Investigation into the circumstances surrounding the death of a man at outside hospital in February 2010, whilst a prisoner at HMP Woodhill

Report by the Prisons and Probation Ombudsman for England and Wales

May 2011

This is the report of an investigation into the death of a man at outside hospital in February 2010. The man was a serving prisoner at HMP Woodhill and was 63 years old when he died. He died suddenly following a heart attack.

I offer my sincere condolences to his partner and all those affected by his passing.

The investigation was conducted by one of my senior investigators. One of my family liaison officers spoke to the man's partner about the care he received at HMP Woodhill. I hope that this report provides her with a fuller understanding of events, and answers the questions that she raised. I apologise for the delay in issuing the report, which has been because of work pressures.

I would also like to extend my thanks to the Governor of Woodhill and in particular a further governor who acted as liaison officer throughout the investigation. A clinical review was commissioned through Milton Keynes PCT and they appointed a clinical reviewer to undertake the review. I am grateful for her thorough and timely contribution to this report.

The man arrived at HMP Woodhill in January 2010, although he had been in prison since 2008. He had previously suffered with leukaemia but had been in remission since 2007. After he arrived at Woodhill, the man complained of chest pain on a number of occasions. He was seen by healthcare staff and was in the process of being referred for further treatment when he became ill on the morning of his death in February 2010.

The clinical reviewer has made three recommendations, which I endorse. These relate to record keeping and the prescribing of medicines at HMP Woodhill. I make no other recommendations of my own.

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

Jane Webb
Acting Prisons and Probation Ombudsman **May 2011**

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SUMMARY

The man was sentenced to life imprisonment at Crown Court in July 2008 after being convicted of serious sexual offences. He started his sentence at HMP Bullingdon.

In 2007, the man was diagnosed with hairy cell leukaemia (a cancer of the blood or bone marrow). He made a full recovery, but continued to have blood tests every four months to help monitor his condition.

The man was transferred to HMP Woodhill in January 2010 as he refused to undertake group work designed to reduce the risk of him re-offending. He was unhappy about the transfer and told prison staff at Woodhill that this would mean it would be difficult for him to receive visits from his partner. The man also told reception staff that he believed the transfer would have a negative impact on his appeal against conviction. HMP Woodhill provided equipment to the man to assist him in planning his appeal including a laptop computer.

On 12 January, the man reported that he felt unwell. Healthcare staff responded by undertaking blood tests and an ECG (electrocardiogram - a test that measures the electric activity of the heart). The tests apart from two exceptions were within normal range.

The man was next seen on 2 February, when he was diagnosed with high blood pressure and prescribed medication to help manage this. On the eve of his death, the man was seen in his cell by a nurse who examined him and then telephoned the duty doctor to discuss his symptoms. The doctor confirmed that the man had a booked appointment to see another doctor the following day and that he would be reviewed then.

The man was seen in the afternoon the following day and, following examination, he was prescribed medication for angina (pain or discomfort in the chest) and referred to the Rapid Access Chest Pain Clinic. The doctor also planned for the man to have another ECG.

At approximately 5.30pm that evening, however, the man was found unconscious in his cell by his cellmate. Staff were alerted and called for medical assistance. Cardio Pulmonary Resuscitation was attempted by officers, healthcare staff, paramedics and hospital staff. Unfortunately the man was certified dead at outside hospital at 6.58pm.

The clinical reviewer has made three recommendations, which I endorse. These relate to record keeping and the prescribing of medicines at HMP Woodhill. I make no other recommendations of my own.

THE INVESTIGATION PROCESS

1. After this office was notified of the man's death, the investigation was allocated to one of my investigators. He visited Woodhill and spoke to staff who had come into contact with the man, including wing staff who had daily contact with him. Notices were posted to staff and prisoners about the investigation, inviting them to contribute if they wished. No prisoners have come forward requesting an interview with my investigator.

