Investigation Report

Investigation of a complaint against the South Eastern Health & Social Care Trust (Prison Healthcare)

NIPSO Reference: 19098

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The Role of the Ombudsman

The Northern Ireland Public Services Ombudsman (NIPSO) provides a free, independent and impartial service for investigating complaints about public service providers in Northern Ireland.

The role of the Ombudsman is set out in the Public Services Ombudsman Act (Northern Ireland) 2016 (the 2016 Act). The Ombudsman can normally only accept a complaint after the complaints process of the public service provider has been exhausted.

The Ombudsman may investigate complaints about maladministration on the part of listed authorities, and on the merits of a decision taken by health and social care bodies, general health care providers and independent providers of health and social care. The purpose of an investigation is to ascertain if the matters alleged in the complaint properly warrant investigation and are in substance true.

Maladministration is not defined in the legislation, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping.

The Ombudsman must also consider whether maladministration has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. A remedy may be recommended where injustice is found as a consequence of the failings identified in a report.

Reporting in the Public Interest

This report is published pursuant to section 44 of the 2016 Act which allows the Ombudsman to publish an investigation report when it is in the public interest to do so.

The Ombudsman has taken into account the interests of the person aggrieved and other persons prior to publishing this report.

TABLE OF CONTENTS

Page

SUMMARY ………………………………………………………… 6

THE COMPLAINT ………………………………………………. 7

INVESTIGATION METHODOLOGY …………………………. 8

THE INVESTIGATION ………………………………………….. 9

CONCLUSION …………………………………………………... 33

APPENDICES ……………………………………………………. 35

Appendix 1 – The Principles of Good Administration

Appendix 2 – The Principles of Good Complaints Handling

SUMMARY

I received a complaint about the care and treatment received by a patient of the Prison Healthcare team within the South Eastern Health and Social Care Trust (the Trust). The patient said that she was not administered all of her medication following her committal at Hydebank Wood Prison (the prison). She also complained about the handling of her complaint to the Trust.

The investigation did not find maladministration nor failures in the care and treatment in relation to the following matters:

i. The Prison Healthcare team's decision not to prescribe or administer zolpidem and codeine phosphate to the patient during her stay in prison;
ii. The Prison Healthcare's actions in referring the patient to a prison GP;
iii. The failure of the Trust to appropriately record its findings and respond to all the issues raised by the patient in her complaint; and
iv. The Trust's failure to provide an apology to the patient in its response to her complaint.

THE COMPLAINT

1. The patient complained that the Prison Healthcare team within the Trust failed to provide her with her prescribed medication during her stay at Hydebank Wood Prison (the prison).

2. She also complained that the Trust did not appropriately handle her subsequent complaint. In particular, she stated that the response to her complaint did not fully answer questions she raised nor provide her with reasons for the treatment she received during her stay at the prison. She also complained that the Trust did not provide her with an apology for the treatment she experienced.

INVESTIGATION METHODOLOGY

3. In order to investigate the complaint, the Investigating Officer obtained from the Trust all relevant documentation together with the Trust's comments on the issues raised. This documentation included information relating to the Trust's handling of the complaint.

Independent Professional Advice Sought

4. After further consideration of the issues, independent professional advice was obtained from the following independent professional advisors (IPA):

   - A Registered Nurse with 25 years' experience of working within a Prison Healthcare setting (N IPA); and
   - A General Practitioner for 13 years and 12 years' experience of working within a Prison Healthcare setting (GP IPA).

5. The information and advice which have informed my findings and conclusions are included within the body of this report. The IPAs have provided 'advice'; however how this advice has been weighed, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards

6. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those which are specific to the circumstances of the case.

7. The general standards are the Ombudsman's Principles[1]:
    - The Principles of Good Administration
    - The Principles of Good Complaints Handling
    - The Public Services Ombudsmen Principles for Remedy

8. The specific standards are those which applied at the time the events occurred and which governed the exercise of the administrative functions of the Trust staff whose actions are the subject of this complaint.

9. The specific standards relevant to this complaint are:
    - The Nursing and Midwifery Council's (NMC) Standards for Medicine Management, 2007 (the NMC Standards);
    - The Nursing and Midwifery Council's (NMC) The Code: Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates, 2015 (the NMC Code);
    - The National Institute for Health and Care Excellence's (NICE) Physical Health of People in Prison guideline [NG57], 2016 (NICE Guideline NG57);
    - The National Institute for Health and Care Excellence's (NICE) Patient Experience in Adult NHS Services: Improving the Experience of Care for People Using Adult NHS Services Clinical Guideline [CG138], 2012 (NICE Guideline CG138);
    - The Royal College of General Practitioner's (RCGP) Safer Prescribing in Prisons, 2011 (the RCGP's prescribing guidelines);

[1] These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.

- The South Eastern Health and Social Care Trust's Insomnia Treatment Clinical Guidance (Prison Healthcare), 2015 (the Trust's insomnia treatment guidelines); and
- The Department of Health's (DoH) Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning, April 2009 (the DoH Complaints Procedure).

10. I have not included all of the information obtained in the course of the investigation in this report but am satisfied that everything considered to be relevant and important has been taken into account in reaching the findings.

11. As part of the NIPSO process, a draft of this report was shared with the complainant and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations.

INVESTIGATION

Whether the patient received appropriate care and treatment during her stay at Hydebank Wood Prison.

Detail of Complaint

12. The patient said that the Prison Healthcare team within the Trust failed to provide her with all of her medication during a five day stay in prison in November 2017. She stated that her GP prescribed this medication while she was in the community. She complained that she suffered abdominal cramps, difficulty sleeping, diarrhoea and nausea as a result of not being prescribed this medication. She further complained that the Prison Healthcare team refused her access to a GP while she was in prison.

