of failure that may put prisoners with medication requirements at risk.
- There are two key IT systems in use in prisons – one for healthcare records and one for the operational needs of the prisons. These systems have no interoperability, which causes inefficiency within the prison system and makes it impossible to automatically share essential information across the prison service.
- CQC and HMIP inspections focus more on prisoners being released into the community than on the routine transfer of prisoners between prisons.
- NHS England/Improvement health and justice regional commissioning teams apply varying levels of oversight and governance of the healthcare services, resulting in poor incident investigations and reports.

HSIB makes the following safety recommendations

Recommendation 2019/047:

It is recommended that the Care Quality Commission amends its inspection criteria to ensure that inter-prison transfer processes are fully encapsulated within the inspection schedule to assure the provision of care throughout.

Recommendation 2019/048:

It is recommended that the National Prison Healthcare Board for England oversees work to implement interoperability between SystmOne and the Prison National Offender Management Information System, enabling sharing of essential information across the prison service which does not impinge on the confidentiality requirements of either system.

Recommendation 2019/049:

It is recommended that NHS England/Improvement health and justice national commissioning team review how they monitor and assure the provision of healthcare in prisons to reduce variability in standards, particularly in the areas of incident reporting and investigations.

HSIB makes the following safety observations

1. It would be beneficial for healthcare providers to ensure that there are robust mechanisms in place for accessing urgently needed medicines in order to minimise the risk of patients missing doses.
2. There may be benefits to prisons' healthcare providers having sufficient numbers of authorised prescribers to ensure that a safe prescribing environment is maintained in prisons to meet the standards of service provision they are contracted to provide.

Background and context

1.1 Ministry of Justice

1.1.1 The Ministry of Justice (MoJ) is the government department responsible for the justice system.

The justice system includes:

- courts
- prisons
- probation services
- attendance centres (Ministry of Justice, n.d.).

1.1.2 There are 122 prisons and 500 courts within the justice system in England and Wales (Ministry of Justice, n.d.).

1.2 Prison healthcare

1.2.1 The House of Commons Health and Social Care Committee report on prison health (House of Commons Health and Social Care Committee, 2018) states that, 'Prison health and care services should be delivering standards of care, and health outcomes, for prisoners that are at least equivalent to that of the general population.'

1.2.2 In 2012 the Health and Social Care Act directed that healthcare services should be commissioned by NHS England/Improvement (NHSE/I). This responsibility was transferred to NHSE/I in 2013. NHSE/I commissions services via specialist regional teams.

1.2.3 NHSE/I health and justice commissioning teams use the principle of equivalence when commissioning healthcare in prisons. This means that people who are detained by the justice system should receive an equivalent level of health service to the rest of the population. However, for prisons financed through the Private Finance Initiative model, NHSE/I only commissions mental health and substance misuse services.

1.2.4 NHSE/I is also responsible for quality assurance within the commissioned services, which aims to ensure services meet their contractual obligations and deliver services to the required standards.

1.3 National Partnership Agreement for Prison Healthcare in England

1.3.1 The National Partnership Agreement (NPA) is an agreement between the MoJ, Her Majesty's Prison and Probation Services (HMPPS), Public Health England, the Department of Health and Social Care and NHSE/I (Fig 1). The NPA is set out in a document which details objectives for 2018-2021.



Fig 1 National Partnership Agreement for prison healthcare in England 2018-2021: co-signatories

1.3.2 The NPA sets out three core shared objectives:

- to improve the health and wellbeing of people in prison and reduce health inequalities
- to reduce reoffending and support rehabilitation by addressing health-related drivers of offending behaviour
- to support access to and continuity of care through the prison estate, pre-custody and post-custody into the community.

1.3.3 The NPA states that the three objectives will be delivered 'by focussing on 10 key priorities'. These priorities are detailed in the NPA

1.4 Her Majesty's Prison and Probation Service

1.4.1 HMPPS is an executive agency sponsored by the MoJ. It works with partner organisations to enable the sentences of the courts to be carried out, either in custody or the community.

1.4.2 Within England and Wales, HMPPS is responsible for:

- running prison and probation services
- rehabilitation services for ex-offenders leaving prison
- making sure support is available to stop people re-offending
- managing contracts for private sector prisons and services such as: - the Prisoner Escort and Custody Service - electronic tagging.

1.4.3 Through HM Prison Service it manages public sector prisons and the contracts for private prisons in England and Wales.

1.4.4 Through the National Probation Service it oversees probation delivery in England and Wales including through community rehabilitation companies (Her Majesty's Prison and Probation Service, n.d.)

1.5 Prison categorisation

1.5.1 Prisons for adult males are categorised by level of security. There are four categories, which are described in the Prison Service Instruction (PSI) 40/2011 (Ministry of Justice, 2011)(2) as follows:

'Adult male prisoners may be held in one of four security categories.

Category A

Prisoners whose escape would be highly dangerous to the public or the police or the security of the State and for whom the aim must be to make escape impossible.

Category B

Prisoners for whom the very highest conditions of security are not necessary but for whom escape must be made very difficult.'

Category C

Prisoners who cannot be trusted in open conditions but who do not have the resources and will to make a determined escape attempt.

Category D

Prisoners who present a low risk; can reasonably be trusted in open conditions and for whom open conditions are appropriate.'

1.5.2 Prisoners are assessed regularly to ensure they are being held in the most appropriate category of prison for the risk that they pose.

1.5.3 A Category B local prison serves the courts in its surrounding region, receiving prisoners straight after they have been convicted and those who have been put on remand. Prisoners are held there until they are allocated to other establishments following their categorisation assessment. Not all Category B prisons serve the same function.

(2) PSI 40/2011 was scheduled to expire in 2015 but is still in use.

1.6 Population Management Unit

1.6.1 The Population Management Unit (PMU) is a department within HMPPS that is responsible for the management of the prison population. One of its tasks is to ensure that local prisons have enough space to house prisoners that have been sentenced or put on remand by courts in the region.

1.6.2 The movement of prisoners is controlled from the PMU by area managers who monitor all categories of prison and the spaces available; dictating daily the numbers of prisoners to be moved between prisons.

1.6.3 The prison's Offender Management Unit (OMU) is informed of the details of required transfers. The prison's Offender Categorisation and Assessment (OCA) unit, which is a department within the OMU, is responsible for identifying suitable prisoners for transfer

1.7 Prisoner transfers

1.7.1 In 2018 there were nearly 614,000 prisoner movements⁽³⁾. The movements include the following, including any return journeys:

- police station to Crown/Magistrate's Court (29.7% - 182,452)
- police station to prison (3% - 18,248)
- Crown/Magistrate's Court to prison (55.5% - 340,858)
- prison to prison (10.7% - 65,735)
- other (1.1% - 6,690).

(3) Figures obtained from the Population Management Unit. They represent routine transfers of prisoners (see 1.8.1).

1.8 Inter-prison transfers

1.8.1 There are several reasons why prisoners may be transferred between prisons. Transfers may be routine (for example moving prisoners who were on remand and have received a custodial sentence, who need to access specific interventions, or whose security risk level has been re-categorised). Transfers may also occur in response to major incidents such as the disturbance at HMP Birmingham in 2016.

1.8.2 The number of inter-prison (prison-to-prison) transfers conducted in 2018 was just under 66,000. This equates to approximately 5,500 per month or 275 per day. The proportion of prisoners taking medication is reported as 44% of the whole prison population (House of Commons Justice Committee, 2013), which equates to approximately 120 prisoners with medication needs being transferred daily. These figures are based on a four-week month.

