



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at HMP Wymott
in September 2010**

Our Vision

*To be a leading, independent investigatory body,
a model to others, that makes a significant contribution
to safer, fairer custody and offender supervision.*

This is the report of an investigation into the circumstances of the death of a man, a prisoner at HMP Wymott. He died in September 2010. He was 67 years old. He had a history of heart disease; however his death from a large blood vessel that suddenly burst open (aortic aneurysm) was sudden and unexpected. I offer my sincere sympathy and condolences to his family and all those affected by his loss. My report has been delayed and I apologise for the extra distress this may have caused.

The investigation was carried out by my colleague. An independent review of the man's clinical care in custody was undertaken by a clinical reviewer on behalf of the local Primary Care Trust. I am most grateful to her for her valuable contribution to the investigation.

I would also like to thank the Governor of Wymott and his staff for their cooperation. I am particularly grateful to the liaison officer who provided a very high standard of liaison with my office. I appreciate the assistance of prisoners and staff on the man's wing who also provided valuable information to the investigator.

The clinical review concluded that the man was given appropriate medical care whilst he was in prison. I am satisfied that his death could not have been prevented. However, there is scope for improvement in some of the clinical practice at Wymott. I make four recommendations, the first two relate to implementing both the local protocol for prisoners with specific blood pressure readings as well as the outcome of medical assessment reports. The other two recommendations concern routine blood tests for prisoners prescribed statins (medication to lower cholesterol) and improving record keeping. All four recommendations were accepted.

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

July 2011

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SUMMARY

The man was sentenced to nine years imprisonment on 8 February 2008. He was initially remanded to HMP Liverpool where he had a first reception health screen. This identified that he had a history of angina (chest pain), osteoarthritis (a disease that affects joints in the body) and was prescribed medication which included a drug to reduce his cholesterol. The healthcare screen initially concluded that he was fit for work.

On 20 February, the man transferred to HMP Wymott, where a transfer health screen was completed. This repeated the information in the first reception health screen, but staff also noted that he had chronic heart disease and hypertension (high blood pressure). On the same day, a doctor completed a medical assessment report in which he considered him unfit for any form of employment.

The man moved to a wing specifically for elderly prisoners in March, and worked in the prison's tea bag department. Eight months later, healthcare staff referred him to hospital for a chest x-ray after he had a positive reaction to a skin test for tuberculosis (a lung disease). The result of the x-ray showed no abnormalities. He continued to go to work and, in March, he first mentioned to the older persons' lead nurse that he struggled as it involved lifting heavy equipment. He also requested a blood test for his cholesterol and this was duly done. On 7 August, he told a prison doctor that he found blood in his bed around the genital area. He was examined and no abnormalities were detected.

During 2010, the man saw healthcare staff on a further three occasions when he complained about a chest cough and a skin complaint. He also had a blood sample taken for routine blood tests in relation to his prescribed medication.

In September, an officer found the man collapsed in his cell at 2.04pm. Attempts were made to revive him, but he was later pronounced dead by a prison doctor at 2.45pm. The post mortem report identified the cause of death as a ruptured aortic aneurysm (a large blood vessel that suddenly burst open).

After the man's death, one of the prison governors held a debrief for staff. Both staff and prisoners were offered the opportunity for further support. The prison's family liaison officer and a member of the Care Team visited the man's next of kin, his ex-wife, to break the news of his death. The Governor subsequently wrote to her.

The clinical review found that overall the man received a level of care that was equal to what he could have expected in the community. I make four recommendations, the first two relate to implementing both the local protocol for specific high blood pressure readings as well as the outcome of medical assessment reports. The other recommendations concern routine blood tests for prisoners on prescribed statins (medication to reduce cholesterol) and improving record keeping.