Evidence Considered

Legislation/Policies/Guidance

13. In relation to this issue of complaint, the NMC medicine management guidelines were considered. The following relevant extracts were identified:

i. The NMC Standards: Section 1, methods of supplying and/or administration of medicines state that *'[Nurses] must only supply and administer medicinal products in accordance with one or more of the following processes:*

- *Patient specific direction (PSD)*
- *Patient medicines administration chart (may be called medicines administration record MAR)*
- *Patient group direction (PGD)*
- *Medicines Act exemption*
- *Standing order*
- *Homely remedy protocol*
- *Prescription forms'*.

ii. The NMC Code was also considered. The following relevant extract was identified:
Standard 2 - Listen to people and respond to their preferences and concerns
To achieve this, you must:
2.1 Work in partnership with people to make sure you deliver care effectively
2.2 Recognise and respect the contribution that people can make to their own health and wellbeing
2.3 Encourage and empower people to share in decisions about their treatment and care
2.4 Respect the level to which people receiving care want to be involved in decisions about their own health, wellbeing and care
2.5 Respect, support and document a person's right to accept or refuse care and treatment
2.6 Recognise when people are anxious or in distress and respond compassionately and politely

iii. The NICE Guideline NG57 was considered. The guideline '…*covers assessing, diagnosing and managing physical health problems of people*

in prison. It aims to improve health and wellbeing in the prison population by promoting more coordinated care and more effective approaches to prescribing, dispensing and supervising medicines…'

The following extracts were considered relevant to this issue of complaint:

'1.1 Assessing health

First-stage health assessment at reception into prison

1.1.1 At first reception into prison, a healthcare professional (or trained healthcare assistant under the supervision of a registered nurse) should carry out a health assessment for every person. Do this before the person is allocated to their cell. As part of the assessment, identify:

- *any issues that may affect the person's immediate health and safety before the second-stage health assessment*
- *priority health needs to be addressed at the next clinical opportunity.*

1.1.2 Ensure continuity of care for people transferring from one custodial setting to another (including court, the receiving prison or during escort periods) by, for example:

- *accessing relevant information from the patient clinical record, prisoner escort record and cell sharing risk assessment*
- *checking medicines and any outstanding medical appointments...*

1.1.4 The first-stage health assessment should…cover:

- *physical health*
- *alcohol use*
- *substance misuse*
- *mental health*
- *self-harm and suicide risk.*

Following the first-stage health assessment

1.1.5 Give the person advice about how to contact prison health services and book GP appointments in the future...

1.1.7 Enter in the person's medical record:

- *all answers to the reception health assessment questions*
- *health-related observations, including those about behaviour and mental state (including eye contact, body language, rapid, slow or strange speech, poor hygiene, strange thoughts)*
- *details of any action taken.*

1.1.8 Carry out a medicines reconciliation (in line with NICE's guideline on medicines optimisation) before the second-stage health assessment. See also recommendations 1.4.1 and 1.7.10 for recommendations on risk assessments for in-possession medicines and ensuring continuity of medicine.

1.4 Managing medicines

Access to medicines

1.4.1 Carry out an individual risk assessment to determine if the person can hold their medicines in-possession. Allow people in prison to hold all medicine in-possession unless the person does not pass the risk assessment…

Continuity of medicines

1.7.10 Ensure the person can keep taking their medicines after coming into prison.

1.7.11 Give critical medicines in a timely way to prevent harm from missed or delayed doses. Use the examples of critical medicines in table 2 in conjunction with clinical judgement and any safety alerts'.

ii. NICE guideline CG138 was also considered. The following relevant extracts were identified:

'***Patient views and preferences***

1.3.4 Hold discussions in a way that encourages the patient to express their personal needs and preferences for care, treatment, management and self-management. Allow adequate time so that discussions do not feel rushed.

1.3.5 Review with the patient at intervals agreed with them:

- *their knowledge, understanding and concerns about their condition and treatments*
- *their view of their need for treatment.*

1.3.6 Accept that the patient may have different views from healthcare professionals about the balance of risks, benefits and consequences of treatments…'

iii. The Trust's insomnia treatment guidelines were considered. The following relevant extracts were identified:

3.0 Roles/Responsibilities

Prescribers are ultimately responsible for patient assessment, prescribing and monitoring of non-benzodiazepine[2] hypnotics / sleep medication although assessment and monitoring will be a shared responsibility with nursing staff. Prescribers are responsible for ensuring that they are aware of, and adhere to, the contents of this guidance.

Operational Nurse Managers are responsible for ensuring this guidance is communicated and implemented effectively within their prison establishment. Nurses are responsible for clinically assessing a patient on committal and for repeating this assessment if required. They should follow the Nursing Triage Protocols and making appropriate referrals for patients to see the GP.

They should also ensure that all patient interventions relating to sleeping difficulties or medication requests are recorded appropriately on the EMIS clinical system[3].

Nurses are responsible for recording medicines management issues and bringing these to the attention of the prescriber…

[2] Typically prescribed to patients who have trouble either falling asleep or staying asleep.

[3] The clinical system used by the Prison Healthcare team. It provides real-time access to patient data via a shared electronic patient record (EPR).

4.1 Initiation of insomnia treatment

Prescriptions for medications to treat insomnia should only be initiated after a face to face clinical assessment when there is a clear clinical indication for doing so…when making their clinical assessment the prescriber must take into account the particular challenges of the prison environment where the majority of hypnotic / sleep medication have high misuse potential and trading value. ..

5.2 Zolpidem[4] / zopliclone[5] / non-benzodiazepine hypnotics

These are NOT [emphasis in guidelines] to be routinely initiated in prison.

Exceptions can be made at the prescriber's discretion and according to clinical assessment however it is advised this is for EXCEPTIONAL CIRCUMSTANCES ONLY [emphasis in guidelines]. If an exception is to be made then the recommended hypnotic is zolpidem 10mg x 5 tablets. If a patient is committed to prison while taking a non-benzodiazepine hypnotic or 'z-drug', the medication will be discontinued as per this guidance. If there is a documented dependence on the medication, consideration should be given to conversion to diazepam and a reduction regime followed…'

iv. The RCGP's prescribing guidelines were considered. The following relevant extracts were identified:

Pain

Codeine[6]: Short duration use in patients who do not have opiate[7] addiction problems. Special care in patients with substance misuse histories. Consider dispersible / effervescent[8] preparation with 'co' preparations.

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[4] Zolpidem is a sedative, also called a hypnotic, and is used to treat insomnia.

