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HEALTHCARE SAFETY INVESTIGATION BRANCH

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INTERIM BULLETIN

MANAGEMENT OF CHRONIC HEALTH CONDITIONS IN PRISONS

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This interim bulletin contains facts which have been determined up to the time of issue. It is published to inform the NHS and the public of the general circumstances of events and incidents and should be regarded as tentative and subject to alteration and correction if additional evidence becomes available.

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IDENTIFICATION OF EVENT AND DECISION TO INVESTIGATE

The Healthcare Safety Investigation Branch (HSIB) identified an issue within the judicial system concerning the management of chronic health conditions in prisons. The concern centred around the continuity of care for prisoners with chronic health conditions, particularly during transfer between prisons. Following a detailed scoping investigation, the Chief Investigator authorised a full investigation as it met the following criteria:

Criteria 1: Outcome Impact – What impact has a safety issue has had, or is having, on people and services across the healthcare system?

There are large numbers of prisoners being transferred between establishments daily. 44% of the prison population report taking medication[1] mostly for chronic health conditions. The discontinuation of medication for chronic conditions, even for a short period of time, can have potentially serious adverse health effects. This discontinuity during transfer is widely recognised amongst prisoners and prison healthcare staff. There are conflicting priorities, policies and requirements between all those involved in transferring prisoners (prisoner, dispatching & receiving prison, healthcare staff and healthcare provision). Disruption of routine medication continues to result in prisoners being taken to local Emergency Departments or the ambulance services attending the prisons; either outcome also has an impact on the prison security staff being taken away from normal duties.

[1] House of Commons Justice Committee, Older Prisoners, 12 September 2013, HC 89 2013-14, Ev 44.

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Criteria 2: Systemic Risk - How widespread and how common a safety issue is this across the healthcare system?
The safety issue impacts a large number of similar settings spread across a wide geographic area and across all parts of the prison system, prison health care, acute and primary care. The safety issue is identified readily through normal processes of monitoring and detection and appears to be persistent.

Criteria 3: Learning Potential – What is the potential for an HSIB investigation to lead to positive changes and improvements to patient safety across the healthcare system?
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.

HISTORY OF THE EVENT

A 43-year-old male, with a history of epilepsy since childhood, was identified, from a prison population perspective, as a possible person for transfer from a Category B to a Category C prison. The prison healthcare department were notified, and, after a check of his medical condition and ongoing treatment, it was confirmed that he was suitable for transfer. At 07:00hrs on a Friday, prior to transfer, the patient was given his usual medications. He was not allowed to administer these drugs himself or hold this medication in his cell. As part of his daily routine, a further set of medication was scheduled to be administered at 17:30hrs. Later that morning he was processed by the prison through the transfer routine and placed onto the vehicle.

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That afternoon the patient was received by the Category C prison and processed by their healthcare department. During this process it was identified that he had been transferred without medication. The nurse recorded this on the electronic patient record system, which is used in all prisons, at 15:02hrs and sent an electronic message to the GP to prescribe the patient's medication.

The GP completed an electronic prescription the same day at 19:16hrs. This included all the patient's regular medication except his epilepsy medication, Tegretol Prolonged Release 400mg, the only medication on the list which was not held in stock by the prison. The patient received his medication, as required, except for the Tegretol. Further requests were sent to the GPs and to the Pharmacists on the Saturday morning as the medication was deemed an urgent requirement. However, there was no GP available on the premises to prepare a written prescription until Monday morning.

At 15:01hrs on the Sunday the patient suffered a generalised seizure, which lasted for approximately seven minutes. A second seizure started soon afterwards but was controlled when a nurse administered rectal diazepam. An ambulance was called and paramedics attended the patient at the prison, during which time the patient suffered two further brief seizures. The patient was taken to the local Emergency Department where he was administered Tegretol Prolonged Release 400mg. No more seizures occurred.

On the Monday the GP prescribed the medication which was administered to the patient.

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NATIONAL CONTEXT

Her Majesty's Prison and Probation Service organises approximately 5500 inter-prison transfers per month. The bulk of the transfers are conducted between Category B and Category C prisons. Prisoners arriving without their medication following transfer from another prison is a commonly reported problem.
Variation across the system creates problems in multiple areas, including commissioning, healthcare provision, back-up systems and communication on a national scale.

IDENTIFIED SAFETY ISSUES

The following safety issues were identified during the HSIB initial investigation and will form the basis of the wider investigation:

- There is large scale transfer of prisoners with nearly half of them requiring medication and variation in the receiving prison's ability to administer non-routine or non-stock drugs.
- There are no standardised processes for communication of healthcare information between transferring and receiving prisons.
- Communication of healthcare requirements between prisons and between departments within prisons is poor.
- There is variation in how prison health care systems provide out of hours prescription services.

NEXT STEPS

The HSIB investigation will continue to explore the identified safety issues and welcomes further information that may be relevant, regardless of source.

The HSIB will report any significant developments as the investigation progresses.