INVESTIGATION PROCESS

1. The investigation was opened on 21 September 2010, when the investigator issued notices announcing the investigation to staff and prisoners. The notices included an invitation to those who wished to submit information related to the man's death to make themselves known to the investigator. No prisoners or staff came forward as a result.
2. The investigator also wrote to HM Coroner to advise him of the investigation. The Coroner subsequently sent a copy of the post mortem report, which gave the cause of his death as:
 - 1a Ruptured Aortic Aneurysm
 - 1b Atheroma and Systemic Hypertension

The clinical reviewer summarises 1a as a tear in this major blood vessel which had thinned over time causing internal bleeding and 1b, hardening of the arteries (blood vessels) and high blood pressure.

3. The investigator was given access to the man's prison file, including his medical and core records. She visited HMP Wymott on 27 September and spoke to a number of healthcare staff and prisoners who knew him.
4. The clinical reviewer carried out a clinical review of the man's health needs whilst he was in custody on behalf of the local Primary Care Trust. I received the report of the review in February 2011.
5. One of my family liaison officers wrote to the man's next of kin on 12 October to inform her of the investigation and invite his family to raise any issues they wished the investigation to address. A copy of the draft report was also sent to them. I hope that my report helps to clarify any issues that remain unclear and helps them to understand what happened in the time leading to his death.

HMP WYMOTT

6. HMP Wymott is a large category C prison which holds sentenced prisoners. (Prisoners are risk assessed when they come into prison and given a category based on their offence and the risk that they pose to the public should they escape. There are four levels: A, B, C and D, with category A prisoners being the most dangerous.) Category C are prisoners who cannot be trusted in open prison conditions but who would not have the ability or resources to make a determined escape.) Some, like the man, are classed as vulnerable prisoners (prisoners deemed at risk, often due to the nature of their offence) and others are held on ordinary location. The ordinary prisoners and vulnerable prisoners are held in separate accommodation and so Wymott is effectively two separate prisons with their own range of workshops, education and training facilities. The prison opened in 1979 and new accommodation was added in 1996. Vulnerable prisoners mainly live in the original house blocks. Wymott can hold a maximum of 1,176 prisoners.
7. Primary healthcare services at Wymott are commissioned and provided by NHS Central Lancashire Primary Care Trust. The prison does not have in-patient facilities. HMPs Wymott and Garth use the same agency for doctors; the same doctors work across these prisons and HMP Preston. Surgeries run from Monday to Saturday mornings. There is also an older persons' lead nurse. The prison has eight automated external defibrillators (a portable electronic device which measures electrical activity in the body and advises on action to be taken) placed in strategic points throughout the prison. Each has an emergency bag. They are checked daily and maintenance records are kept.
8. Wymott was last inspected by HM Inspectorate of Prisons in October 2008. The Inspectorate found the delivery of health services was "reasonable", but identified some concerns, notably that routine waiting times were too long and some staff shortages impacted on service delivery.
9. The Independent Monitoring Board (IMB) is a body of people appointed to each prison by the Secretary of State for Justice to be independent watchdogs of the public interest. They are not members of the Prison Service, nor are they part of the prison's management team. They are required to produce an annual report for the Secretary of State, highlighting good practice and flagging up areas of concern.
10. The IMB report for 2009-2010 concluded that the healthcare provision at Wymott was "satisfactory". However, they highlighted a number of areas that required improvement. They also referred to staffing levels as well as the lack of completion of care plans for elderly prisoners. However, the Board said that they were being addressed by the prison. They noted that some elderly and disabled prisoners were held on a "dedicated wing" (I wing). The facilities on this wing such as recreation, employment, education and a gymnasium were "applauded" by the IMB. At the time of writing their report, the IMB found that there were 118 prisoners over the age of

60 at Wymott, but 69 could not be accommodated on I wing due to insufficient space. They urged the prison to address the matter.

11. My office began investigating deaths in custody in England and Wales in 2004. Since this time, there have been 26 deaths at Wymott of which 22 have been due to natural causes. The reports into the two most recent investigations made one recommendation, but the issues were not similar to the man's case.