[5] Zopiclone is a hypnotic agent used in the treatment of insomnia.

[6] Codeine belongs to a group of medicines called opioid analgesics which act to relieve pain.

[7] A term used in pharmacology to mean a drug derived from opium.

[8] Tablets that are uncoated or film-coated tablets that can be dispersed in liquid before administration.

Insomnia
…sedating antihistamines, benzodiazepines, Z drugs and melatonin[9] *are licensed for the short term management of insomnia…*
Recommended drugs:
Z drugs: zopiclone, zolpidem and zaleplon[10]*.*
These can be used for short periods if there is a clear necessity for a hypnotic. Zopiclone is the most widely used in the community. They may be diverted and do enter the illicit economy. Prescribe with caution in prisons'.

The Trust's response to investigation enquiries

14. In response to the complaint regarding the care and treatment by the Prison Healthcare team, the Trust explained that it '*can confirm that Prison Healthcare personnel did not stop all of [the patient's] medication when she entered custody. However, not all medications prescribed within the community are appropriate to continue within a secure setting'*. It further explained that the *'medication was prescribed in line with that prescribed by her community GP with the exception of Zolpidem 5mgs one tablet at night and Codeine 30mgs two tablets three times daily'*.

15. In relation to the codeine phosphate and zolpidem medications, the Trust explained that '*these are potential drugs of misuse and present a risk of being diverted within a custody setting therefore must be prescribed with caution, only where there is a clear clinical need and following consultation with a GP. The RCGP Safer Prescribing in Prisons Guidance states in relation to Zolpidem that it "may be diverted and does enter the illicit economy. Prescribe with caution in Prisons*". *Codeine is an opiate based medication and the RCGP Guidance states "specific consideration should be given to the appropriateness of prescribing opiate based medication within a consultation and whether an alternative medication or adjuvant could be utilised for an individual presentation of a patient*"'. The Trust further explained that the Prison

[9] A hormone that regulates the sleep–wake cycle.
[10] A sedative-hypnotic, used to treat insomnia.

Healthcare team '*have a responsibility to ensure the safety of all people in custody and to prevent harm from divertible medications. It was therefore clinically appropriate that these medications were not automatically continued on entry into custody'*.

16. The Trust explained that when the patient *'reported symptoms of diarrhoea on the morning of Sunday 12 November 2017, she was offered loperamide*[11] *medication by the primary care nurse as an alternative treatment for her symptoms. Loperamide was clinically appropriate as an alternative medication and is in line with RCGP Guidance. Records indicate that [she] declined this medication and requested codeine stating this was prescribed by a consultant for Crohn's disease*[12]*. The nurse explained […] that she would require a GP appointment for Codeine to be prescribed within the prison. The nurse placed a note for the GP in this regard'*.

17. The Trust was asked if another alternative was considered when this was refused. It explained that '*when [she] refused this on 12 November 2017, the nurse listed for GP consideration the next day, requesting prescription for Codeine Phosphate and Diaoralyte*[13]*. The GP reviewed the EMIS record on the morning of 13 November 2017 and prescribed Loperamide and Dioralyte. The GP confirmed an appointment would be required for Codeine Phosphate to be considered. A GP appointment was arranged for 14 November 2017 for this purpose. [She] was released from Prison and transferred to Holywell Hospital*[14] *prior to this appointment taking place'*.

18. In relation to the complaint that the Prison Healthcare team denied her access to a GP, the Trust explained that she '*was not refused to see a doctor. The discussion between [her] and the nurse about a GP appointment took place on Sunday 12 November 2017 and the nurse placed this request for the attention of the Prison Healthcare GP. The GP considered [the] request for codeine on Monday 13 November 2017 and prescribed alternative medications for*

[11] A medication used to decrease the frequency of diarrhoea.
[12] An inflammatory bowel disease that causes inflammation of the digestive tract.
[13] Used to replace the water and salts lost from your body when you have diarrhoea.
[14] Holywell Hospital in Antrim, Northern Ireland, provides a range of acute and other in-patient mental health services.

diarrhoea, namely loperamide and dioralyte. This was in line with RCGP Guidance'.

19. The Trust further explained that '*the GP confirmed that [she] would require a GP appointment to discuss her request for codeine. Further information was then sought from [the patient's] community GP with regard to the clinical indication for the prescription of codeine. The primary care nurse made contact with [the] GP to confirm that codeine had been recommended by a consultant for the treatment of Crohn's disease. The GP practice confirmed that there was no record of [the patient] having a diagnosis of Crohn's disease but confirmed codeine had been prescribed for chronic diarrhoea associated with psychogenic[15] IBS[16] [irritable bowel syndrome]. This information was necessary to inform the Prison Healthcare GP's clinical decision. A GP consultation was to take place on Tuesday 14 November 2017 but [she] was transferred to Holywell Hospital'*.

20. In relation to the procedure followed, the Trust explained that '*there is no specific policy or guidance in relation to access to a doctor within prison. GP appointments are facilitated as requested and the timeframe for routine appointments is within 14 days. In this case, [the patient's] care was reviewed by a GP and treatment prescribed within one day. [She] would have been seen by a GP within two days of her request had she remained in custody. [She] was seen by nursing staff and offered and prescribed medication for the treatment of diarrhoea during that time, which she declined'*.

21. In relation to considering if there is a requirement for a prisoner to see a GP urgently, the Trust explained that *'clinical need determines if a person needs to see a GP urgently. The healthcare professional (HCP) arranging or requesting the appointment is responsible for making this determination. This is normally a registered nurse but could be another HCP, including a GP for example when considering prescription requests or when consulted for advice'*.

[15] Physical illnesses that are believed to arise from emotional or mental stressors, or from psychological or psychiatric disorders
[16] A common condition that affects the digestive system. It causes stomach cramps, bloating, diarrhoea and constipation.