2. My investigator was provided with all relevant prison records relating to the man. These included his main prison record, medical records and statements made by staff after he died. My investigator also visited the cell where the man was taken ill.

3. Milton Keynes Primary Care Trust identified a clinical reviewer to carry out a review of the man's clinical care whilst he was at Woodhill. I am grateful to her for undertaking the review. My investigator also attended the Death in Custody Panel Review Meeting which was held on 18 May at NHS Milton Keynes. This meeting was called and organised by Milton Keynes Primary Care Trust in order to review the clinical services provided to the man.

4. My investigator also contacted HM Coroner to inform him of the scope and nature of my investigation and to request a copy of the post mortem report. The Coroner will receive a copy of my report to assist in his enquiries into the man's death.

5. My investigator interviewed three prison officers. The interviews were recorded. My investigator also interviewed two members of the healthcare team with the clinical reviewer appointed on behalf of Milton Keynes PCT. The interviews were recorded. The clinical reviewer also interviewed two other healthcare staff and notes of these interviews were provided to my investigator.

6. One of my family liaison officers wrote to the man's partner and sister. This was to explain the purpose of my investigation and to provide an opportunity to raise any issues about the care the man received at Woodhill for consideration as part of this. The man's partner asked the Ombudsman to clarify the following points; what treatment the man received on 15 February (having used his cell bell to request assistance because of pain in his chest) and also clarity about the treatment he received on the day he died.

7. The man's partner and sister received a copy of the draft version of the report as part of the consultation process. In her response to the report, the man's partner was critical of the actions of healthcare staff who she feels were lax in their approach to record keeping as well as the overall care afforded to the man. She believes they should have acted sooner in admitting her partner to hospital. She understands this may not have changed the outcome for him. However, feels this could make a

significant difference should a similar situation arise in the future. The man's partner felt healthcare staff were too ready to dismiss her partner's chest pain as "skeletal". She believes this was less likely to have been missed, had he been in the wider community. On the whole the man's partner agreed with the Ombudsman's findings and recommendations and expects the prison to be receptive to changing their practice for the better in response to these.

8. The man's sister said she had found it helpful to know the full circumstances of her brother's death and agreed overall with the findings of the report and the Ombudsman's recommendations to improve practice. The man's sister was also critical of healthcare staff, particularly with regard to the poor level of record keeping. The man's sister mentioned her brother had noted in his diary about the worsening pain in his chest and is concerned this was never properly dealt with. The man's sister asked that her thanks be relayed to prison staff, particularly their family liaison officer, for the care and support provided following her brother's death. She found prison staff to be kind and considerate and responsive to her family's needs.

HMP WOODHILL

9. HMP Woodhill opened in 1992. The prison holds some Category A prisoners (the highest level of security) as well as some of the most disruptive prisoners in the prison system in the close supervision centre. The man was a category B prisoner (Category B prisoners still require high levels of security such as high walls and locked doors around the prison).

10. Milton Keynes Primary Care Trust is responsible for commissioning healthcare at HMP Woodhill. The prison has a nursing healthcare team, a mental health in reach team and x-ray, dental, pharmacy and podiatry services.

11. The PCT also commissions a number of other agencies to provide healthcare services at Woodhill including;

    - Resuscitate Medical Services Limited who provide general medical services.
    - The Seagrave Trust, who provide substance misuse services, and
    - Howcroft and Selly, who provide ophthalmic services.

12. Prisons in England and Wales are assessed for performance by the National Offender Management Service (NOMS). For public prisons, NOMS use a combination of the Prison Performance Assessment Tool (PPAT, which looks at 33 indicators) and the public prison weighted scorecard (which looks at a set of 44 indicators). Each establishment is then given a rating between one and four (one being “serious concerns” and four “exceptional performance”). For the last four quarters, Woodhill has been given a rating of three, or “good performance”.