KEY EVENTS

7. The man was sentenced to nine years imprisonment on 8 February 2008. He was initially remanded to HMP Liverpool where a first reception healthcare screen was completed by healthcare staff. It identified that he had osteoarthritis (a disease that affects joints in the body), angina (chest pain) and documented details of his prescribed medication which included a statin to reduce cholesterol. (Cholesterol is produced by the liver and found in the blood. There are two types of cholesterol and one is linked to an increased risk of heart attacks.) The electronic clinical record described him as anxious, but he had not expressed any thoughts of self-harm or suicide. He was deemed fit for normal location, work and any cell occupancy.
8. The man transferred to HMP Wymott on 20 February. A staff nurse completed a transfer health screen form the same day. She recorded that he had angina, arthritis and noted details of his medication. However, she added that he had chronic heart disease and hypertension (persistent raised blood pressure). As part of the screening process, she took his blood pressure (the strength of blood pushing against the sides of the arteries). This was recorded as "160/96" and underneath this was an instruction to "refer to local protocol if higher than 149/90", but there was no evidence that this was done. (Blood pressure is recorded as two numbers and 120/80 is considered to be a normal reading. If the blood pressure is too high this puts strain on the arteries and could lead to a heart attack.)
9. A doctor also completed a medical risk assessment report on the same day. The man was classified as "labour III" (unsuitable for any form of work) and unfit for the gym. However, the section to provide an explanation about why he was excluded from work was left blank.
10. The following month, the man reported that another prisoner had gone into his cell and taken some of his medication. The allegation was dealt with under Wymott's tackling antisocial behaviour procedures. Consequently, he was moved to another wing on 19 March. On the same day, his wing history sheet said that he was unfit for work due to ill health. It also noted that he was a "good candidate" for I wing (accommodation specifically for elderly prisoners) and he was subsequently moved there on 28 March. A few months later on 12 May, his wing history sheet indicated that he had "settled well" and for the first time showed that he was employed in the prison workshop making teabags.
11. A referral was made to the primary care mental health worker on 25 September. This was to assess the man's suitability to participate in a study to look at depression amongst older adults in prison.
12. On 13 November, the man's prescription record showed that he was re-prescribed a statin, but this not fully dated to show the year. The drug was issued the following day. He was reviewed by a nurse later that month on 24 November and given a mantoux skin test. (This detects whether a person has been in contact with the

bacteria (germs) that causes tuberculosis, a disease that affects the lungs.) A few days later on 27 November, he was examined again. The nurse found that he had reacted to the test and he was referred to hospital for a chest x-ray on the same day. This took place at hospital on 12 December. Three days later on 15 December, he told a member of staff that he was waiting for the results due to “long standing chest problems”.

13. The hospital sent the chest x-ray results to the doctor at Wymott. It concluded that the man’s “heart size is normal” and “the lung fields are clear”. However, there was nothing noted on either the electronic or continuous clinical record to show when the prison received it.
14. The primary care mental health worker assessed the man on 29 December for the study on depression amongst older adults in prison. She noted that he was considered to be suitable. At the time, he said he was increasingly emotional and tearful after he started a programme to address his offending behaviour. He was offered a number of individual sessions to look at ways to improve his mood.
15. The man again told a member of staff on 12 January 2009, that he was still waiting for his chest x-ray results. He continued to work in the tea bag workshop.
16. Between 13 January and 17 March, the continuous clinical record shows that the mental health worker saw the man seven times, although the times of these meetings were not always documented. She noted that there were fluctuations in his mood and he reported sleep problems. Consequently, he was offered relaxation training and techniques to manage his anxiety. She noted in mid March, that there had been an improvement in his mood.
17. The Older Persons’ Lead reviewed the man on 27 March and he asked for his cholesterol to be checked. She noted that no previous results could be found and asked for a number of blood tests. For the first time, he mentioned to her that he washed the pans in the kitchen which involved lifting heavy equipment. He explained that he struggled with the work and it had increased his “angina pain”. She noted “to discuss lighter duties with the kitchen”, but there was no record that this was done. A blood sample was taken from him on 3 April, and sent to a hospital. The electronic clinical record showed that Wymott received the results five days later on 8 April.
18. Almost a week later, the mental health worker saw the man for the final time on 14 April. He felt able to cope with negative thoughts and he was discharged. In her final report, she said that at the end of the study his anxiety, stress and depression were found to be “within normal range”.
19. On 7 August, a prison doctor saw the man, who told the doctor that when he woke up that morning he found “blood in his bed in the genital area”, but could not identify the source. He added that two days before, the front of his underwear was “red”.

