

**Investigation into the circumstances surrounding the
death of a male prisoner from HMP Wakefield at a hospital
in June 2007**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

May 2009

This is the report of an investigation into the circumstances surrounding the death of a man on 14 June 2007. The man died at Pinderfields General Hospital, Wakefield, whilst in the custody of HMP Wakefield. The post mortem examination showed the cause of death as superior vena cava obstruction with bronchopneumonia due to carcinoma of the lung (lung cancer).

The man had arrived at HMP Wakefield in December 2005 with little in the way of health problems, save for the fact he was a heavy smoker. In February 2007, the man began to feel unwell with what was believed to be a chest infection. It transpired that this was most likely the onset of the lung cancer that killed him. In the end stage of the man's illness, he became very short of breath and so desperate for help that he cut his arm. Coupled with his shortness of breath, this led to his admission to hospital where he was diagnosed with cancer. He died four days later.

I extend my condolences to the family and friends of the man for their loss. After the issuing of my draft report, the man's ex wife was given the opportunity to respond to the content of my report. She wrote to my Family Liaison Officer explaining that she found the whole experience too traumatic to relive by reading my report. She did however want some points reiterated in the hope that 'it will stop this ever happening again'. The man's ex wife expressed her unhappiness that, as she saw it, the prison doctors and governors did not take sufficient heed of the man's illness. She praised the compassion of nursing staff, particularly those who ensured the man got to hospital and the nurses at Pinderfields Hospital. I hope, when the man's ex wife feels strong enough to fully read this report, that questions she has at the moment are fully answered within it.

One of my investigators conducted the investigation. I am grateful to two members of the Wakefield District Primary Care Trust who undertook the clinical review into the care and treatment afforded the man whilst he was in prison. I would also like to thank the Governor of HMP Wakefield, her predecessor, and their staff for their help and co-operation during the investigation.

I make three recommendations in this report in respect of health related matters. I draw attention to an act of self-harm that might well not have occurred had the man been referred earlier for tests and appropriate treatment.

The issuing of this report has been delayed in part by the clinical review, and I must apologise to all those affected.

Jane Webb
Acting Prisons and Probation Ombudsman
May 2009

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SUMMARY

In February 2002, the man was sentenced to ten years imprisonment at a local Crown Court. He was taken to HMP Doncaster where, at his initial health screening, he declared he was a heavy smoker and had had problems with alcohol since his early twenties. He denied the offences of which he had been convicted.

Later that year, in November 2002, the man was transferred to HMP Full Sutton. Whilst there, the man had some blood test results that were abnormal and required referral to the consultant haematologist at York General Hospital. He underwent tests and was given a clean bill of health in October 2005.

In December 2005, the man was transferred to HMP Wakefield. With the exception of the matters that had been investigated by the doctors at Full Sutton, the man's health caused neither him nor the health services at Wakefield any concern. The most longstanding problem the man had was neuralgia (a severe facial nerve pain), which persisted for many years and required constant pain relief.

The man continued to deny involvement in the offences for which he had been found guilty. This meant he could not undertake any of the offending behaviour courses that were a requirement of his sentence management plan.

In February 2007, the man was assessed by nursing staff as he had a persistent cough and breathlessness. He was treated for a chest infection. He was seen on 27 April when he complained of similar symptoms and was treated for another chest infection. In addition, this time the nurse recommended investigation for asthma and/or Chronic Obstructive Pulmonary Disease (COPD - a disease of the lungs that affects their effectiveness and is often found in heavy smokers).

The man was seen again on 4 May, but he was no better. The nurse recommended that he should be seen by the doctor and sent for a chest x-ray. The man was seen by the doctor on 8 May, who agreed that he needed a chest x-ray and so referred him to the local hospital. It is not clear when the referral was despatched to the hospital.