1.8.3 Routine inter-prison transfers are conducted on weekdays (Monday to Friday) for the purposes outlined in paragraph 1.8.1.

1.8.4 The above figures average out the daily transfer numbers across the week and do not reflect the fact that more prisoners are transferred on Mondays and Fridays, which are the busiest days for inter-prison transfers. 1.8.5 On Fridays there is a need to clear spaces in the Category B local prisons to ensure that there is capacity to serve the courts over the weekend.

1.9 Prison - National Offender Management Information System (p-NOMIS)

1.9.1 p-NOMIS is the single database used across the justice system for managing prisoners. It was introduced in 2004 by the National Offender Management Service, which is now HMPPS

1.9.2 A new suite of products is currently being developed, referred to collectively as Digital Prison Services, which will replace p-NOMIS.

1.9.3 p-NOMIS covers all aspects of a prisoner's management except for healthcare.

1.10 SystemOne

1.10.1 SystemOne is a clinical computer system produced by TPP (The Phoenix Partnership). It enables healthcare staff to record patient information securely in an electronic format. This information can then be shared with other healthcare professionals so that everyone caring for the patient is fully informed about their medical history, their current medical status, what medication has been prescribed and any allergies the patient may have.

1.10.2 SystemOne is currently used in GP practices, child health services, community services, prisons, hospitals, urgent care and out-of-hours services, palliative care services and many other settings.

1.10.3 SystemOne is the only patient care record system used within English prisons.

1.11 Person Escort Record (PER)

1.11.1 The PER is a mandatory form which must be completed prior to every prisoner transfer, regardless of the destination or purpose of the transfer. The PER must accompany the prisoner during the journey and be handed over to the receiving establishment on arrival. Completed PERs are kept on file by the receiving prison.

1.11.2 The PER contains details of the prisoner and their conviction, and a risk assessment for the transfer. It also contains details of any medical conditions that are relevant and medication that is accompanying the prisoner on the transfer.

1.11.3 The PER is a paper document which prisons order. An electronic version of the PER is currently being trialled but has not yet been rolled out across the country.

1.11.4 A copy of the healthcare section of the current version of the PER is shown at Fig 2.

OFFICIAL - SENSITIVE ONCE COMPLETE
MEDICAL AND SOCIAL CARE

ve		FIRST NAME & SURNAME	
HEALTH RISKS			
CONTACT NUMBER FOR HEALTH QUESTIONS			
RISK	DETAILS OF CURRENT & RELEVANT RISK		
HEALTH - MEDICAL			
HEALTH - MENTAL INCLUDING L&D ASSESSMENT			
SOCIAL CARE and OTHER VULNERABILITIES		Note any other vulnerabilities, hearing, poor sight, or other disability that would affect the escort	
		Does the person meet the definition of a person at risk?	YES / NO
		Does the person require support with personal care, mobility or meeting toileting / hygiene needs?	YES / NO
Comments			
KNOWN ALLERGIES			
NAME / ID No.	SIGNED	DATE	TIME
PRESCRIBED MEDICATION		YES	NO
PROVIDE DETAILS			LAST TIME MEDICATION TAKEN
			NEXT TIME MEDICATION REQ'D
MEDICATION	WITH ESCORT	YES / NO	
	WITH DETAINEE	YES / NO	
MEDICATION HANDED OVER BY (If different to above person)			
NAME / ID No.	SIGNED	DATE	TIME

Fig 2 Healthcare section of the Person Escort Record form

1.12 Her Majesty's Inspectorate of Prisons

1.12.1 Her Majesty's Inspectorate of Prisons (HMIP) is an independent inspectorate which reports on conditions in prison and the treatment of those in prison in England and Wales.

1.12.2 The responsibilities of Her Majesty's Chief Inspector of Prisons are set out in section 5A of the Prison Act 1952 (legislation.gov.uk, n.d.). They are to:

- inspect or arrange for the inspection of prisons in England and Wales and to report to the Secretary of State on them
- in particular, report to the Secretary of State on the treatment of prisoners and conditions in prisons
- report on matters connected with prisons in England and Wales and prisoners in them referred by the Secretary of State
- submit an annual report to be laid before Parliament

1.12.3 The number of HMIP healthcare inspectors undertaking each inspection varies depending on the establishment being inspected, but usually consists of two healthcare inspectors working in partnership with an inspector from each of the Care Quality Commission (CQC) and the General Pharmaceutical Council

1.13 Care Quality Commission

1.13.1 The CQC is the independent regulator for health and adult social care in England.

1.13.2 The CQC inspects prisons in conjunction with HMIP, measuring healthcare departments against the same criteria that are applied to other healthcare providers. CQC inspections ask the same five questions of all services:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people's needs?
- Are they well led? (Care Quality Commission, 2018).

1.13.3 For a routine prison inspection, the CQC provides one inspector to work with the HMIP healthcare inspectors. CQC inspection reports are amalgamated into the main report produced by HMIP, rather than being submitted separately.

1.13.4 The CQC may inspect a prison healthcare department if there is a concern with a certain area of the care being provided, or to conduct a re-inspection of an area, HMIP presence is not required. Under these circumstances the CQC inspector will produce a bespoke report.

2 The reference event

2.1 Martin's story

2.1.1 Martin, a 43-year-old man, was being held within a Category B local prison, where he had been housed since being taken into custody.

2.1.2 Martin had epilepsy since childhood; he informed the investigation that his mother and half-sister also have epilepsy.

2.1.3 To control his epilepsy, Martin was prescribed a 400mg, twice daily dose of Tegretol Prolonged Release. In interview Martin told the investigation, "Even with my meds I still have a couple of seizures a year." He also informed the investigation that the Tegretol stays in his system for a couple of days but on the second day (if he missed his doses) he "can feel the seizures coming on".

2.1.4 Martin had several other healthcare issues that were being treated with medication. At the time of the reference event he was on a drug and alcohol detoxification (detox) programme and a smoking cessation programme.

2.1.5 After sentencing, Martin was identified as a Category C prisoner by the Offender Categorisation and Allocation (OCA) department.

2.1.6 The reference event detailed below occurred approximately seven weeks after he was sentenced.

Thursday

2.1.7 The OCA in the Category B prison (the dispatching prison) received an email from the Population Management Unit (PMU) advising them of the numbers of prisoners that were to be transferred from their prison to regional Category C prisons. Ten prisoners were to be sent to two prisons the following day; five of these prisoners were designated to the Category C prison that Martin was transferred to.

2.1.8 The list of prisoners who were to be transferred was emailed to the SystemOne administrator in the healthcare department. After checking the list of prisoners against their healthcare requirements, the SystemOne administrator replied to the OCA confirming the prisoners' suitability for transfer. Martin was identified as suitable for transfer.

Friday

01:57 hours

2.1.9 Healthcare night staff reviewed Martin's Person Escort Record (PER) form for transfer the following day, and the form was signed. This confirmed that he was fit to be transferred.

07:00 hours

2.1.10 Martin was escorted to the medication hub to receive his morning medication, which was part of his daily routine; he was due to receive his second batch of medication at 17:30 hours. Martin's medication was provided, which he took under supervision to ensure it was taken correctly.

Unknown time in the morning

2.1.11 The prison officers informed Martin that he would be transferring to another prison and was to get himself ready, which involved packing his belongings and waiting to be processed.