22. The Trust further explained that '*based on the information and guidance available, [the patient] was not deemed to require an urgent appointment at the point of committal. Urgent appointments are for cases of urgent clinical need. There was no urgent clinical need at this time. It is not uncommon for people entering custody to be prescribed medication that is not suitable for continuation within a Prison environment. Registered nurses will review the person and, where clinically indicated, provide alternate medication or seek GP advice, as occurred in [this] case. Following the change in clinical presentation, as reported to the nurse on 12 November 2017, the GP reviewed the EMIS records on 13 November 2017 and prescribed Loperamide and Dioralyte medications for the management of diarrhoea. The GP advised that an appointment would be required to consider a prescription for Codeine Phosphate. This appointment was arranged for the following day, 14 November 2017, however, [the patient] was transferred to inpatient care [Holywell Hospital] before this appointment took place'*.

23. The Trust was referred to the clinical records from 10 November 2017. The records document that the patient was found to be '*tearful*' and '*shaking*'. The Trust explained that her '*presentation at that time was considered in the context of her mental health and managed accordingly under the Supporting Prisoner at Risk*[17] *(SPAR) procedures. There was involvement of the mental health team who liaised with the Northern HSC Trust in relation to transfer to mental health inpatient care at Holywell Hospital. [She] was transferred to Holywell Hospital on 14 November 2017. There was no reference that [she] was experiencing gastro-intestinal symptoms at that time [of her transfer to Holywell Hospital]'*.

Clinical Records

24. The patient's clinical records provided by the Trust were carefully considered.

25. Information relating to her prescribed medication from her GP practice was also considered. The records document that she was regularly prescribed zolpidem prior to entering the prison on 9 November 2017. They further document that

[17] The procedures to protect and support prisoners at risk of suicide or self-harm.

the Crisis Response Team[18] requested a short term increase in her prescription for zolpidem from 5mg to 10mg on 4 November 2017. The records document that the increase was arranged and a review was due to take place the following week.

26. The Practice's records document that she was prescribed 30mg tablets of codeine phosphate on 23 October 2017. However, the Practice documented that the prescription was not dispensed and was cancelled. The records document that a further prescription was issued on 1 November 2017 (two tablets to be taken three times a day). This was dispensed to her the same day.

Relevant Independent Professional Advice

27. As part of investigation enquiries, the advice of an independent registered nurse was obtained (N IPA). In relation to the patient's complaint, the N IPA advised that the '*key responsibilities of nurses for administering medication to prisoners upon their committal are to ensure that patients have access to medicines and for continuity of medicines'*. He explained that '*in this case, there were two medications previously prescribed (by the patient's community GP) that were liable to be misused and identified as medicines requiring caution – these were codeine phosphate and zolpidem'*. The N IPA further explained that *'both medicines have an 'amber' rating under the Safer Prescribing Guidance, which means that the prison registered nurse (and prison GP) would have had to consider these medicines with caution as they are not to be routinely initiated in prison and only when there are exceptional circumstances'*.

28. The N IPA agreed that the patient was not administered codeine phosphate nor zolpidem by the nursing team during her stay in prison. He advised that this decision was '*reasonable and appropriate'*. The N IPA referred to the NMC Standards and explained that *'all medication for a patient in prison, even if it has been previously prescribed by the GP in the community, must be reviewed by the prison GP and only that medication which the prison GP prescribes, or*

[18] A home treatment service for people with a severe mental health crisis.

authorises to be administered, can be administered by the prison nurse to the patient (prisoner)'. He advised that '*it is clear then that the prison nurses could only have administered medicines with a prescription form made out by the prison GP…it is also clear that these two particular medicines must be considered with caution and the nurses appropriately sought direction by referring to the prison GP. At all times the prison nurses can be seen to have acted in line with the above guidance and standards [the NMC Code and the NMC Standards]*'.

29. In relation to the communication with the patient, the N IPA referred to the consultation notes on 12 November 2017 at 10.10 and also on 13 November 2017 at 12.39. He advised that '*the nursing team informed [the patient] that she would not be prescribed codeine phosphate and zolpidem while she was in prison'*. He further advised that she '*was informed of the rationale for not being administered these two medicines and that her request for being prescribed (and administered) these particular medicines would be referred to the prison GP. She was also offered appropriate alternative medicines for her diarrhoea, however she refused these'*. The N IPA advised that he could not '*find any specific queries about zolpidem; however this medication does not seem to have been much as an issue as the codeine phosphate seems to have been for [her]'*.

30. In relation to booking a GP appointment, the N IPA explained that *'at first stage health assessment, the nurse will ask a series of questions that includes questions about the patient's prescribed medicines…where the nurse identifies (assesses) that there are other concerns about the prisoner's physical health then the nurse will be required to refer the person to the GP or relevant clinic'*. The N IPA advised that although the nursing team did make a referral to the GP, an appointment was not made at any time during her stay in prison.

31. The N IPA advised that the nursing team did not make an urgent (or emergency) appointment for the patient during her stay in prison. He explained that *'in this case and context these circumstances could not be considered to be an 'emergency' or even urgent. The circumstances in this case were that if an urgent GP appointment was to be made then the nurse would have had to*

justify that urgent appointment'. The N IPA further advised that the '*health problems that were identified and referred onward following first stage health assessment were not of a seriousness or urgency to warrant a referral for an urgent GP appointment. There was no 'emergency' at any time during [her] stay in prison and based on my review of the clinical records, her care management and onward referral to the GP were facilitated appropriately'*.

32. The N IPA was referred to the entry made in the consultation notes on 10 November 2017 at 10.40. This documented that the patient received codeine phosphate and zolpidem for '*mental problems'*. The N IPA advised that he did '*not consider that a nurse should have arranged an emergency, or urgent' appointment with a GP for [her] at this stage'*. He explained that '*at first stage health assessment, [she] was appropriately referred to the prison mental health service'*. The N IPA further advised that '*it was not indicated or necessary that [she] be referred for an emergency or urgent GP appointment at this stage because the prison mental health team was already sighted on her case and there was a firm plan for her soon-to-be transfer to a psychiatric hospital'*.

33. The N IPA was also referred to the entry made in the consultation notes on 10 November 2017 at 15.33. This entry documented that the patient was found '*tearful and shaking'* on her bed. The N IPA advised that he did '*not consider that a nurse should have arranged an emergency appointment with a GP for [her] at this stage'*. He further advised that *'an emergency or urgent appointment to see the GP was not indicated. [The patient] was clearly distressed but reassurance and attention from the nurse in line with The [NMC] Code was appropriate and to a degree, evidence by the clinical entries, was given'*.