HM Chief Inspector of Prisons’ report

13. The last inspection of Woodhill by the Chief Inspector of Prisons covers a full, unannounced follow-up inspection held between 16-20 November 2009. The then Chief Inspector commented in her foreword to the inspection report:

    > “Woodhill had largely maintained its progress since the last inspection. It is a largely safe place, providing appropriate levels of security for a very diverse population, and with improved staff-prisoner relationships. Health services remain a significant concern, and need urgent attention.”

14. Inspectors made several further recommendations as a result of the inspection. They also commented on several matters of relevance to this investigation. On medication, they said:

    > “A central medication process had been introduced earlier in 2009 but was not working effectively. Prisoners complained to us about missing and late medications and there was

inadequate follow-up of prisoners, particularly those detoxing, who missed appointments."

15. The lack of an electronic medical record was also noted, although inspectors did report that a new computer recording system was due to be introduced the week after the inspection. Inspectors noted that "healthcare staff were proactive in their approach", and cited several examples of good care.

Independent Monitoring Board (IMB) report

16. Every prison is monitored by an Independent Monitoring Board, members of which are drawn from the local community whose role is to ensure standards of decency and care are maintained. They have full access to prisoners and every part of the establishment, and produce an annual report for the Secretary of State for Justice. In their last published report, covering the period from June 2008 to May 2009, the IMB described the previous year as "challenging", listing several areas where budget cuts has affected the prison.

17. In the section on healthcare, the IMB noted that there was a shortfall of nurses that "needed to be urgently addressed." They also noted that a new medical records system was to be introduced.

Previous PPO investigations at Woodhill

18. This is the eighth death at Woodhill as a result of natural causes since the Ombudsman took responsibility for investigating deaths in custody in 2004. I have previously made recommendations about the standard of record keeping as a result of these recommendations. In the report of an investigation into a death following a suicide, I also made a national recommendation that all staff should be issued with protective face masks to assist staff if required to carry out resuscitation. Although the national recommendation was rejected, Woodhill confirmed that "[they have] already purchased and issued pouches containing gloves and a protective face mask, to all staff who work directly with prisoners".

KEY FINDINGS

19. The man was sentenced to a sentence of life imprisonment in July 2008 at Crown Court. He was sentenced under the terms of indeterminate period of imprisonment for public protection (IPP, a sentence which sets a minimum term of custody, after which release can only be authorised by the Parole Board). At the time of his death, he was appealing against his sentence.

20. The man first went into custody at HMP Bullingdon. During a healthscreening interview at reception, he told medical staff that he had been diagnosed with hairy cell variant leukaemia in March 2007 for which he received chemotherapy. He also told staff that he had been told he was in remission (cured) in July 2007. During his healthscreen, he also told staff that he had "never had chest pain". (The clinical reviewer has found a letter from outside hospital, where the man was being treated for leukaemia, which states "he had a single episode of chest pain some weeks ago which was central and crushing in nature but does not recur".) There is no further reference to chest pain prior to 2010.

21. After he continued to refuse to attend sex offender courses (which were part of his sentence plan), the man was transferred to HMP Woodhill. According to prison records he denied his guilt regarding his convictions and refused to undertake courses designed to reduce the risk of him re-offending.

22. The man arrived at HMP Woodhill on 8 January 2010. On reception, he told one of the officers that he was surprised that he had been transferred to Woodhill and that he was concerned that his partner would not be able to visit him at his new location. The officer also wrote on the first night centre record that the man raised no other problems, was polite and appeared to listen to what he had said to him.

23. As part of the reception process, the man saw a nurse for a first healthscreening interview. The nurse noted that he was in remission from leukaemia, overdue a blood test and that he reported tightness of the chest with nausea and dizziness. She also noted that he had osteoarthritis (a degenerative joint disease) of the right knee and also took his blood pressure and pulse.