2.1.12 Martin was moved from his accommodation wing and processed through the prison dispatch procedure. Registered mental health nurses (RMNs) conducted the healthcare aspects of the dispatch process.

09:55 hours

2.1.13 Martin was handed over from the dispatching prison into the custody of the contractor conducting the transportation. He was then taken to the Category C prison (the receiving prison).

11:35 hours

2.1.14 Martin arrived at the Category C prison. After the prison reception process was completed, he was taken to the healthcare department to be seen by a general practitioner (GP) and have his healthcare needs assessed.

14:04 hours

2.1.15 Martin's healthcare screening process was conducted by a nurse. The information was entered into Martin's electronic patient record on SystmOne after his arrival. The entries documented his medication, including the doses and times of administration. In addition, the system was updated to stop all Martin's prescriptions from the dispatching prison.

14:58 hours

2.1.16 As part of the reception screening process, a nurse documented Martin's medication status as 'Not in possession'(4). The nurse also documented that Martin had concerns about his physical health, including his epilepsy.

2.1.17 Martin informed the healthcare staff that he needed his epilepsy medication. He stated during interview, "I told them that without my meds I would have a seizure."

14:59 hours

2.1.18 The nurse made a medication reconciliation entry on SystmOne which listed all of Martin's medication as prescribed by the dispatching prison.

15:02 hours

2.1.19 The nurse then made an entry in Martin's health record to the effect that he had arrived with no medication from the dispatching prison.

2.1.20 At the same time an urgent priority task was sent to the Doctors Group(5) on SystmOne, requesting for the prescriptions to be created so that the medication could be ordered. The entry stated, 'Please could you prescribe all this mans [sic] meds - not arrived with any meds - we will arrange a delivery tomorrow.' Collection of any medication not held in stock was to be arranged for the following morning (Saturday) if the prescription was received in time for submission to the pharmacy.

15:03 hours

2.1.21 A second urgent priority task was sent to the Doctors Group, again requesting that all Martin's medication be prescribed.

19:16 hours

2.1.22 The duty manager of the healthcare provider responded to the second task and marked its status as 'Completed' on SystemOne. It was noted by the investigation that the duty manager was a GP and was working remotely from home.

19:18 hours

2.1.23 The duty manager of the healthcare provider responded to the first task and marked it as 'Completed' on SystemOne.

Saturday

08:13 hours

2.1.24 A nurse realised that the prescription for Martin's epilepsy medication had been missed the previous evening. She sent another task to the Doctors Group which read, 'Hi The Tegretol has not been re-prescribed when asking for new scripts. This man is epileptic we need this urgently. Thanks.'

08:14 hours

2.1.25 The same nurse then sent the following urgent priority task to the Pharmacy Group: 'The Tegretol has not been prescribed for this man when the other scripts have been done. I have tasked the GP group please chase and get back urgently Thanks.'

12:23 hours

2.1.26 The Pharmacy Group task was updated as follows: 'Dr [X] stated she has done the script Saturday so please print and get signed Monday please Thanks.'

Sunday

15:01 hours

2.1.27 The healthcare department was alerted to the fact that Martin was having a tonic-clonic(6) seizure. During the seizure he was looked after by prison officers until a nurse arrived approximately five minutes after the start of the seizure. Martin was laid on his side and had his head supported by a pillow; he had vomited a small amount, but his airway was clear. Martin stopped shaking and came around approximately two minutes after the arrival of the nurse. The total seizure time was approximately seven minutes. He was drowsy but the nurse was able to explain to him what had happened.

While the nurse was with him Martin had a second seizure. After clearing the cell for privacy, the nurse administered rectal diazepam(7) , which stopped the seizure. The second seizure lasted approximately two minutes. Martin stated to the investigation that when he has seizures they tend to come in clusters.

15:01-16:38 hours

2.1.28 The emergency services were called and an ambulance with two crew members arrived and attended to Martin in his cell. During the time they were in the prison with Martin he had two smaller seizures.

16:38 hours

2.1.29 Martin was taken to the local emergency department (ED), where he was assessed and administered Tegretol. It was reported to the investigation that the ED consultant expressed their frustration that Martin did not have his epilepsy medication available to him.

2.1.30 Martin spent the next three hours in the ED before being discharged and taken back to the prison.

Monday

15:30 hours

2.1.31 The Pharmacy Group task that had been sent at 08:14 hours on Saturday was updated on SystmOne and marked as 'Completed'.

15:47 hours

2.1.32 The Doctors Group task that had been sent at 08:13 hours on Saturday was updated on SystmOne with 'Done by Dr [X]'. The task was also updated as 'Completed'.

17:30 hours

2.1.33 Martin was given his first dose of Tegretol Prolonged Release 400mg, which he has received twice a day since.

(4) Not in possession prisoners are not allowed to hold their own medication.

(5) A pre-defined distribution list for the SystmOne messaging system.

(6) A tonic-clonic seizure, previously known as a '**grand mal**', is what most people think of as a typical epileptic fit.

(7) A sedative drug commonly used to stop epileptic seizures.

3 Involvement of the Healthcare Safety Investigation Branch

3.1 Referral of the reference incident

3.1.1 The Healthcare Safety Investigation Branch (HSIB) identified an issue within the criminal justice system concerning the management of chronic health conditions in prisons. The concern focused on the continuity of care for prisoners with chronic health conditions, specifically relating to the management of their medication when they were being transferred between prisons. Martin's case was identified as fitting into this scenario and was selected as the reference incident.

3.2 Decision to investigate

3.2.1 Following preliminary information gathering, HSIB concluded that the safety issues represented by this event met the criteria for investigation. HSIB's Chief Investigator authorised a national investigation.

3.2.2 A summary of the analysis against HSIB's investigation criteria is given below.

Outcome impact - What was, or is, the impact of the safety issue on people and services across the healthcare system?

3.2.3 Large numbers of prisoners are transferred between establishments every day. Within the prison population as a whole, 44% of prisoners report taking medication (House of Commons Justice Committee, 2013); this figure rises to 70% for older prisoners. The discontinuation of medication for chronic conditions, even for a short period of time, can have potentially serious adverse health effects. Discontinuity of medication during prison transfers is a widely recognised issue among prisoners and prison healthcare staff. There are conflicting priorities, policies and requirements among all those involved in transferring prisoners (prisoner, the dispatching and receiving prison, healthcare staff and healthcare provision). Harm caused by the disruption of routine medication results in prisoners being taken to local emergency departments, or ambulance services being called to prisons. Either outcome also has an impact on prison security staff who are taken away from normal duties.

Systemic risk - How widespread and how common a safety issue is this across the healthcare system?

3.2.4 The safety issue affects a large number of similar settings spread across a wide geographic area and across all parts of the prison system, prison healthcare, and acute and primary care. The safety issue is identified readily through normal processes of monitoring and detection and appears to be persistent.

Learning potential - What is the potential for an HSIB investigation to lead to positive changes and improvements to patient safety across the healthcare system?

3.2.5 Initial observations highlight that only local level actions have been taken to address this issue, which although adequate, may impact upon other areas of the system. Investigating the safety issue from a different perspective could result in systemic safety recommendations and improvements.

3.3 Evidence gathering and investigation methods

3.3.1 The investigation used two methods of analysis, one that examined the incident by plotting the sequence of events within it, and another that focused on the work activities carried out in relation to the incident:

- Sequentially Timed Events Plotting (STEP)
- Functional Resonance Analysis Method (FRAM).