The doctor saw the man again on 17 May, and found that he had oedema (swelling) of the ankles and around the heart. She prescribed a diuretic to reduce the swellings. She asked that he should return a week later on 24 May. However, the man was not seen for two weeks until 31 May when he was found to have improved breathing and the swelling had reduced.

On 9 June, the man was seen by nursing staff in the afternoon because he felt unwell and was finding it hard to breathe. When the nurse took his clinical observations, she found he had high blood pressure and low oxygen saturations (a measurement of how much oxygen was in the man's blood). She suggested that he should be admitted to the prison's in-patient unit, but he declined. He was seen again at 6.30pm that evening with the same health concerns, and again refused to be admitted to the healthcare centre.

At 12.10am on 10 June, the man was seen by the night nurse because he had cut his forearm. He said he had done this because he could not cope any longer with being unable to breathe properly. A locum doctor was called and decided to send the man to the local hospital (Pinderfields General Hospital). The man was admitted to the hospital and transferred on 11 June to the Intensive Therapy Unit. On 12 June, the man was diagnosed with lung cancer. The man remained poorly on a ventilator throughout the next two days. At 2.43pm on 14 June 2007, he died from lung cancer.

THE INVESTIGATION PROCESS

1. My Investigator visited HMP Wakefield on 11 July 2007. He was given access to the man's prison records and the wing where the man was resident prior to his admission to hospital. Notices of my investigation for staff and prisoners were already on display throughout the prison when the Investigator visited. As a result of these notices, two prisoners asked to see the Investigator. The Investigator informally interviewed both men on 11 July.
2. The man's family were also visiting the prison on 11 July for a memorial service. The service was held in the prison chapel and attended by a small number of the man's friends. The Investigator took the opportunity to introduce himself to the family and explained the role of the Ombudsman's office and the nature and scope of this investigation. The family raised their concern at this meeting regarding the man's self harming behaviour prior to his admission to hospital. They were shocked to learn of this, as the man had never previously tried to hurt himself.
3. The Investigator also met a member of the prison's Independent Monitoring Board (IMB) and a representative of the Prison Officers' Association (POA) on this visit to Wakefield. The Healthcare Manager assisted the Investigator in ensuring all the clinical records were available as some documents seemed to be missing at this time.
4. Wakefield Primary Care Trust carried out an independent clinical review of the man's healthcare at Wakefield. A member of Staff from Wakefield Primary Care Trust commissioned the review, which was completed by a Doctor from the PCT. The PCT's intention was that this clinical review, in conjunction with two other clinical reviews being undertaken at the same time, should be the subject of a clinical panel review of three deaths that had recently occurred at Wakefield. Unfortunately, this led to a significant delay in my receiving a clinical review into the care afforded the man.
5. One of my Family Liaison Officers contacted the man's family in writing on 3 July 2007 to advise them of the aims of the investigation and to offer the opportunity to raise any concerns or questions they might have. Other than at the meeting with the Investigator on 11 July, the family have not expressed any further issues or concerns.
6. The Investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion, a copy of my report was sent to HM Coroner to assist his enquiries into the man's death.