34. The N IPA was referred to the entry made in the patient's consultation notes on 12 November 2017 at 10.10. This entry documented that she was informed that in order to be prescribed her medication, she would need to see a GP. The N IPA advised that *'an emergency or urgent appointment with a GP at this stage would not have been warranted…there are sound reasons for the extra controls in place for these medicines [codeine phosphate and zolpidem] as set out in the guidance'.* He further advised that *'the nurse followed correct policy*

and procedure as per these guidelines and a firm plan/intention was implemented to enable [the patient] to have access to these particular medicines but only following referral and review by the prison GP'.

35. In relation to the patient's complaint that she was '*not allowed'* to visit a GP while in prison, the N IPA advised that in his professional opinion, she '*was not denied access to a GP by the Prison Healthcare nursing staff'*. He explained that '*nurses did make a referral for [her] to see the GP…there is no evidence in the clinical record or in the nurses' notes that there was any deliberate strategy or ploy to deny [her[from access to seeing the GP'*.

36. The N IPA also considered the Supporting Prisoner at Risk (SPAR) care plan that was put in place for the patient during her stay at the prison. The N IPA advised that '*the SPAR Care Plan and overall care/case management […] met the required standards [that is the] NI [Northern Ireland] Prison Service SPAR and also relevant NICE guidelines…my conclusion then is that the SPAR Care Plan and its operational procedures/processes provide additional evidence that [she] received appropriate care and support from the Prison Healthcare team (working in collaboration with prison staff) that met the relevant standards'*.

37. The N IPA advised that '*overall the care and treatment provided during her stay in prison from 9 to 14 November 2017 by the Prison Healthcare nursing staff was reasonable and appropriate. The care and treatment was in line with relevant guidance and standards'*.

38. As part of investigation enquiries, independent professional advice was also sought from a general practitioner (GP IPA). In relation to the medications prescribed upon her committal, the GP IPA advised that '*with regards to assessing a new committal, the prescribing doctor has a duty to assess the safety of any community prescribing and weigh this against any other issues relating to the patient and/or the environment'*. He explained that *'in view of the fact that [the patient's] presentation at that time was consistent with that of a mental health disorder, continuing her mental health medications was the most appropriate course of action'*.

39. In relation to the decision not to prescribe the patient codeine phosphate or zolpidem upon her committal, the GP IPA advised that it was '*quite appropriate for [the doctor] to have considered whether or not to include any further sedative medications if they were not immediately necessary. In not prescribing codeine or zolpidem, [the doctor] acknowledged the relevant patient safety risks of the medications he had chosen to continue and this fell within the accepted range of clinical practice'*.

40. The GP IPA acknowledged that the patient had been prescribed zolpidem on a '*continued basis'* by her community GP. He advised that *'any cessation or withdrawal effects would have been appropriately addressed through the prescription of diazepam which was provided by [GP A]'*.

41. In relation to codeine phosphate, the GP IPA advised that the records from the patient's community GP '*clearly specify that [she] was not prescribed codeine on a regular basis prior to her arrival in prison and therefore she would not have experienced any cessation or withdrawal effects. Therefore, there was no clinical indication for providing a tapered or reducing dose of codeine. There was no clear clinical indication for the use of codeine for the management [her] reported history of diarrhoea'*.

42. In her complaint, the patient stated that she suffered pains and sickness due to not receiving her medication. The GP IPA advised that there was *'no clinical basis for [her] reported history of abdominal pain diarrhoea and/or nausea given that she was not prescribed codeine on a regular basis prior to her committal…and therefore could not have suffered with symptoms of cessation or withdrawal'*.

43. The GP IPA was referred to GP B's decision to prescribe loperamide to the patient as an alternative to codeine phosphate. The GP IPA advised that '*loperamide would be considered the appropriate first-line treatment for the symptoms of acute diarrhoea and would also be considered a 'safe' treatment within the secure setting'*.

44. In relation to the procedure followed by GPs for booking appointments in a

prison setting, the GP IPA advised that *'on this occasion, a request for medication, including codeine and zolpidem would not fall into the category of necessitating an urgent appointment to see the prison GP. Furthermore, requests for medications of this nature would not necessarily require a face-to-face appointment with the GP and could effectively be dealt with in a number of other ways, including via electronic messages or other discussions with healthcare staff'*. In relation to arranging an urgent appointment with a GP for the patient, the GP IPA advised that he *'would not have expected a prison GP to have requested to see the patient urgently on the basis of the patient's request for these medications'*.

45. The GP IPA was referred to the entry in the consultation notes made by GP A's on 10 November 2017. The GP IPA advised that '*there was no indication that [the GP] should have scheduled or arranged an emergency appointment to discuss her medication'*. He explained that '*it falls within the accepted range of practice for the prison GP to assess the list of medications being prescribed for a patient in the community on arrival into prison and to ensure the clinical need and appropriateness of that medication and to consider that any continued prescriptions are managed safely in line with RGCP Safer Prescribing in Prisons and local policies'*.

46. The GP IPA was also referred to the entry in the consultation notes made by GP B on 13 November 2017 at 12.20. This entry related to a request from the patient [made to a nurse] for codeine phosphate. The records document that GP B wrote, '*see GP to discuss'*. The GP IPA advised that '*there was no indication that [the GP] should have scheduled or recommended an emergency appointment … with the prison GP on 13 November 2017'*.

47. The GP IPA advised that '*there is no indication based on her presentation at this time that an urgent appointment with the GP was required'*. In relation to the complaint that she was '*not allowed'* to visit a GP while she was in prison, the GP IPA advised that '*there is no evidence in the records that [she] was in fact refused an appointment with the prison GP'*.

48. The GP IPA advised that *'the care provided to [the patient] by the Prison*

Healthcare was reasonable, appropriate and in accordance with the relevant guidelines and standards'.