3.3.2 The analysis methods were used simultaneously throughout the investigation and were used to analyse different aspects of the issue, whilst providing a cross reference and check for each other

3.4 Investigation scope

3.4.1 Following the initial phase of the investigation, the investigation scope was set to ensure that realistic and valuable results could be achieved within a timeframe of approximately one year.

3.4.2 To ensure the investigation's objectives were met, only inter-prison transfers were considered to be in scope. The following types of inter-prison moves were excluded from the scope of the investigation:

- transfers to Category A prisons
- all security moves(8)

- rehabilitation moves
- moves involving one prisoner for relocation or perhaps to attend court or a course
- emergency moves to clear prisons in an area in anticipation a high-profile large gathering, for example the G8 Conference, an England football match or disturbances at other prisons where evacuation of large numbers of prisoners may be required.

3.4.3 All the moves considered to be out of scope had security implications or nuances that meant the learning from these incidents would be minimal in the context of the reference event, routine transfers and the HSIB's ability to influence the prison system. However, the majority of inter-prison transfers fall within the scope of the investigation.

(8) Moves conducted at short notice due to prisoner conflict, riots etc.

4 Findings and analysis of Martin's management in relation to national and local guidance and policy

4.1 Prison policies

4.1.1 Prison Service Order (PSO) No 3050 - Continuity of Healthcare for Prisoners

4.1.1.1 PSO 3050 (Her Majesty's Prison Service, 2006) provides guidance for prisons and their healthcare departments, to ensure continuity of care for prisoners during 'reception, transfer and discharge of prisoners, with particular focus on those with ongoing health needs'.

4.1.1.2 Chapter 5 of the PSO specifically deals with the transfer of prisoners. The chapter covers all aspects of transfers including prisoners with complex medical needs and clinical holds⁹.

4.1.1.3 Chapter 5.4 states:

'Previously prisoners have been passed 'fit' for transfer. In future, local policies should ensure that there are systems in place to ensure appropriate and continuing clinical care in any transfer or release. These should include systems for:

A clinical hold

B restrictions on transfer

C continuity of care between establishments.'

4.1.1.4 Martin was transferred without his medication. The head of healthcare for the dispatching prison stated that 'prior to the incident, [not in possession] medication wasn't sent with the prisoners'. However, he also gave information about scenarios where medication had been sent to receiving prisons after the transfer had occurred following complaints by the receiving prisons. The methods used included healthcare staff driving to the receiving prison and prison officers taking taxis to the receiving prison in order to deliver medication.

4.1.2 Offender Categorisation and Allocation (OCA) department policy

4.1.2.1 The dispatching prison OCA staff told the investigation that they always tried to give the healthcare department 24 hours' notice of any prisoner moves. However, due to operational pressures and changing numbers of prisoners needing to be transferred, this was not always possible. The Royal Pharmaceutical Society's standards for optimising medicines for people in secure environments set out that prisoners should be transferred with seven days' of medication (see paragraph 5.2 for more details). There was awareness among the OCA staff who spoke to the investigation that the short lead-times for prison transfers made it difficult for the dispatching prison's healthcare department to order medication in time to meet this standard.

4.1.2.2 The timeframe within which the dispatching prison healthcare department should be notified of prisoners identified for transfer was not documented anywhere. When asked, staff told the investigation that they were aware they needed to give the healthcare department enough time to prepare the prisoner for transfer, but other than an inter-departmental understanding there was nothing detailed in any policy.

4.1.3 Dispatching prison transfer policy

4.1.3.1 The dispatching prison healthcare department changed its internal policy following the reference event. The investigation was supplied with a flowchart that had been put into place for staff in an attempt to ensure that prisoners were not transferred without medication again.

4.1.3.2 The feedback from the receiving prison was that this had improved things and that it was now less likely that prisoners would arrive without their medication. Representatives of the two prisons' healthcare departments spoke to each other after the reference event, resulting in the drafting of the new policy.

(9) A clinical hold prevents a prisoner from being transferred on the basis of medical need.

4.2 Identification of Martin for transfer

4.2.1 The identification process started with the Population Management Unit (PMU) looking at an overview of the prison population. After identifying capacity in the surrounding prisons and estimating the spaces required in the local prisons, the PMU decided on transfer numbers. The PMU sent a standard format email to the dispatching prison stating the numbers that were to be transferred and the prisons they were to be transferred to.

4.2.2 The OCA staff in the dispatching prison used the Prison-National Offender Management Information System (p-NOMIS), which holds all the information they required to identify prisoners suitable for transfer to the prisons specified by the PMU.

4.2.3 The OCA staff determined that there were approximately 700 prisoners who were suitable for transfer to Category C prisons. This number was significantly reduced when other criteria were applied, for example, sentence length, hospital appointments, court appearances etc.

4.2.4 It was reported to the investigation that OCA staff often found it difficult to identify enough prisoners who were suitable to be transferred. This would be fed back to the PMU, and subsequently the OCA would be told to identify prisoners who were 'best fit' for transfer. A 'best fit' prisoner is considered a prisoner who is the closest to meeting the criteria for the receiving prison, but would not normally be considered for transfer.

4.2.5 Martin had several medical needs, including a detoxification programme, which required multiple medicines to be taken. In some prisons, he may have been considered to be a 'complex' patient. Staff in the receiving prison stated that Martin may have been considered a complex patient and, therefore, not suitable for transfer. The investigation did not identify any prison service policies that specifically addressed the issue of prisoners with complex medical needs and their suitability for transfer. However, PSO 3050 Chapter 5.12 states: 'patients with more complex health care needs may require more detailed planning such as communicating directly with the receiving health care team in advance of transfer'.

4.2.6 This policy would not have precluded Martin from being transferred. The section of the PSO which covers the transfer of prisoners with significant health issues does not particularly deal with prisoners in the same situation as Martin. Martin was identified as suitable for transfer and was not deemed a 'best fit' transferee. However, because of his multiple treatment plans, whether or not he should have been considered for transfer was a point of debate during the investigation.

4.2.7 To complicate matters for the dispatching prison, Martin's participation in a detoxification (detox) programme would ordinarily place him in a detox wing, which the OCA staff told the investigation would likely exclude him from their consideration for transfer despite the policy. There was a consensus among the staff that, where possible, prisoners on detox programmes should not be transferred. However, Martin had asked not to be placed on a detox wing and his request had been granted. This meant that the OCA staff were unaware of his participation in the detox programme

4.3 Preparation of Martin for transfer

4.3.1 Martin was identified by the OCA clerk as being suitable for transfer and placed on the transfer list on Thursday for transfer the following day.

4.3.2 The healthcare administrator checked Martin's medical records on SystemOne to see if there were any reasons why he could not be transferred. In line with the prison policies at the time, there were no reasons for the transfer to be stopped. The transfer list was agreed by the healthcare administrator, who sent a confirmation email to the OCA, although it was not possible to identify exactly what time that agreement was made.

4.3.3 The continuity of Martin's care between establishments was not considered adequately enough to ensure that it was achieved. PSO 3050 Chapter 5.12 states: 'An up to date patient summary card [significant events/ problems page], the clinical record and a sufficient supply of medication will often be all that is required.' The ordering of seven days of medication for prisoners being transferred was not routinely conducted at that time.