24. The nurse booked an appointment for the man to see the prison doctor on 12 January to review his chest pain and osteoarthritis. However, because of his medical conditions, he was seen later the same evening by the duty doctor. He examined the man and noted that he used painkillers for osteoarthritis of the knee, was in remission for leukaemia for two years and that blood tests were carried out every four months. The duty doctor confirmed the appointment for 12 January, but recommended that an Echocardiogram (ECG-a test which measures the electrical activity of the heart) should be conducted.

25. During a reception interview the next day, the man told an officer that he was not happy to be at Woodhill and was concerned that the move had undermined the progress he had made towards his appeal. The officer also wrote in the observations section of the second day interview "would it be possible to talk to OC&A [Operations, Classification and Allocations; the office within the prison which manages prisoner security classification and placements] in regards to moving [the man] back to Bullingdon as his appeal process has been halted by his move to Woodhill".

26. The man also saw the nurse, again the same day for a secondary health assessment. She noted that the man was blind in his left eye and that he believed his hearing was also deteriorating, which he put down to his age. During this interview, the nurse wrote in the medical record that the man thought he was overdue a blood test to help monitor for leukaemia. The nurse took the man's blood pressure and she also noted that the man felt like he had indigestion.

27. On 12 January, the man was seen by the duty doctor whom he saw on his arrival into the prison on 8 January, for his planned GP appointment. The man reported that he felt unwell and cold in his cell with body aches and pains, and that he had a slight cough. He was also worried that his toe nails were changing colour. The doctor examined the man and wrote on the medical record that there was no evidence of shortness of breath or chest pains. The doctor noted that the man's chest was clear, there was no heart murmur and that his toe nails looked normal with no obvious fungal infection. The man's blood pressure was taken and was noted to be a little high.

28. The doctor arranged for blood tests to be done to check the man's blood count as well as his renal and liver function. An ECG was also undertaken, which the duty doctor stated was normal.

29. The man's blood test results came back the same day and showed slight abnormalities in the levels of serum potassium (which helps nerves and muscles) and serum bilirubin (a pigment found in bile). Both of these levels were higher than then expected range. Other tests were within normal limits. When interviewed by the investigator and clinical reviewer, the doctor explained that the test results did not need further intervention.

30. On 2 February, the doctor saw the man in his surgery. The man told the doctor he was still experiencing some central chest pain and was dizzy in the mornings. He also said that he had good and bad days but reported no shortness of breath or pain radiating down his left arm. His blood pressure was taken and was found to be high. The doctor prescribed 2.5 mgs of ramipril (a drug used to treat high blood pressure).

31. The man was next seen by a nurse on 15 February, following a request from prison staff who reported that the man had been in pain during the night. The nurse was on the wing attending to another matter when he was asked to see the man. (He told the investigator and reviewer when

interviewed that he was not called to the wing to respond to an emergency). The man told the nurse that he had seen the doctor two weeks earlier but was still experiencing chest pain at night, which came off and on. The nurse recorded that the pain was “radiating to the back”. The man’s blood pressure was taken, and was again high. The nurse pinched the tip of the man’s finger to time how long it took for the finger to go pink again. The nurse noted that there was ‘good capillary refill’.

32. The man’s partner asked my investigator to check whether her partner had rang the cell emergency bell on the morning of the day before he died. My investigator asked the prison to check whether the emergency bell was used. An officer from HMP Woodhill checked the wing log for the man’s wing. There is no entry in the wing log to suggest that the man used the cell bell that morning and there is no automatic system for recording use of the cell bell.

33. The nurse telephoned the doctor and told him about the pain the man was experiencing. The doctor told the nurse that the man had an appointment booked for the next day.

34. A second duty doctor saw the man at the GP surgery on the day of the man’s death. He wrote up his notes from this consultation at 3.02pm having seen the man a few minutes earlier. He noted the man’s recent history of chest pain and that the pain had been severe two nights previously and had moved to both arms and that he experienced nausea. The second doctor noted that there were no other symptoms such as paleness, sweating, blushing and shortness of breath.