HMP WAKEFIELD

7. Wakefield is a high-security prison for men in security categories A and B. It is now a main lifer centre with the focus on serious sex offenders. The prison dates back to 1845 and the wings are arranged in the Victorian radial style. The segregation unit and healthcare centre are separate from the main residential areas. Each wing is built on four levels or landings. All cells have integral sanitation and the prison recently underwent a refurbishment programme. All wings have been refurbished, with A wing most recently completed in January 2006.
8. A number of concerns relating to the provision of healthcare services were raised in a report by HM Chief Inspector of Prisons, following an unannounced inspection in April 2005. It was highlighted that only the clinical director was in post and the development of a pharmacist-led minor ailments clinic to free up doctor and nurse time was needed. It was also noted that the use of locums to cover for the shortfall of doctors in the prison led to a concern over the continuity of care. These worries were re-iterated by the Independent Monitoring Board in its report of 2006-07.
9. The transfer of commissioning responsibility for HMP Wakefield's health services to the West Wakefield Primary Care Trust (PCT) took place in April 2005. The PCT is also responsible for the provision of healthcare at HMP/YOI New Hall. Staff at Wakefield told HM Chief Inspector that they felt priority was being given to New Hall at the expense of Wakefield, and there was concern about the development of clinical services at Wakefield and the future management of healthcare staff.
10. The IMB also raised a concern in their report covering 2006-07, as prison healthcare was still being affected by the commissioning of PCT services. At that time the situation was that the Governor employed the staff whilst the budgets were held by the PCT.
11. A full-time locum, plus another locum doctor who was working two hours in an afternoon, provided medical cover in 2006-07. At night, the prison relied on local care direct for the out of hours service. Problems had arisen between the hours of 5.00am and 6.00am when the deputising service is not staffed and calls are handled by prison nurses.
12. There have been 14 deaths at HMP Wakefield since I was given responsibility for investigating all deaths in prison custody in 2004, eight of which have been due to natural causes. One recommendation contained within this report is similar to one I made in an earlier report in respect of referral of patients to other services.

KEY FINDINGS

13. The man married in the 1970s and had two children. He and his wife had divorced and were living apart.
14. In February 2002, the man was sentenced to ten years imprisonment for serious offences at a local Crown Court and taken to HMP Doncaster. The first entry on his Continuous Medical Record (CMR) at HMP Doncaster was dated 26 February 2002, but this should presumably read 28 February. It says that this was the man's first time in prison, that he felt okay and was calm, open and relaxed. His initial health screening form recorded that he had no past medical history of note, that he was not suicidal or suffering any mental health problems, and that he was worried about how he would cope with prison (although he was not thought to be depressed). The only other comment was in respect of his smoking 40 cigarettes a day and his use of alcohol in the past, although there was no indication from this assessment that he had a current problem with alcohol.
15. The entries dated 14 March in the CMR indicate that the man had been taken to the healthcare centre to be interviewed. The first entry said that the man had no history or intention of self harm. It also noted that the man was a recovering alcoholic who had low periods but would seek help if needed. It concluded that there was no need of "... a watch" (a reference to the need for the man to be on observation as a suicide risk).
16. A second entry on 14 March 2002 is identified as a secondary mental health assessment. It says that the man was very calm and understood why he had to attend the healthcare centre for a chat. The man was described as being very open and communicative. The entry concluded that there was no need for a watch.
17. The man complained of tooth problems in June 2002, and requested a prescription for pain relief. He was prescribed Ibuprofen. On 5 July, he was seen and treated by the dentist.
18. The man was transferred to HMP Full Sutton on 5 November 2002. His reception health screening noted that "... he is physically and mentally well" and that he had transferred from Doncaster. It was also noted that he suffered sciatica in his right leg and occasional paraesthesia (pins and needles) in his left leg. He had no history of asthma, was not prescribed medication at the time, had no history of allergies, and no history of drug abuse.
19. Regarding his mental health, the screening said the man had no history of self harm or suicide attempts, and was not thinking of self harm or suicide at that time. It noted that the man was smoking three ounces of tobacco a week and that he was a recovering alcoholic prior to prison and had undergone alcohol detoxification before. It finished by saying that the man looked healthy and maintained good eye contact, was in "average" mood and that he was fit and well for prison work. It noted a tattoo on his right forearm.