4.3.4 No medication order was placed to enable the dispatching prison to receive the medication in time for it to accompany Martin to the receiving prison. This was primarily due to the time that the transfer list was ratified. In addition, the investigation noted that there was no on-site pharmacy at the dispatching prison; an on-site pharmacy may have been able to meet the short lead-time. 4.3.5 Martin

was given his morning medications, which included Tegretol Prolonged Release 400mg, at 07:00 hours on the day of transfer. This was the last time he received his medication before having seizures on Sunday afternoon.

4.4 Person Escort Record (PER) form

4.4.1 The PER was completed at the dispatching prison. Martin was assessed by the healthcare department as 'fit for transfer', allowing him to be transferred. On the front page of the form there is a section where health risks of the prisoner that should be considered during the transfer can be detailed. The section allowed the healthcare staff to detail both medical health risks and mental health risks. This section was completed on the morning of the transfer; the time of completion was recorded on the form as 01:57 hours. There is another box on the form relating to medical matters, entitled 'Prescribed Medication'. This box was left blank (Fig 3), which reflected the situation, as Martin was transferred without his medication.

Prescribed medication		Yes	No
With escort	<input type="checkbox"/>		
With person/detainee	<input type="checkbox"/>		
Name	<input type="text"/>	Signature	<input type="text"/>
It is not essential to list medication below. Refer to Guidance opposite for instructions.			
<input type="text"/>		<input type="text"/>	
<input type="text"/>		<input type="text"/>	
<input type="text"/>		<input type="text"/>	
<input type="text"/>		<input type="text"/>	

Fig 3 Prescribed Medication box on Martin's PER form

4.5 Safe prescribing environment

4.5.1 The receiving prison does not have 24/7 healthcare (healthcare is available between 07:30 hours and 19:30 hours, Monday to Friday). Prescription capability is covered by a combination of general practitioners (GPs) and an advanced nurse practitioner (ANP). Ordinarily a GP would have been available in the prison on

Fridays; however, on the day of the reference event the GP was absent due to illness. The ANP did not work on Fridays, which left the healthcare department without an authorised prescriber on the day of the transfer.

4.5.2 Prescribing medication for prisoners being transferred on Mondays through to Thursdays would not have been an issue, as the medication order could have been placed and received the next day. However, the reference event started with the transfer on a Friday; medication ordered on Fridays at the receiving prison could not be delivered until Monday. However, it is important to note that if a signed FP10 prescription form (the standard prescription form used in England) was delivered to the local pharmacy then the medication could have been dispensed immediately.

4.5.3 The healthcare department did not have an on-site prescriber at weekends. For in-stock medications this did not cause an issue; Martin's other medications were prescribed electronically by the duty manager, who was working remotely, and Martin received them accordingly. For out-of-stock medication, the healthcare department needed to order the medication from the local pharmacy, which required a signed FP10. However, with no GP or authorised prescriber on-site this was not possible.

4.5.4 Without a proven, trusted, recovery plan(10) the receiving prison was left with a system with a single point of failure for not-in-stock medication. On Mondays to Thursdays this would result in a maximum delay of one day for the prisoner receiving their medication. However, because the system failure took place on a Friday, it resulted in a three-day wait for medication.

HSIB makes the following safety observation

1 It would be beneficial for healthcare providers to ensure that there are robust mechanisms in place for accessing urgently needed medicines in order to minimise the risk of patients missing doses.

4.6 Out-of-hours GP service

4.6.1 The NHS out-of-hours GP service is accessed through the NHS 111 service. The recovery plan for the medication, as detailed by the healthcare provider's policy, would have been to access the GP out-of-hours service, which would allow the healthcare staff to obtain a signed FP10, thus enabling them to order the medication through the local pharmacy.

4.6.2 The staff did not use this option because of reported occurrences of push-back from the out-of-hours GP service about prescribing medication without seeing the prisoners. A member of staff told the investigation that there was no point in calling the NHS 111 service as “they’re not happy about doing prescriptions”.

4.6.3 The perceived reluctance of the GP out-of-hours service to sign FP10s meant that the receiving prison’s healthcare staff were not able to acquire the signed prescription needed to obtain Martin’s medication from a local pharmacy. This medication would likely have prevented Martin having seizures on the Sunday afternoon.

4.6.4 Prisons’ healthcare provision should not rely on recovery plans for prisoners arriving without their medication. The reference event would not have occurred if Martin had been transferred with his medication. However, the event has highlighted an area of the system which was fragile and may impact upon other scenarios, not just the arrival of prisoners without not-in-stock medication.

4.7 Clinical hold

4.7.1 It was the dispatching prison’s policy not to automatically exclude prisoners on detox programmes from transfer. A decision about whether to place a prisoner on clinical hold (which would prevent the prisoner being transferred for medical reasons) would be based on the stage they were at in their detox programme and the type of programme they were on. Martin was not put onto a clinical hold.

4.7.2 The decision not to place Martin on clinical hold had a direct impact on the reference event. The transfer of prisoners who have complex medical needs or multiple medication requirements increases the risk of the prisoner being transferred without sufficient measures in place to ensure continuity of care between establishments.

HSIB makes the following safety observation

2 There may be benefits to prisons’ healthcare providers having sufficient numbers of authorised prescribers to ensure that a safe prescribing environment is maintained in prisons to meet the standards of service provision they are contracted to provide

4.8 Information technology systems

4.8.1 SystemOne, the electronic health record system, was updated throughout the process of dispatching Martin to, and receiving him at, the two prisons. From an information technology (IT) perspective, the handover of care worked as expected. The process for transferring care to a different establishment is based on a 'pull-system'; when Martin arrived at the receiving prison the healthcare staff pulled his medical records forward and could then access them as required.

4.8.2 Martin's medical records were not accessible to prison officers. The decisions prison officers made about Martin's transfer were based upon prisoner behaviour and categorisation. Once the decision was made to transfer Martin, the healthcare department was consulted to ensure that there was no medical reason for this not to happen.

4.8.3 Communication between the OCA and the healthcare department was conducted by email. The transfer list was sent back and forth numerous times during the reference event before a ratified list was reached.

4.8.4 The Prison-National Offender Management Information System (p-NOMIS) was used by the prison staff in the OCA to identify Martin and the other prisoners that were to be transferred.

4.8.5 The two IT systems (SystemOne and p-NOMIS) have no direct interoperability and, therefore, no information was passed between them to highlight to staff in the OCA, or in the healthcare department, that prisoners were being selected for transfer or were unfit for transfer. The result of this was the email traffic between the departments to ratify the transfer list. It was reported to the investigation that this was a daily occurrence and occasionally took considerably longer than it did during the reference event.

4.9 Receipt of Martin

4.9.1 No preparation for receiving Martin was conducted by the receiving prison, the preparation was limited to waiting until he had arrived at the prison. There was no forward communication from the dispatching prison to the receiving prison.

4.9.2 The lack of communication meant that the operational staff in the receiving prison were unable to alert the healthcare department to his arrival.

4.9.3 In addition, Martin had not been granted 'in possession' status, due to his security classification and the risk assessment carried out when he was first put into prison. This meant he was not allowed to hold his medication, or a supply of it, in his cell or on his person and instead had to attend the healthcare department/dispensing centre to receive his medication. This put Martin in a position of complete reliance upon the healthcare department for his medication. Whilst this is not an uncommon situation, it reduces the flexibility of the system, as in possession status prisoners will have a supply of their medication prior to transfer.