The doctor examined him and found no haemorrhoids, nor any evidence of cuts or wounds to his penis or scrotum. The doctor noted that no abnormality was detected and no further complaints were reported.

20. Five months later on 27 January 2010, the man complained of a chesty cough and green phlegm. A prison doctor examined him and prescribed some medication.
21. A probation officer contacted Wymott on 31 March and reported that the man said he was going to kill himself if he did not get parole. (This is the early release of a prisoner who is subject to certain conditions.) Prison staff spoke to him, who denied saying it. He was offered the support of a Listener, but refused. (Listeners support prisoners who may be at risk of suicide and/or self-harm. They are trained, selected and supported by Samaritans to offer confidential emotional support, 24 hours a day, to fellow prisoners in distress.)
22. The electronic clinical record noted that the man saw a nurse on 14 June, about a skin complaint. He was examined and given advice about how to manage it. Just over a week later, a blood sample was taken for routine tests. The electronic clinical record indicated that the results were received on 23 and 24 June and documented that the results were normal on 29 June.

Events on 21 September 2010

23. Officer A was working on I wing on 21 September. He made a statement following the man's death, explaining that at approximately 1.45pm, the prison control room asked wing staff to send prisoners to work and so he let them out of the wing. He noted that some of them did not report for work and went to check on their whereabouts. He was able to account for everyone except him.
24. The officer went to the man's cell and looked through the observation window. He saw him sitting on the floor, leaning against his cell table. The officer said that it was obvious that there was a serious problem. He used his radio to contact the prison's control room and called a code blue emergency. (Code blue is used over the radio when a prisoner is found not breathing or having breathing difficulties or fits.) The prison's control room log confirmed that the call was made at 2.04pm. He said that he then went into the cell and placed him in the recovery position.
25. Officer B was also working on I wing. He explained that at 1.45pm, Nurse A had asked him to escort her around the wing as she wanted to speak to a number of prisoners. Whilst this was taking place, a code blue was announced over the radio at approximately 2.04pm. It identified I wing as the location and the man's cell. He said that they both went there and arrived at 2.05pm.
26. The nurse said in her statement that they met Officer A at the cell door. He said that he had found the man collapsed and that "it might be too late". She sent him to get

emergency equipment. The officer said this was a red emergency bag that contained oxygen which was stored in the treatment room on the wing.