Analysis and Findings

Administration of medication by the nursing team

49. The patient complained that she was not provided with all of her medication while she was in prison between 9 and 14 November 2017. The investigation identified that she was provided with the medication prescribed by her community GP apart from codeine phosphate and zolpidem. Having reviewed the records provided by her GP practice, I note that prior to her committal, the patient was prescribed codeine phosphate on 1 November 2017. I further note that she was on a continued prescription of zolpidem and this was temporarily increased on 4 November 2017 from 5mg to 10mg.

50. I note from the clinical records that the patient underwent a first stage health assessment upon her committal on 9 November 2017. I further note that the list of medications taken prior to committal recorded by the nurse included both codeine phosphate and zolpidem. However, these were not administered by the nursing staff. I have considered the Trust's insomnia treatment guidelines, the RCGP's prescribing guidelines and the NMC Standards. I accept the N IPA's advice that '*all medication for a patient in prison, even if it has been previously prescribed by the GP in the community, must be reviewed by the prison GP*'. I also accept the N IPA's advice that '*it is clear then that the prison nurses could only have administered medicines to [the patient] with a prescription form made out by the prison GP*'. I am satisfied that the nursing team's decision not to administer these medications to the patient upon her committal was reasonable, appropriate and in accordance with recognised guidelines.

51. I note from the clinical records that a prescription was issued for her on the morning of 10 November 2017 by GP A, the Prison Healthcare GP. I further note that neither codeine phosphate nor zolpidem was prescribed. I have considered the Trust's insomnia treatment guidelines and the RCGP's prescribing guidelines regarding the prescribing of these medications. I note

that the guidelines recommend that caution is exercised when prescribing these medications in a prison setting. I accept the GP IPA's advice that it was '*quite appropriate for [GP A] to have considered whether or not to include any further sedative medications if they were not immediately necessary. In not prescribing codeine or zolpidem, the GP's prescribing acknowledged the relevant patient safety risks of the medications he had chosen to continue and this fell within the accepted range of clinical practice'*.

52. The patient complained that she was not provided with all of her medication during her stay in prison. I have identified that she was provided with all of her the medication by the nursing team, as prescribed by the prison GP, apart from codeine phosphate and zolpidem. Having reviewed the guidelines, I accept the N IPA's advice that '*overall the care and treatment provided … [by the nursing team]…was reasonable and appropriate. The care and treatment was in line with relevant guidance and standards'*. I am satisfied that the nursing team's decision not to provide these medications was reasonable, appropriate and in accordance with recognised standards. **Therefore, I do not uphold this element of the complaint.**

Prescribing of medication by the prison GPs

53. The clinical records also document that GP A prescribed the patient with an oral dose of diazepam. I have reviewed the Trust's insomnia treatment guidelines and note that this is listed as an alternative to zolpidem. I accept the GP IPA's advice that '*any cessation or withdrawal effects would have been appropriately addressed through the prescription of diazepam which was provided'*.

54. In relation to the decision not to prescribe codeine phosphate, I considered the records from her community GP. I note that this was not prescribed on a continued basis while in the community. I accept the GP IPA's advice that '*there was no clinical indication for providing a tapered or reducing dose of codeine. There was no clear clinical indication for the use of codeine for the management of [the patient's] reported history of diarrhoea'*. I am satisfied that the prison GP's actions in not prescribing codeine phosphate nor zolpidem to

the patient on 10 November 2017 was reasonable, appropriate and in accordance with recognised guidelines.

55. In relation to the communication regarding the prescription of these medications, I note the entry into her clinical record on 12 November 2017 at 10:10 and also on 13 November 2017 at 12.39. I accept the N IPA's advice that she '*was informed of the rationale for not being administered these two medicines and that her request for being prescribed (and administered) these particular medicines would be referred to the prison GP*'. I am satisfied that it was sufficiently communicated to her and recorded in her clinical records that her request would be referred to the prison GP.

56. I note that the nursing team referred the patient's medication request to the prison GP using the online system on 12 November 2017. I further note that GP B reviewed the request and informed the nursing team that the patient was required to see a GP before these medications could be prescribed. I accept the GP IPA's advice that he '*would not have expected a prison GP to have requested to see the patient urgently on the basis of the patient's request for these medications'*. I note that following the request, GP B prescribed loperamide as an alternative to codeine phosphate. I accept the GP IPA's advice that '*loperamide would be considered the appropriate first-line treatment for the symptoms of acute diarrhoea and would also be considered a 'safe' treatment within the secure setting'*. I note that the patient refused the alternative medication. I am satisfied that GP B's actions regarding this request were reasonable, appropriate and in accordance with recognised guidelines.

57. The patient complained that she was not prescribed all of her medication during her stay in prison. I have identified that she was prescribed all of her medication prescribed by her community GP apart from codeine phosphate and zolpidem. Having reviewed the guidelines, I accept the GP IPA's advice that the care and treatment provided to the patient by the prison GPs was '*reasonable, appropriate and in accordance with the relevant guidelines and standards'*. **Therefore, I do not uphold this element of complaint.**

Access to a GP while in prison

58. The patient further complained that the Prison Healthcare team refused her access to a GP. I note that she did not have a face to face consultation with a GP during her stay in prison. However, as referred to previously, I note that she was referred to a prison GP on 12 November 2017 following her request for codeine phosphate. I accept the N IPA's advice that '*nurses did make a referral to see the GP…there is no evidence in the clinical record or in the nurses' notes that there was any deliberate strategy or ploy to deny [the patient] from access to seeing the GP'*. I am satisfied that there is no evidence to suggest that the prison nursing team denied the patient access to a GP during her stay in prison. Instead, the clinical records document that she was referred to a GP. However, this consultation did not occur as she was transferred out of the prison.

59. I note from the clinical records that following the patient's presentation at her first stage health assessment, the prison nursing team had concerns regarding her mental health. I further note that she was found to be '*tearful and shaking'* on her bed on 10 November 2017 at 15.33. Her clinical records indicate that she was referred to and seen by the prison mental health team. I accept the N IPA's advice that '*an emergency or urgent appointment to see the GP was not indicated. [The patient] was clearly distressed but reassurance and attention from the nurse in line with the [NMC] Code was appropriate and to a degree, evidence by the clinical entries, was given'*. Also that she was '*appropriately referred to the prison mental health service'* by the prison nursing team.