4.9.4 Upon his arrival Martin was assessed by the healthcare staff for his medical needs, in line with prison policy. This was documented in his notes on SystmOne. The staff member who assessed Martin realised that he had been transferred without his medication, resulting in tasks being sent to the relevant groups on SystmOne.

4.10 Emergency department visit impact

4.10.1 The number of prisoners visiting the emergency department (ED) local to the receiving prison was quite low, with an average of 100 visits per annum.

4.10.2 When prisoners arrive at the ED they are always accompanied by at least two prison officers. They are handcuffed and wearing their prison clothes. The ED places prisoners into a 'majors' cubicle (usually assigned for patients with serious/urgent health problems) so they are hidden from view. This aims to reduce stress among ED staff and other patients, whilst also protecting the dignity of the prisoner.

4.10.3 The result of this is that a majors cubicle is occupied for the duration of the visit, regardless of the condition of the prisoner. In the ED involved in the reference event this accounted for 10% of its capacity. Martin was treated according to his medical priority.

4.10.4 Over the two-year period until 4 September 2018, the ED had received 200 prisoners requiring attention. The vast majority of the visits were for physical injury. There were six cases of prisoners having seizures (this included Martin) and 15 cases of worsening asthma or hypertension.

4.10.5 Even with a low attendance rate over the two-year period, the ED manager stated that "the impact on the ED had been fairly considerable". Martin was in the ED for approximately three hours, occupying a majors cubicle for the duration.

4.10.6 Due to the unplanned nature of the hospital visit, the operational side of the prison was also affected by the reference event. The prison was required to provide two officers to escort Martin to the ED. These officers were taken from other duties.

4.10.7 When hospital appointments are made, the prison can plan for the officers being away and can arrange for extra officers to provide cover. In the reference event, two officers were out of the prison, at short notice, for over three hours.

In addition, prison officers spent time maintaining security and treating Martin in his cell before the healthcare staff arrived and while Martin was being treated by the paramedics. This unplanned reallocation of prison officers' time has a knock-on effect on the running of the prison. It can result in restrictions to the prison's regime and may increase the amount of time prisoners are locked in cells.

5 Findings and analysis from the wider investigation

5.1 National guidance

5.1.1 Prison Service Order (PSO) 3050, Continuity of Healthcare for Prisoners (Her Majesty's Prison Service, 2006) is the key national guidance that applies to inter-prison transfers and healthcare.

5.1.2 Paragraph 4.5.2 of the PSO states: 'Alternative service models may also be appropriate where patient numbers, security risk and availability of clinical facilities indicate. Such models might include:

- Members of specialist teams visiting the prison
- Arranging with local trusts that hospital and A&E waiting times take place in the prison allowing prompt access on arrival
- Telemedicine.' Elements of this were seen during the investigation, with telemedicine facilities common in all prisons visited. However, the investigation did not see any evidence of the other alternative models being used.

5.1.3 Chapter 5 of the PSO is titled 'Transfer of prisoners'. It sets out what should be done to ensure continuity of care for prisoners before, during and after transfer. This should not differ whether it is a transfer between establishments within the health and justice system or a transfer to the community.

5.1.4 Paragraph 5.3 states that continuity of care should be ensured for the prisoner by, among other things:

- 'Ensuring information on continuing care is conveyed to other establishments on transfer and to NHS hospitals for outpatient and in/ outpatient appointments
- Medication, appropriate to clinical need, is provided to ensure supply until a GP prescription can be obtained.'

5.1.5 The PSO is available electronically and hard copies were available in most of prisons the investigation team visited. It is also available on the internet and can be found at: <https://www.justice.gov.uk/offenders/psos>

5.1.6 It was evident throughout the investigation that prisons across the country were applying the PSO in different ways and with different levels of effectiveness. The PSO is written in a way which allows prisons to apply it in the most effective manner to suit the needs of the individual prison. However, the varied way in which the PSO is applied creates variety in practice and effectiveness, which means continuity of care for prisoners is not being ensured.

5.2 Royal Pharmaceutical Society (RPS) standards

5.2.1 The standards set out in RPS's document, Professional standards for optimising medicines for people in secure environments (Royal Pharmaceutical Society, 2017), are divided into five domains. Domain 1 is entitled 'Arriving and meeting people's initial medicines needs'. Standard 1.2 details that critical medicines needed by people are accessed and continued during and outside healthcare and pharmacy core hours.

5.2.2 Specifically, the standard states: 'services are modelled to maximise people's access to medicines during initial hours following admission to enable continuation of current critical medicines or initiate medicines if necessary'.

5.2.3 Domain 3 is entitled 'People can continue to take their medicines if they are released or transferred elsewhere'. The domain covers standards required to ensure that prisoners can access their medication when they are transferred between establishments within the secure environment.

5.2.4 Domain 3, 'Standard 12. People have access to a supply of medicines once they leave' states that people should have sufficient medicines when they are transferred to ensure continuity of care between establishments. It also states in

Standard 12.1 that: 'This supply will be for a minimum of 7 days'. In the reference event, this standard was not met and was not referred to by the dispatching prison during the investigation.

5.2.5 Standard 12.2 states: 'People can receive substance misuse medication and other not in possession doses of "once daily" medicines before they leave to maximise the time available before their next dose'. This standard was met by the dispatching prison, as Martin was given his morning medications at 07:00 hours. There was no further action taken to ensure compliance with the other RPS standards.

5.3 Care Quality Commission (CQC)/ Her Majesty's Inspectorate of Prisons (HMIP) inspections

5.3.1 Handbooks and guidance for CQC and HMIP health inspectors set out the areas and topics they must inspect. The CQC handbook (Care Quality Commission, 2015) gives healthcare providers information on how inspections are conducted in the health and justice environment.

5.3.2 During inspections the CQC and HMIP inspectors gather evidence in partnership and against both organisations' inspection frameworks.

5.3.3 HMIP has two key documents for the inspection of adult male prisons. One is a guide for inspectors on how to conduct an inspection (Her Majesty's Inspectorate of Prisons, 2018) and the second details the expectations or standards that are required (Her Majesty's Inspectorate of Prisons, 2017)

5.3.4 CQC inspection guidance

5.3.4.1 The inspection teams from CQC follow the 'Key Lines of Enquiry, Prompts, Characteristics' as set out in the handbook. There are two key lines of enquiry (KLOE) within the 'Are they effective?' question, which are relevant to inter-prison transfers. They are:

- 'E.4 How well do staff, teams and services work together to deliver effective care and treatment?
- 'E.5 Do staff have all the information they need to deliver effective care and treatment?'

5.3.4.2 Prompt 3 from the first KLOE (E.4) asks: 'Do staff work together to assess and plan ongoing care and treatment in a timely way when detainees are due to move between teams or services, be transferred to another secure setting or be

removed or released?’ The question points towards making plans for inter-prison transfers to ensure ongoing care and treatment, which implies continuity of care and the availability of medication during that process.

5.3.4.3 There are five characteristics listed that clarify the question for the healthcare providers and therefore indicate what the inspectors would look for. Characteristic one and five have some relevance to the transfer of prisoners:

- ‘Detainees with continuing health and social care needs are prepared and assisted to access services in the community prior to their release.’ •
- ‘Services promote continuity of health and social care on release.’

5.3.4.4 Both of the above characteristics focus on the release of the prisoner and not on the transfer of the prisoner to another secure setting, such as a routine inter-prison transfer. None of the other characteristics refer to transfer or continuity of care; they deal with accessing addiction or contraception clinics.