20. The man was seen on 18 August complaining of kidney pain. The assessing nurse noted that nothing abnormal was detected in a urine sample provided by the man and that he had no problem passing urine. The man was advised to see the doctor if the problem continued.
21. In February 2004, the man was found to have high blood pressure (an initial reading of 173/110) and was suffering from a persistent cough. The blood pressure test was repeated later that same day when it had dropped to 150/90. The man had an electrocardiograph (ECG) which was followed up by a further blood pressure reading on 27 February (140/95) and an x-ray was ordered.
22. The man went for an x-ray on 1 March which was reported on by the radiologist on 6 March. He wrote, "There is what I take to be chronic pleural thickening at right CPA. I cannot see any active changes but old film would be required to be absolutely certain. Overall low probability of active disease." This does not appear to have been followed up.
23. Also on 1 March the man had blood taken for blood tests. During the procedure it appears that he fainted and was given oxygen and a glucose tablet, after which he quickly recovered. His blood pressure was taken (BP120/75, which is a normal reading) and he was returned to his wing.
24. In March and April 2005, the man was investigated for feelings of tiredness and having persistent headaches. The blood test results showed that he had a slight abnormality and he was therefore referred to a Consultant Haematologist at York Hospital. After further investigation, the Consultant diagnosed that the man had probably had a recent viral infection and did not need any further treatment. However, he did recommend that the man be seen for an endoscopy and colonoscopy in order to eliminate any cancer risk.
25. On 19 October, the man was seen at York Hospital by a Doctor who performed the endoscopy and colonoscopy. The results of the investigations were normal.
26. The man was transferred to HMP Wakefield on 6 December 2005. He received the standard reception health screening procedure and was said to be feeling fine and not suicidal, with no sign of low mood detected.
27. From early in March 2006, the man complained on a number of occasions of left trigeminal neuralgia (a tooth pain that goes up into the upper jaw and head). He was initially prescribed Carbamazepine (Tegretol) for this pain, with frequent reviews of the medication.
28. On 2 January 2007, the man was seen by the doctor because he was suffering with the side effects of the Carbamazepine (a rash, swelling and tenderness). The Carbamazepine was stopped and replaced with Gabapentin 300mg to be taken once each day for 28 days.

29. Sometime between 2 and 25 January the man must have been seen again as the entry on 25 January says, "No IMR. Gabapentin is helping at 400mg tds [medication to be taken three times a day]." This was signed by a Prison Doctor but there is no clear record of when the Gabapentin was increased or by whom.
30. On 20 February, the man was seen at the First Contact Clinic which is run by nursing staff. A Nurse examined the man and found that he was coughing up phlegm, was breathless, and reported having these conditions for the previous three weeks. She diagnosed that he had a chest infection and prescribed the antibiotic Amoxicillin 500mg to be taken three times a day. She also noted that the man had a raised cholesterol level in his blood. She wanted to see him again one month later.
31. The man returned to the First Contact Clinic on 20 March (it is not known which nurse saw him on this occasion) but there is no mention of cough or breathlessness, just neck and shoulder pain with some sinusitis. He was prescribed nasal spray and Ibuprofen for these conditions.
32. On 27 April, the man was seen by a Healthcare Officer (who is a registered nurse also) at the First Contact Clinic. She recorded that the man had a cough with thick green sputum being produced. She listened to his chest and found him to be wheezy with a "tight" chest and "rattly". She diagnosed a chest infection and again prescribed a course of antibiotics (this time Amoxicillin 250mg to be taken three times a day). She questioned whether the man might also be asthmatic or suffering from COPD. She asked that he return to see her on 4 May.
33. The Healthcare Officer saw the man again at the First Contact Clinic on 4 May at 10.10am. She found that the man's chest was no better and that he was still short of breath when walking and talking to staff. She tested his peak flow (although did not record the result) and checked that he had inhalers and knew how to use them. The Healthcare Officer thought that the man needed to be sent for a chest x-ray and a spirometry test (a test that measures the capacity of the lungs). She also decided to refer the man to the doctor the following week.
34. The Prison Doctor saw the man on 8 May in response to the Healthcare Officer's referral. Her entry in the CMR reads, "Referral from 1st contact clinic. Prolonged cough, smokes 1½ oz tobacco per week. Referral for spirometry to ascertain a diagnosis of COPD. Sent [or send] for CXR."
35. The Prison Doctor saw the man again on 17 May as she was concerned about his previous history of tuberculosis (TB). She spoke with the TB specialist in the Respiratory Clinic at Pinderfields Hospital. (The man had apparently suffered TB in 1973 and been treated, but this had never been recorded in his prison medical history.) The Prison Doctor also wrote to the labour allocation clerk in the prison asking that more suitable work be found for the man where he did not have to walk so far and there was "no dusty atmosphere".