35. The second doctor noted that the recent ECG was normal and that the man had no history of cardiovascular disease. The man told the doctor that his lipid levels (lipids are molecules such as fat and cholesterol which, when present in the blood, can be associated with an increase in the risk of heart disease) were measured before he was sentenced and that these had been borderline.

36. The second doctor examined the man and diagnosed atypical chest pain (this phrase covers a range of symptoms concerning chest pain). He prescribed a trial of glyceryl trinitrate spray (GTN; a medication to be taken under the tongue to alleviate angina), aspirin and increased the dose of ramipril. The second doctor also made plans for the man to have another ECG and to be referred to the Rapid Access Chest Pain Clinic (RACPC; a Department of Health initiative aimed at getting patients with angina specialist treatment within one to two weeks).

37. On the afternoon of the man’s death, at the start of association (association is a specified time in the prison regime whereby prisoners are unlocked from their cell and allowed to socialise), the man’s cellmate approached an officer and told him that he could not get a response from the man. In interview with my investigator, the officer confirmed that he first became aware that the man was unwell at approximately 5.40 pm. He

went to the man's cell and saw him lying in his bed facing towards the wall in a "half turned" position. The officer attempted to talk to him and at the same time rubbed his arm to get a response before trying to find a pulse.

38. The man did not respond and the officer called to a colleague who was outside the cell to get medical assistance. That officer then called to another officer on the wing to call for medical assistance and went to assist the officer who had found the man in the cell. Neither of the officers used a radio to call for assistance, but a call for urgent medical assistance went out on the prison radio network from the wing office.

39. The officer who first discovered the man in his cell continued to try and get a response from him by rubbing his chest. Whilst doing this, the officer told my investigator that "a gasp of air came from [the man]", which he took to be a sign of life and asked the other officer who was there to assist him in placing the man on the floor to attempt CPR (Cardio Pulmonary Resuscitation). As the officers did this, they both heard another "gasp of air "coming from the man.

40. At this time the officers were joined by a prison governor who asked the officers if either of them had a resuscitation face mask. One of the officers passed his mask to the governor who then gave it to the officer who had originally found the man in his cell. The same officer then removed the man's false teeth, put the mask over the man's mouth and gave two deep breaths whilst the governor applied chest compressions.

41. At approximately 5.32pm, the duty senior officer arrived at the cell and was asked to lock up the prisoners on the wing. One of the officers left the cell to assist the duty senior officer. The duty senior officer then collected the wing defibrillator (a defibrillator is a machine which delivers therapeutic doses of electricity to the heart in order to restart it) and brought it to the cell as healthcare staff were arriving. The duty senior officer said in interview that it took him no more than 30 seconds to collect the defibrillator and return it to the cell.

42. There is a discrepancy in the timings given to my investigator by the officers interviewed. My investigator has addressed the discrepancy directly in interview with prison staff and is satisfied that the timings given by the officer who originally found the man in his cell are approximate and there were no delays in his response to the man.

43. Three nurses arrived at the cell having been called at 5.30pm over the prison radio system. On arriving they started to assist the officers with CPR. One of the nurses brought the healthcare resuscitation bag which included a defibrillator, which was then used to shock the man. Healthcare staff continued to administer CPR, following instructions displayed on the defibrillator (defibrillators can also advise users how to proceed during an emergency). The duty senior officer told my investigator that he also assisted healthcare staff with CPR.

44. At 5.46pm, a first response paramedic crew arrived and took over resuscitation. A second paramedic team arrived at 5.58pm, at the same time as a prison doctor. The man was moved to the corridor outside the cell area to give the paramedics more space to work on him. He was given drugs and saline intravenously

45. An ambulance took the man to outside hospital by ambulance at 6.30pm, and resuscitation attempts continued. At 6.58pm, however, the team agreed to stop resuscitation and he was pronounced dead.