5.3.4.5 Although prompt 3, detailed in paragraph 5.3.4.2, refers to prisoners being transferred to another secure setting, there is no detail in the following characteristics to describe any part of an inter-prison transfer for the inspectors to assess the prison against.

5.3.4.6 Prompt 2 from the second KLOE (E.5) asks:

- ‘When people move between teams and services, are transferred to another secure setting or are removed or released, is all the information needed for their on-going care shared appropriately, in a timely way and in line with relevant protocols?’

This prompt is phrased similarly to the prompt within KLOE E.4 (see 5.3.4.2). It clearly references transfers between secure settings, which encompasses routine inter-prison transfers.

5.3.4.7 The first characteristic within prompt 2 of KLOE E.5 states: ‘Staff can access the information they need to assess, plan and deliver care to people in a timely way, particularly when people move between services or during transition.’

This characteristic applies to both the dispatching and receiving prisons. Staff at the dispatching prison are required to prepare the prisoner, from a healthcare perspective, for the transfer and this is often limited by the short notice they are

given. The amount of notice the receiving prison is given of arriving prisoners and their healthcare requirements will allow them to prepare for their arrival, possibly enabling them to put measures in place to ensure continuity of care.

5.3.5 HMIP inspection guidance

5.3.5.1 HMIP's Guide for inspectors informs inspectors of the conduct that is expected of them and how to approach the inspection, and provides information about timelines for contacting the different departments of the prison. The healthcare inspectors are advised to contact the healthcare department in the first week of the prison inspection in order to gather information, to minimise disruption to the department during the inspection the following week.

5.3.5.2 HMIP's document, Expectations - Criteria for assessing the treatment of and conditions for men in prisons sets out the standards that are expected of the prison, and, therefore, the measures the inspectors will check against.

5.3.5.3 Three paragraphs within the 'Health, well-being and social care' section cover aspects of the inspection that are relevant to inter-prison transfers:

- 'Patients are cared for by services that accurately assess and meet their health, social care and substance use needs and which promote continuity of health and social care on release.'
- 'Patients' individual ongoing health care needs are addressed through an appropriate range of care services. Continuity of care is maintained on transfer or release.'
- 'Prisoners receive community-equivalent, person-centred medicines optimisation and pharmacy services.'

5.3.5.4 The first paragraph describes methods of evidencing the care, the last of which is 'Information is shared within the bounds of medical confidentiality to promote continuity of care and maintain patient safety'. This would be relevant to sharing information with the operational side of the prison, ensuring that medical appointments are kept, for example, by providing escorts for the appointments. Sharing information with the Offender Categorisation and Assessment (OCA) unit would also come under this expectation.

5.3.5.5 The second paragraph lists the following indicators of evidence for continuity of care being maintained, both during release to the community and inter-prison transfers:

- 'Prisoners can access all necessary primary care services, including pain management, memory/dementia support services and effective out-of-hours GP services, within equivalent waiting times to the community.'
- 'Patients receive secondary care services within community-equivalent waiting times and care is not disrupted by prison transfers.'
- 'Timely joint working with relevant internal and external departments/services supports continuity of care.'

5.3.5.6 These three indicators, which focus on continuity of care and equivalence of care, are relevant to the reference event. The investigation found evidence that prisons are regularly failing to put in place measures which would achieve the standards of care set out in the expectations and accompanying indicators. Some prisons gave examples of processes they had introduced in an attempt to improve care, however, they have not always been able to make the necessary improvements. The investigation also identified that other prisons had made no attempt to introduce measures to prevent standards falling below those set out in the expectations.

5.3.5.7 The third paragraph details expectations to ensure medicines optimisation where:

- 'Any disruption in prescribing regimens is minimised and urgent/critical medicines can be accessed promptly.'
- 'Prisoners going to court or being released/ transferred receive adequate supplies of medication or a community prescription to meet their needs.'

5.3.6 An inspection team looks at a sample of recent incidents, deaths and complaints and may follow them up to assess patient outcomes.

5.3.7 During interviews with staff at prisons around the country, the investigation was told that the inspections did not routinely look at inter-prison transfers from start to finish, following the prisoner through their pathway.

5.3.8 When comparing the inspection of prisoner transfers within the prison service and transfers of prisoners who were being discharged into the community, CQC inspectors will talk with staff, review a sample of records of current detainees and those who have recently been discharged, observe the discharge process and talk

to detainees about their experience. Although they will follow a prisoner from the start of the discharge process through to their care in the community, to ensure the continuity of care from the prison system into the community is maintained, they currently do not assess the complete prisoner pathway during transfer between prisons.

HSIB makes the following safety recommendation:

Recommendation 2019/047:

It is recommended that the Care Quality Commission amends its inspection criteria to ensure that inter-prison transfer processes are fully encapsulated within the inspection schedule to assure the provision of care throughout.

5.4 Health and Social Care Committee Report

5.4.1 In October 2018 the Health and Social Care Committee (HSCC) published its report on prison health (House of Commons Health and Social Care Committee, 2018). The government response to the report was published in January 2019.

5.4.2 In Chapter 4 of the report, entitled 'People's journey through prison', under the section 'Experiences of health and social care', paragraph 68 states: 'Prisoners can experience delays in getting access to medicines, including medicines they've been prescribed before they enter prison or when they are transferred to another prison.' This is the only time that inter-prison transfers are mentioned in the report, with the rest of the paragraph describing how prisoners may be bullied for their medication, which causes wariness among healthcare staff about prescribing the medicines. The report does not make any specific recommendations about inter-prison transfers or any of the issues identified during the investigation.

5.4.3 The government response does not discuss inter-prison transfers, and therefore does not mention putting any actions in place to deal with this subject.

5.4.4 In the next section, Medical Appointments, the report states that 'prisoners can also wait too long for external appointments', which can be due to the requirement for an escort by prison officers. The investigation was told that, depending on the prisoner and their perceived security risk, this would normally involve two to three prison officers. This section also states that 'escorts are allocated to those in most immediate need rather than someone who may have an appointment, such as a cancer investigation or treatment appointment that is

urgent but not immediately life threatening'. Whilst this may not have been relevant in the reference event, with the emergency occurring on the Sunday, there are other emergency cases nationally which have occurred during inter-prison transfers between Monday and Friday.

5.4.5 The report recommended that 'The Government in its response should set out how it intends to drastically reduce the number of missed appointments both in and outside of prison across the prison estate to ensure that clinical need is always met'.

5.4.6 The government response, in Section 7 under the heading, Workforce, indicates that it will put measures in place to increase prison officer numbers and retain those officers already employed. In addition, it would allow prisons to divert from their standard working day and innovate new working regimes, adding flexibility to the system. There was no plan to reduce the number of emergencies arising from inter-prison transfer issues, which divert staff away from their duties, because this issue was not highlighted in the HSCC report.

5.4.7 A reduction in emergencies arising during the inter-prison transfer process should assist the government in reducing missed appointments, whilst helping to reduce pressure on healthcare and prison staff.

5.5 Information technology (IT) systems

5.5.1 The two key IT systems in use in prisons have no direct interoperability. It is possible to perform a manual upload from p-NOMIS to SystmOne, which updates information such as prisoner cell location. This information is updated on a daily basis. Staff within the prison environment, who are required to access both systems, must access the systems via individual terminals with respective accounts for each system. Information that is relevant to both systems must be entered on each system, with information being copied from one system to the other manually. This creates an entry point for error that could be eliminated by the automatic transfer of appropriate information between the systems. This would also support the interoperability concept of 'Input once use many times' which has benefits for both the patient and the system user (The Office of the National Coordinator for Health Information Technology, 2019).