36. The Prison Doctor examined the man and found that he was short of breath with crepitation (a grating sound) in the lungs. He was suffering from pulmonary oedema (heart failure) and oedema (swelling) at the ankle. The man was prescribed Frusemide 40mg (a diuretic designed to reduce the swelling of the ankles and heart failure by making him pass more urine) daily for seven days, and was to be reviewed the following Thursday (24 May).
37. It appears that the man was next seen on 31 May. He was found to have better breathing and the ankle oedema had also improved. His existing medication, including the Frusemide and inhalers, was repeated.
38. On Saturday 9 June at 2.15pm, the man asked to be seen by the nurse again. He complained of feeling generally unwell and of difficulty breathing. He was seen by a Nurse, who reviewed his medical record before seeing him. She noted that the man had been seen by the doctor several times for the same breathing complaint over the preceding few months. In her interview with the investigator, the Nurse said that she had noted that, although the man had previously complained about a similar breathing condition, he had not had any clinical observations recorded. Consequently, there were no baseline readings to compare any subsequent observations against. She therefore measured his blood pressure (184/103 which is high), pulse (84, which is a bit fast), blood oxygen saturation (92 per cent, which is low), temperature (36°C - normal), and peak flow (160, very low). The Nurse offered to admit the man to the healthcare centre, but he declined her offer. She advised the man to rest and to attend the First Contact Clinic on the Monday (11 June). Wing staff arranged to assist the man collect his meals and hot water.
39. At 6.30pm, the man asked to be seen again. He told the same Nurse that he was struggling to cope and that his inhalers were not working. The Nurse again took his observations. She measured his blood pressure (173/92 which is again high), pulse (89, too fast), blood oxygen saturation (90 per cent, which is too low), and respirations (32, too fast). The Nurse provided the man with 5mgs of Salbutamol in a nebuliser, which the man was happy to use as he told the Nurse he had borrowed one from another prisoner previously. The Nurse repeated the offer of a place in the healthcare centre, but the man again declined.
40. The Nurse arranged for a Healthcare Officer to collect the nebuliser from the wing later as it was required by another prisoner that evening. She also gave a verbal handover to the night staff (the Healthcare Officer who saw him when he went to the first contact clinic and a Night Nurse) to familiarise them with the man's condition.
41. At 00.10am on Sunday 10 June, a call was received at the healthcare centre from a prison officer on the wing to say that the man had cut his arm. The Night Nurse and the Healthcare Officer who saw the man in the first contact clinic went to see the man in his cell. (The Officer was supernumerary to the usual complement of staff on the night shift, and was familiarising himself with the duties of a healthcare worker at night.)