46. The inquest into the man's death was opened on 22 February. The pathologist who examined him gave the cause of death as Left Ventricular Failure due to myocardial infarction as a result of coronary atheroma and coronary thrombosis. This means that the man had thickening of his arteries and a blockage from a blood clot which resulted in heart failure and a heart attack.

47. A family liaison officer made contact with the man's declared next of kin. She was informed of his death and the prison made arrangements for her to be taken to the hospital.

48. The coroner for Milton Keynes instructed the prison to locate the man's children to inform them of his death. The police liaison officer at HMP Woodhill contacted them through the man's sisters, who made arrangements for his cremation. HMP Woodhill contributed towards the cost of the man's funeral.

49. The prison staff involved in helping the man were offered immediate support following his death as well as longer term support and counselling. Other staff and prisoners were informed of the man's death by way of notices around the prison.

50. The man's cellmate, who had reported that he was unwell, went into shock and was placed on constant observations for twenty four hours. An Assessment, Care in Custody and Teamwork (ACCT: this is a process which seeks to provide such support as is necessary to ensure the safety of a prisoner identified as being at risk of suicide or self harm) document was opened. The ACCT document was closed on 25 February.

51. The prisoner was also offered access to the Samaritans and to prison listeners. (Listeners are prisoners trained selected and supported by Samaritans to offer support twenty four hours a day, to fellow prisoners in distress.)

ISSUES

Clinical care

52. A clinical reviewer was appointed by Milton Keynes PCT to carry out a full clinical review of the medical treatment and care the man received at Woodhill. She reviewed all necessary records and conducted interviews with medical staff.

53. In her review, the clinical reviewer examined whether the man displayed "clear symptoms of cardiac chest pain (angina) and/or symptoms of stable or unstable angina" (stable angina occurs during exercise, unstable angina at rest). From her review of the records, and interviews, she concludes that "the symptoms may suggest a picture of unstable angina". However, she continues that both doctors were clear that, in their opinion, the symptoms did not indicate that the pain was cardiac in origin. The clinical reviewer showed the medical record to the Medical Director of Milton Keynes Community Health Services for another opinion. They found that, in the absence of other symptoms such as unstable blood pressure or shortness of breath, the assessment and actions of the doctors at Woodhill was appropriate.

54. However, the clinical reviewer notes that on several occasions, staff did not follow guidance or good practice. In particular, on 12 February 2010, the duty doctor assessed the man but did not, in the clinical reviewer's opinion, record the assessment fully. She notes that items such as the nature and frequency of the complaint, exacerbating factors, examination findings and a management plan were all missing from the record, and adds that he should have recorded any reasons for discounting ischaemic heart disease.

55. Following the secondary healthscreen, the man's weight was not recorded, and he was reported to be both a smoker and an ex-smoker. The clinical reviewer points out that obesity and smoking are both factors associated with an increased risk of heart disease. It is important, therefore, that these are recorded correctly in medical notes.

56. Overall, the clinical reviewer comments that the standard of record keeping was "satisfactory". However, she makes two recommendations, which I endorse.

    The Head of Healthcare should ensure that staff fully document the circumstances in which prisoners are seen and all presenting symptoms, including lengths of episode of symptoms; and all communications regarding decisions made relating to patient care and treatment.

    The Head of Healthcare should ensure that staff record assessments in line with the guidance contained in the GMC "Good Practice Guidance".

Medication

57. The clinical reviewer has identified that the prescription charts do not show whether the man was prescribed ramipril (for his high blood pressure). Having discussed the matter further with both the pharmacist and the duty doctor, the clinical reviewer is sure that ramipril was prescribed and administered to the man, but not recorded on the same prescription chart as other medication. Although noting that an electronic prescribing system is due to be implemented at Woodhill in December 2010, the clinical reviewer makes the following recommendation.