5.5.2 The investigation asked staff what would make their work easier; a common theme in their responses was "a single IT system throughout". At a minimum, information passage between the two systems would make tasks easier for both healthcare and prison staff.

5.5.3 The lack of interoperability between the two IT systems has resulted in inefficiencies in the system. Information-sharing between prison staff and healthcare staff is done by email or telephone calls. Prisons visited during the investigation told of occurrences where it had taken until 02:00 hours on the day of transfer to ratify transfer lists. This gave the healthcare department very little time to prepare prisoners for their move, especially with regards to making arrangements for their medication. This would frequently result in a prisoner being transferred without their medication, putting pressure on the receiving prison to reconcile their medication upon arrival.

5.5.4 However, it is important to note when considering interoperability between the two confidential systems, that sharing of information should not impinge on the confidentiality requirements of either system.

5.5.5 Health and Justice Information Services

5.5.5.1 The Health and Justice Information Services (HJIS) is an IT programme owned by NHS England/Improvement which aims to provide continuous healthcare communication and information throughout a prisoner's passage through the justice system. The system will aim to provide the following benefits:

- patient records can be transferred between health and justice organisations
- records can be passed back to community NHS services when leaving the justice system
- patients can register with a justice healthcare team as their registered GP service for continuity of care
- access to NHS Spine services (IT infrastructure for health and social care in England, joining together over 23,000 healthcare IT systems in 20,500 organisations)

5.5.5.2 Currently SystemOne is the only electronic patient record system used by healthcare providers in the health and justice system. It allows medical records to be transferred seamlessly between prisons across the secure estate. However, it is not compatible with all IT systems in the community and, therefore, records cannot be transferred to GPs or secondary services (such as specialist hospital clinics) when the prisoner is discharged.

5.5.5.3 The GP2GP programme, which is due to be implemented in mid-2020 as part of the HJIS, is a system for transferring patient's electronic records between GP surgeries. The programme will allow electronic patient records to be passed between prison healthcare departments and GP surgeries in the community, enabling better continuity of care for prisoners upon release.

5.5.6 The p-NOMIS IT system is to be upgraded and work on its replacement, Digital Prison Services (DPS), was taking place whilst the investigation was being conducted. There are a number of flags on the DPS system that can be used to alert staff to issues a prisoner may have, such as self-harm risk and violent conduct.

5.5.7 There is currently still no function for interoperability between DPS and SystmOne, although both developers stated that the systems can be adapted to accept and share information appropriately whilst maintaining system and data integrity as required.

5.5.8 The efficiency gains of the IT systems communicating with each other would be of significant benefit to all.

HSIB makes the following safety recommendation

Recommendation 2019/048:

It is recommended that the National Prison Healthcare Board for England oversees work to implement interoperability between SystmOne and the Prison-National Offender Management Information System, enabling sharing of essential information across the prison service which does not impinge on the confidentiality requirements of either system

5.6 Commissioning of prison healthcare services

5.6.1 NHS England/Improvement (NHSE/I) has a national health and justice team that supports a governance role across seven health and justice regional commissioning teams. The regional teams work autonomously to commission services within respective prisons; the number of services will depend on the type and size of prison.

5.6.2 In Private Finance Initiative (PFI) prisons there are two services that are funded and commissioned by NHSE/I; mental health and drugs misuse services. The commissioning of primary healthcare services in these prisons is carried out by the prison operator to meet the requirements of their contract with the Ministry of Justice.

5.6.3 The investigation observed variations in the level of oversight of commissioned services across the country. A key measurement the investigation used was the standard of reporting within the NHS's serious incident reporting system, the Strategic Executive Information System (StEIS). After reviewing a number of serious incident investigation reports (which included the report from the reference event), the investigation noted that the standard was suboptimal and lacked detail. Staff reported to the investigation that little oversight occurred in some areas, with the contact from commissioners described as 'light touch'.

5.6.4 When reviewing incident reporting across the health and justice system, the investigation identified an ongoing issue surrounding the transfer of prisoners without their medication. Local guidance and recommendations had been issued in attempts to rectify this problem, however, they appeared to have had little or no impact on the frequency of the incidents.

5.6.5 Part of the role of the NHSE/I health and justice commissioners is to ensure the robustness of the reporting of incidents. This includes overseeing the reporting, the quality of the reports, the recommendations that are made and ensuring that any required action detailed within the report is carried out.

A review of the incident report from the reference event, which was a very brief investigation report, highlighted that significant improvements could be made. The Healthcare Safety Investigation Branch investigation did not look at whether the reporting, in both areas of frequency or standards, was due to a lack of staff knowledge, experience or time (due to work pressures). However, it is likely that all of these factors culminated in the investigations and reporting standards that were observed.

5.6.6 Enhanced scrutiny of the serious incident investigation reports built on sound foundations of a robust reporting culture, with appropriate mechanisms to support the delivery of action plans and incorporation of recommendations, should result in system-wide improvements.

HSIB makes the following safety recommendation:

Recommendation 2019/049:

It is recommended that NHS England/Improvement health and justice national commissioning team review how they monitor and assure the provision of healthcare in prisons to reduce variability in standards, particularly in the areas of incident reporting and investigations.

6 Summary of HSIB findings, safety recommendations and safety observations

6.1 Findings

6.1.1 Prison healthcare departments that only have one authorised prescriber on site, particularly during core hours when transfers occur, are single points of failure that may put prisoners with medication requirements at risk.

6.1.2 There are two key IT systems in use in the prison environment, one for the healthcare records and one for the operational needs of the prisons. These systems have no interoperability, which causes inefficiency within the system and the inability to share essential information across the prison service.

6.1.3 The Care Quality Commission (CQC) and Her Majesty's Chief Inspector of Prisons (HMIP) inspection regimes focus more on the transfer of prisoners to the community and not on the routine transfer of prisoners between prisons.

6.1.4 There are varied levels of oversight and governance applied by the NHS Specialised Commissioning regional teams, resulting in poor incident investigations and reports. This limits the opportunity to learn and make improvements to the system.

HSIB makes the following safety recommendations:

Recommendation 2019/047:

It is recommended that the Care Quality Commission amends its inspection criteria to ensure that inter-prison transfer processes are fully encapsulated within the inspection schedule to assure the provision of care throughout.

Recommendation 2019/048:

It is recommended that the National Prison Healthcare Board for England oversees work to implement interoperability between SystemOne and the Prison National Offender Management Information System, enabling sharing of essential information across the prison service which does not impinge on the confidentiality requirements of either system.

Recommendation 2019/049:

It is recommended that NHS England/Improvement health and justice national commissioning team review how they monitor and assure the provision of healthcare in prisons to reduce variability in standards, particularly in the areas of incident reporting and investigations.

HSIB makes the following safety observation:

1. It would be beneficial for healthcare providers to ensure that there are robust mechanisms in place for accessing urgently needed medicines in order to minimise the risk of patients missing doses.
2. There may be benefits to prisons' healthcare providers having sufficient numbers of authorised prescribers to ensure that a safe prescribing environment is maintained in prisons to meet the standards of service provision they are contracted to provide.

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