42. On arrival at the man's cell, the Night Nurse noted that the injury was a three inch cut to his left forearm. She treated it by applying steri strips (butterfly stitches) which stopped the bleeding. In interview, she said that when she spoke to the man, "he was quite agitated. He wasn't really able to give an account really and seemed a little confused." She felt that he did not look well in himself, saying that, "... he looked ashen. I think my knowledge and experience told me that there was something wrong with this man ..."
43. At this point, the Night Nurse decided that, while the man did not warrant an emergency ambulance, she would move him to the healthcare centre to assess him and carry out a set of observations. She got a wheelchair to move the man between his cell and the healthcare centre.
44. At the healthcare centre, the Night Nurse did a set of observations (BP 173/116, pulse 99, oxygen saturation 87 per cent, respirations 32, body temperature normal). The man told her that he had self harmed because he was feeling desperate and could not cope with being unable to breathe. He told the Night Nurse that the nebuliser had not provided any relief.
45. The Healthcare Officer who saw the man when he went to the first contact clinic was in the healthcare centre when the man arrived. She removed the temporary dressing applied by the Night Nurse ready for the doctor who had been called. During the wait for the doctor, the Night Nurse and the Healthcare Officer both attended to the man as each had other duties to perform. It was during this time that the man's condition visibly deteriorated. The nurses were unable to administer oxygen as the man was agitated.
46. The doctor from the out of hours service arrived at 1.30am. He requested that the man's observations be carried out again (BP 173/93, pulse 100, oxygen saturation 86 per cent, peak flow 160). The doctor questioned the man but he was unable to respond due to his agitated state. The Healthcare Officer tried at this point to act as the man's advocate and reply to the doctor's questions, but the doctor was only interested in getting responses from the man. The doctor decided that it would be necessary for the man to go to hospital. An emergency ambulance was called to take him to Accident and Emergency Department at Pinderfields Hospital.
47. The ambulance arrived at 2.00am. The doctor had by this time already left the prison saying that he had to attend another call elsewhere. The man was taken by the paramedics to Pinderfields Hospital.
48. Before the man left Wakefield, an Assessment, Care in Custody and Teamwork (ACCT) form was opened because of his attempt at self harm. (ACCT is the procedure by which staff can work together to provide individualised care to a prisoner who is in distress with the aim of defusing a potentially suicidal crisis or better managing and reducing the person's distress. Any member of staff who has concern about a prisoner can instigate this process.) The night patrol officer completed the document that starts the

ACCT process and recorded that the man had cut himself, “because he was frustrated at not being able to breathe.”

49. An unidentified author wrote in the on-going record of the ACCT document at 1.05am, “Admitted to HCC [healthcare centre]. Found to have made a large laceration to his left forearm with a blade. This is his first attempt at self-harm. Has been having difficulty with his breathing all day and stated that he had cut himself as he was feeling desperate and could not cope with being unable to breathe.”
50. The man was examined by staff at Pinderfields Hospital and admitted to one of their wards. The following day he was transferred to the Intensive Therapy Unit (ITU) where he was so critically ill that he required a ventilator.
51. On 12 June, the hospital diagnosed that the man had lung cancer. He had a large growth within his lungs and was not expected to survive very long. A decision was made that, should he go into “cardiac arrest”, no efforts would be made to resuscitate him. The man remained on a ventilator.
52. It is unclear from the records whether the man suffered any heart attack or whether the consultant in the ITU made the decision to withdraw the ventilator. In any event, the man died on 14 June at 2.43pm. The cause of death recorded in the post mortem report is “superior vena cava obstruction with bronchopneumonia due to carcinoma of the lung”. In other words, the man died of lung cancer.

ISSUES

53. The care that the man received within the prison system up until 20 February 2007 is not criticised in the clinical review undertaken by the Clinical Reviewer. The events that cause concern occur after this date and relate specifically to how the man was managed medically in relation to his shortness of breath.
54. The Clinical Reviewer considers that, because the man was known to be suffering from COPD and had contracted a chest infection in February which improved in March, that this was to be expected. However, the recurrence of the cough, and the shortness of breath coupled with a wheeze, warranted better care than was provided.
55. In the Clinical Reviewer's view the second episode of breathing difficulties, examined by the Healthcare Officer who saw the man when he went to the first contact clinic on 27 April 2007, should have triggered a more urgent referral to a specialist respiratory centre for a respiratory function test. Furthermore, staff at Wakefield could have started by measuring and monitoring the man's peak flow (a simple test undertaken in every doctor's surgery across the country). The Clinical Reviewer also suggests a chest x-ray should have been requested at this time.
56. The clinical review points to a number of significant issues. The first is the lack of baseline measurements generally for the man. It was not until 9 June 2007 (when the Night Nurse took and recorded the man's observations) that any attempt seems to have been made to capture these baseline observations. As a consequence, the Nurse was unable to compare her measurements with any earlier ones and would have had difficulty determining if her findings were within or outside the man's normal limits. As it was, the man's pulse was a little fast, his blood pressure was slightly too high, his oxygen levels were too low and his peak flow reading was very low. The Nurse did, in fact, offer to admit the man to the healthcare centre but he declined. With these readings, she should then have referred the man to the doctor. The Clinical Reviewer says an oxygen saturation level of 92 per cent would warrant medical advice as this is significantly below a normal level.
57. The second issue highlighted by the clinical review is the absence of referral to secondary services. On the man's visit to the First Contact Clinic on 27 April, he should have been seen by the prison doctors. He should also have been referred for a chest x-ray.
58. The man was seen by the Healthcare Officer in the First Contact Clinic on 4 May and she recommended that he be sent for a chest x-ray and a spirometry test. On 8 May, the Prison Doctor saw the man and said "sent" or "send" for chest x-ray. It is not clear from the records that this was acted on. What is clear was that this was not deemed urgent and that everyone thought the system was taking care of this "referral". On 17 May, the man was seen by the Prison Doctor who diagnosed heart failure and treated the man with a diuretic. In the clinical reviewer's opinion, the man's condition on 17 May