    The Head of Healthcare should ensure that a review is undertaken of the prescribing pathway to reduce the use of multiple current prescription charts, including consideration of electronic prescribing.

58. The clinical reviewer says in her report that medical staff carried out appropriate interventions based on presenting symptoms which were equitable to that which would be received in the community. The clinical reviewer also comments that the response to the man's collapse was "rapid, full and prolonged" and in accordance with best practice guidance.

Milton Keynes Primary Care Trust Review

59. Milton Keynes Primary Care Trust death in custody panel met to review the medical services experienced by the man. The panel concluded that:

    - There was nothing untoward in this case and all procedures were followed.

    - On the basis of the presenting symptoms medical staff carried out appropriate interventions that were equitable with that which would be received in the wider community.

    - Recording of assessments and record keeping needs to be improved.

Use of radios

60. On the evening the man died, there were three radios issued to staff on the wing. In order for an emergency call to be sent, two officers both had to alert other staff by calling to them, before the call was sent from the wing office. I do not believe that the number of available radios had any impact on the response to the man or the communication of an emergency to healthcare. As such, I do not make a formal recommendation on this issue. I would, however, suggest that the Governor considers whether there are sufficient radios available to staff on duty.

Contact with relatives following the man's death.

61. The prison family liaison officer made contact with the man's next of kin. At the opening of the inquest into the man's death, the Coroner for Milton Keynes instructed the prison to locate a blood relative . A prison governor instructed the prison's police liaison officer to locate the man's relatives. This was a challenging task, and it is to the prison's credit that the man's sister was located and the family's wishes regarding cremation were followed.

Use of protective face masks during CPR

62. I have recommended in a previous investigation at Woodhill that all staff who have face to face dealings with prisoners should be issued with protective face masks. I was informed that all staff at Woodhill had been issued with the masks. However, during the emergency response on this occasion, a prison governor had to ask an officer for his mask, before giving it to a further officer to use. While not making a further recommendation on this point, I would encourage the Governor to make sure that all staff are aware of face masks and the important role they play for their own safety. The Governor might also wish to check that there is ample provision for all grades of staff.

CONCLUSION

63. The man arrived at HMP Woodhill in January 2010 having been transferred from HMP Bullingdon. He was transferred because he refused to undertake courses aimed at reducing his risk of re-offending.

64. On arrival at Woodhill, the man reported to medical staff that he was experiencing chest pain. He was seen regularly by both nurses and prison doctors. Appropriate referrals were also made to undertake further investigation into the man's chest pain. The clinical reviewer has found that the treatment given to the man was appropriate.

65. The man became very ill suddenly in his cell. The response of both uniformed and healthcare staff when they became aware of his condition was very quick and sustained. Healthcare staff continued to treat him until he was transferred to outside hospital where he unfortunately died.

RECOMMENDATIONS

The recommendations were all accepted and the responses are below.

1. The Head of Healthcare should ensure that staff fully document the circumstances in which prisoners are seen and all presenting symptoms, including lengths of episode of symptoms; and all communications regarding decisions made relating to patient care and treatment.

   Accepted. All staff updated regarding Nursing and Midwifery Council (NMC) standards of documentation.

   Regular teaching sessions given regarding documentation following consultations.

   Electronic Patient Record System now in place, as part of this implementation all staff refreshed on the appropriate documentation of clinical interventions.

2. The Head of Healthcare should ensure that staff record assessments in line with the guidance contained in the GMC "Good Practice Guidance".

   Accepted. As above.

   Documentation standards regularly audited by Clinical Governance Team.

   Issue monitored at contractual meetings.

3. The Head of Healthcare should ensure that a review is undertaken of the prescribing pathway to reduce the use of multiple current prescription charts, including consideration of electronic prescribing.

   Accepted. Prescription charts currently reviewed as part of Medicines Management Action Plan.

   Awaiting news of software construction from TPP for electronic prescribing.