60. I note that two prison GPs reviewed her clinical records during her stay in prison. I further note that neither of the GPs arranged for her to attend an urgent consultation to discuss her medication. I accept the GP IPA's advice that '*there is no indication based on her presentation at this time that an urgent appointment with the GP was required'*. I am satisfied that it was not necessary for the prison GPs to arrange an urgent consultation in these circumstances. However, I note that GP B requested for a routine appointment to be arranged to discuss her request for codeine phosphate. I am satisfied that there is no

evidence to suggest that the prison GPs denied the patient access to a doctor while she was in prison.

61. I have carefully considered the patient's complaint that she was denied access to a GP during her stay in prison. I have been unable to find any evidence to suggest that the Prison Healthcare team denied her access to a GP. I am also satisfied that the actions of the Prison Healthcare team regarding her request to see a GP was reasonable, appropriate and in accordance with recognised guidelines. **Therefore, I do not uphold this element of the complaint.**

Issue 2: Whether the Trust handled the complaint in line with its policy or appropriate standards

Detail of Complaint

62. The patient complained about the Trust's handling of her complaint. In particular, she complained that the Trust did not fully answer the questions she raised. She further complained that the Trust did not provide her with a reason why her medication was withheld from her during her stay in prison. She also stated that the Trust did not apologise for the actions of the Prison Healthcare team, which led her to believe that her medication was stopped '*on purpose, as a punishment'*.

Evidence Considered

Legislation/Policies/Guidance

63. In relation to this element of the complaint, the DoH's Complaints Procedure was considered. The following relevant extracts were identified:

'ANNEXE 1: STANDARDS FOR COMPLAINTS HANDLING

STANDARD 5: INVESTIGATION OF COMPLAINTS

HSC organisations will establish a clear system to ensure an appropriate level of investigation. Not all complaints need to be investigated to the same degree. A thorough, documented investigation will be undertaken, where appropriate, including a review of what happened, how it happened and why it happened.

2. Investigations are robust and proportionate and the findings are supported by the evidence;
3. A variety of flexible techniques are used to investigate complaints, dependent on the nature and complexity of the complaint and the needs of the complainant…

STANDARD 6: RESPONDING TO COMPLAINTS
All complaints will be responded to as promptly as possible and all issues raised will be addressed.
Rationale:
All complainants have a right to expect their complaint to be dealt with promptly and in an open and honest manner.
Criteria…
4. Responses will be clear, accurate, balanced, simple, fair and easy to understand. All the issues raised in the complaint will be addressed and, where appropriate, the response will contain an apology…

Annexe 4: Complaints raised about care or treatment or about issues relating to the provision of Prison Healthcare will be dealt with under the HSC Complaints Procedure'.

The Trust's response to investigation enquiries

64. In response to the complaint that the Trust did not respond to the questions she raised, the Trust explained that '*the complaint responses to [the patient] clarified that the GP required to see her for assessment before Codeine could be prescribed within prison'*.

65. In relation to the complaints process followed, the Trust explained that the patient's '*initial complaint was received on 12 April 2018, some five months after she left custody. There were no meetings held with [her] and all communication has been via written correspondence'*.

66. The Trust was asked to provide details of the investigation conducted into the complaint. It explained that the Prison Healthcare team '*requested the*

Operational Nurse Manager for Hydebank Wood [the prison] investigate the matters raised. The Operational Nurse Manager investigated the matters raised within the complaint and the outcome of this investigation is detailed within the response letter to [the patient] dated 3 May 2018'. The Trust further explained that '*both investigations were conducted by reviewing the clinical records. As [the patient] had left custody, there was no meeting with her and there was no requirement for staff interviews as the clinical record provided the full detail. There are therefore no other documents relating to this investigation'*.

67. The Trust explained that '*the second investigation was undertaken by a different manager as the Operational Nurse Manager who undertook the initial investigation had now retired from the service. This investigation involved a review of [the patient's] EMIS record and the initial complaint and response to same. The findings of the second investigation noted errors in the original response, namely that Codeine Phosphate had been inaccurately referred to as Cocodamol. Whilst both of these medications contain codeine, these are different medications. This was clarified in the letter of response to [the patient] dated 3 July 2018 with an apology for this error'*.

68. A draft copy of this report was provided to the Trust for its review and comment. In its response, the Trust provided an audit record evidencing that the investigators accessed the patient's clinical records in both April and June 2018. It also provided a further response regarding this issue of complaint. These comments are referred to later in this report.

The Trust's records regarding the complaints process

69. The Trust provided documents relating to how it handled the complaint. These were carefully considered.

Analysis and Findings

70. The patient complained that in its response to her complaint raised in April 2018, the Trust did not fully answer the questions she raised. She complained that the Trust did not provide her with a reason why her medication was withheld from her during her stay in prison. I note that in her correspondence to

the Trust, she complained that she was not provided with her '*prescribed medication for some days'*.

71. I have carefully considered the file provided by the Trust. I note that in its response to investigation enquiries, the Trust explained that it reviewed the clinical records prior to providing her with its response. I also note the audit record provided by the Trust in response to a draft copy of this report. This record evidences that the Trust accessed the patient's clinical records for the period she was in custody. I am satisfied that this provides evidence that the Trust conducted a review of the clinical records following receipt of her complaint.

72. I note that in its response to the complaint, the Trust provided a list of the medications prescribed to the patient by the Prison Healthcare team. It also included a narrative of her interactions with the Prison Healthcare team during her time in prison. It is clear that having received the Trust's response, the patient did not understand the reasons for its decision not to uphold her complaint. I acknowledge that the Trust wished to provide her with clear, simple and easy to understand explanations. However, I consider that the Trust's response could have set out more clearly the reasons for the Prison Healthcare's decision to discontinue the community prescription for codeine phosphate and zolpidem while the patient was in custody and until it was reviewed by a GP. I note that in its response to the draft report, the Trust explained that it informed her that a GP appointment was required before the medication could be prescribed. I accept the Trust's further explanation regarding how it approached responding to the complaint. **Therefore, I do not uphold this element of the complaint**. However, I would ask the Trust to consider the points raised regarding the clarity of its response to the patient's complaint.