warranted an urgent referral for a chest x-ray that would see the patient being taken to the local hospital within 24 hours of the referral.

The healthcare manager, in conjunction with the PCT, should ensure there is a robust system in place for appropriate prisoner-patient referrals to other multi-disciplinary health services (including secondary care services).

59. As I have found in many of my investigations, the clinical record was poorly completed. There were entries that were out of date order, some papers were misfiled, and signatures and entries were illegible.

The healthcare manager should ensure that good standards of record keeping in the medical record are maintained, in compliance with the Nursing and Midwifery Council Guidelines for Records and Record Keeping and Department of Health and NHS Code of Practice Records Management.

The healthcare manager, in conjunction with the PCT, should ensure that patient observations are made and recorded.

60. When the man cut his forearm on 10 June, the prison responded by putting him on an open ACCT document. That was the correct action. However, I note that the man's behaviour was completely out of character as he had never self-harmed before. It may be an indication of the distress he was under that the man felt he had no option but to cut his own arm. If prompt and appropriate medical interventions had been afforded earlier, it seems most improbable that he would have resorted to such uncharacteristic behaviour. The Clinical Reviewer says that, "given the ultimate diagnosis, it is unlikely that death would have been avoided. The episode of self-harm however may not have occurred." This is self-evidently a very unhappy finding.

RECOMMENDATIONS

The following recommendations were made in the draft version of the report. The Prison Service's responses are included in italics following each recommendation.

The healthcare manager, in conjunction with the PCT, should ensure there is a robust system in place for appropriate prisoner-patient referrals to other multi-disciplinary health services (including secondary care services).

Recommendation accepted: A formal review/audit of Referrals to Secondary Services will be completed by the Healthcare Manager. The Prison GP and representatives from NHSWD, to assess attendance, waiting time since referral, and cancellation processes etc.

The healthcare manager should ensure that good standards of record keeping in the medical record are maintained, in compliance with the Nursing and Midwifery Council Guidelines for Records and Record Keeping and Department of Health and NHS Code of Practice Records Management.

Recommendation accepted: All Healthcare staff have been issued with the current Guidance on Records and Record Keeping in line with NMC Guidelines. This was also included in all Healthcare Staff SPDR's for 2008/09. HMP Wakefield has also implemented an Electronic patient Record System (SystemOne), which has significantly improved the record keeping of patients in our care. Wakefield PCT have delivered training to all Healthcare Staff in terms of Records and Record Keeping, following a previous DIC [death in custody] Recommendation.

The healthcare manager, in conjunction with the PCT, should ensure that patient observations are made and recorded.

Recommendation accepted: The Healthcare Manager will remind all Healthcare staff of the importance of taking and recording of patient observations. Notice to Staff to be issued.