73. I note that the patient also complained to the Trust that she '*asked many times'* to see a doctor but was '*refused*'. The investigation has established that there was no evidence to suggest that her request to see a GP was refused. In its response to the draft copy of this report, the Trust explained that it informed the

patient that a '*GP appointment was arranged to discuss treatment options'* and that she was '*released…before the GP appointment could take place'*. It is again clear that the patient did not understand the Trust's reasons for not upholding this element of her complaint. I consider that the Trust ought to have explained to her that she had not been denied access to a GP while she was in custody. I also consider that it ought to have provided her with details of the occasions in which a GP was consulted about her care. I consider that this would have adequately addressed her concern. I accept the Trust's further explanation regarding how it approached responding to the complaint. **Therefore, I also do not uphold this element of the complaint**. However, I would again ask the Trust to consider the points raised regarding the clarity of its response to this element of the complaint.

74. I note that the patient also complained that the Trust did not apologise for the actions of the Prison Healthcare team, which led her to believe that her medication was stopped '*on purpose, as a punishment'*. Standard 6 of the DoH's Complaints Procedure states that '*where appropriate, the response will contain an apology*'. I consider that as it was the Trust's view that the Prison Healthcare team's actions were reasonable, an apology was not required. **Therefore, I do not uphold this element of the complaint.** However, I also consider that had the Trust's response fully addressed all of the patient's issues of complaint, this would have helped to alleviate her concerns.

CONCLUSION

75. The patient submitted a complaint to this office about the actions of the Prison Healthcare team's care and treatment of her during her stay in prison. She also complained about the Trust's handling of her subsequent complaint.

76. The investigation did not find maladministration nor failures in the care and treatment of the patient in relation to the following matters:

    i. The Prison Healthcare team's decision not to prescribe nor administer

zolpidem and codeine phosphate to the patient during her stay in prison;

ii. The Prison Healthcare’s actions in referring the patient to a prison GP;

iii. The failure of the Trust to appropriately record its findings and respond to all the issues raised by the patient in her complaint; and

iv. The Trust’s failure to provide an apology to the patient in its response to her complaint.

77. I shared the draft report with the patient and she responded with her comments. I reviewed her response and corrected factual errors identified by her. After careful consideration of the additional comments made by the patient, I have not made any further amendments.

78. A draft copy of this report was also shared with the Trust for its review and comment. The Trust accepted the findings relating to Issue One of this report. It provided comments regarding Issue Two. These comments are referred to previously in this report.

PAUL MCFADDEN
Deputy Ombudsman **January 2020**

APPENDIX ONE

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and with regard for the rights of those concerned.
- Acting in accordance with the public body's policy and guidance (published or internal).
- Taking proper account of established good practice.
- Providing effective services, using appropriately trained and competent staff.
- Taking reasonable decisions, based on all relevant considerations.

2. Being customer focused

- Ensuring people can access services easily.
- Informing customers what they can expect and what the public body expects of them.
- Keeping to its commitments, including any published service standards.
- Dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances
- Responding to customers' needs flexibly, including, where appropriate, co-ordinating a response with other service providers.

3. Being open and accountable

- Being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete.
- Stating its criteria for decision making and giving reasons for decisions
- Handling information properly and appropriately.
- Keeping proper and appropriate records.
- Taking responsibility for its actions.

4. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy.
- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests.
- Dealing with people and issues objectively and consistently.
- Ensuring that decisions and actions are proportionate, appropriate and fair.

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Putting mistakes right quickly and effectively.
- Providing clear and timely information on how and when to appeal or complain.
- Operating an effective complaints procedure, which includes offering a fair and appropriate remedy when a complaint is upheld.

6. Seeking continuous improvement

- Reviewing policies and procedures regularly to ensure they are effective.
- Asking for feedback and using it to improve services and performance.
- Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

Getting it right

- Acting in accordance with the law and relevant guidance, and with regard for the rights of those concerned.
- Ensuring that those at the top of the public body provide leadership to support good complaint management and develop an organisational culture that values complaints.
- Having clear governance arrangements, which set out roles and responsibilities, and ensure lessons are learnt from complaints.
- Including complaint management as an integral part of service design.
- Ensuring that staff are equipped and empowered to act decisively to resolve complaints.
- Focusing on the outcomes for the complainant and the public body.
- Signposting to the next stage of the complaints procedure, in the right way and at the right time.

Being Customer focused

- Having clear and simple procedures.
- Ensuring that complainants can easily access the service dealing with complaints, and informing them about advice and advocacy services where appropriate.
- Dealing with complainants promptly and sensitively, bearing in mind their individual circumstances.
- Listening to complainants to understand the complaint and the outcome they are seeking.
- Responding flexibly, including co-ordinating responses with any other bodies involved in the same complaint, where appropriate.

Being open and accountable

- Publishing clear, accurate and complete information about how to complain, and how and when to take complaints further.
- Publishing service standards for handling complaints.
- Providing honest, evidence-based explanations and giving reasons for decisions.
- Keeping full and accurate records.

Acting fairly and proportionately

- Treating the complainant impartially, and without unlawful discrimination or prejudice.
- Ensuring that complaints are investigated thoroughly and fairly to establish the facts of the case.
- Ensuring that decisions are proportionate, appropriate and fair.
- Ensuring that complaints are reviewed by someone not involved in the events leading to the complaint.
- Acting fairly towards staff complained about as well as towards complainants.

Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Providing prompt, appropriate and proportionate remedies.
- Considering all the relevant factors of the case when offering remedies.
- Taking account of any injustice or hardship that results from pursuing the complaint as well as from the original dispute.

Seeking continuous improvement

- Using all feedback and the lessons learnt from complaints to improve service design and delivery.
- Having systems in place to record, analyse and report on the learning from complaints.
- Regularly reviewing the lessons to be learnt from complaints.
- Where appropriate, telling the complainant about the lessons learnt and changes made to services, guidance or policy.