27. The man was in the recovery position when Nurse A went into the cell. There were no signs of life and he was unresponsive. She added that an ambulance was called and the control room action sheet indicated this was done at 2.05pm. The nurse explained that cardio pulmonary resuscitation (CPR) was started and she asked healthcare staff who arrived within minutes to assist. (CPR is an emergency lifesaving procedure that is performed when a person's own breathing or heartbeat has stopped.) She and Officer B worked together doing chest compressions and Nurse B took control of [the man's] airway. (Chest compression is a procedure that is part of CPR and consists of rhythmic applications of pressure over the lower half of the chest.)
28. Officer A returned to the cell with the emergency bag. He confirmed that Officer B and both nurses took turns to give him CPR. Nurse A then asked him to go back to the treatment room to collect a defibrillator. The nurse connected the defibrillator to the man's chest, but it did not say that a shock should be administered. (Sticky pads with sensors called electrodes are attached to the chest. The electrodes send information about the heart's rhythm to the defibrillator. It then determines if an electric shock is required and indicates when to give one.)
29. Nurse C was called to assist at approximately 2.10pm, via the radio. Officer B and both nurses were performing CPR when she arrived and she assisted with chest compressions. Nurse A said that they continued CPR until the ambulance paramedic technicians arrived at 2.35pm. Documentation from North West Ambulance Service showed that the crew received the call at 2.12pm and arrived at the prison at 2.31pm. They were with the man two minutes later at 2.33pm. Nurse A explained the situation to the paramedic technicians. (The role of the technician is to support a paramedic during the assessment, diagnosis and treatment of a patient.) They were unable to confirm that he had died because they are not qualified to certify a death and so CPR continued.
30. Nurse A asked Nurse D, who had also gone to the cell, to contact the prison doctor at HMP Garth which is a short distance from Wymott. She wanted him to come immediately to Wymott as she was uncertain when the paramedics would arrive.
31. The doctor documented the circumstances surrounding the man's death on the electronic clinical record. He explained that he was the prison doctor for both Wymott and Garth. At 2.30pm, whilst holding a surgery at Garth, he received a telephone call from Nurse D at Wymott. She asked him to come to I wing to see the man who was found in his cell with no vital signs of life, including breathing, blood pressure and pulse. The doctor was told that CPR had been started. He rushed to Wymott and got there at 2.40pm. He found Nurse A and the paramedics performing CPR on him, which had been carried out for 40 minutes without success. He noted that the defibrillator showed a flatline, meaning that there was no heart beat, and

described his pupils as fixed and dilated. (This means that the eyes are no longer reacting to light and the brain is not functioning.) The doctor said that a joint decision was made to stop CPR and, at 2.45pm, he pronounced that the man had died.

32. Following the man's death, a governor held an immediate debrief with staff. They were also individually approached by a member of the prison's care team and offered support. Notices were also issued by the Governor to both staff and prisoners about the death and they were reminded of the facilities available to those affected.
33. The log of events completed by the acting deputy governor noted that a governor was appointed as the family liaison officer. He travelled with an officer, one of the prison's Care Team, to notify the man's next of kin, his former wife, about his death. The Governor wrote to her on 23 September, confirming the role of the officer and telling her that the prison would pay for reasonable funeral costs.

ISSUES

Clinical care

34. The clinical review was undertaken by a clinical reviewer commissioned by the local Primary Care Trust. She reviewed the management of his medical care and has judged that while monitoring of his blood pressure could have been more robust and in accordance with national guidelines, overall, the care he received at Wymott seemed appropriate.

The man's blood pressure reading on his transfer health screen form

35. Wymott's healthcare screen form, completed on 20 February, noted that the man's blood pressure was "160/96" and underneath this was an instruction to refer to the local protocol if it was higher than 149/90. However, there was no evidence that this was done, although his reading exceeded 149/90. The clinical reviewer said that his blood pressure may have needed to be taken regularly, but this is unknown because the local protocol was neither explained nor was it not found on his clinical record. The National Institute for Health and Clinical Excellence (NICE) produced guidance in June 2006, on the management of hypertension in adults in primary care. (NICE is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health.) This confirms that action should be taken if a patient's blood pressure reading exceeds 140/90.
36. In the clinical review, the clinical reviewer suggested that when there is an instruction to refer to a local protocol, this should be included in the clinical notes, together with a record of whether it was "appropriate or unnecessary" and the rationale.

The Head of Healthcare should review the use of the local protocol for prisoners who have an initial blood pressure reading of 149/90, to ensure that it is implemented and reflected in the clinical record.

The man's employment

37. The man's initial reception healthcare screen at Liverpool assessed him as fit for work. However, following his transfer to Wymott, his medical risk assessment report on 20 February 2008 indicated that he was labour III, meaning that he was unfit for any form of employment, although the section to explain why he was excluded was not completed. His wing history sheet on 19 March and 20 March confirmed that he was unfit for work. In spite of this, almost two months later on 12 May, it was noted that he worked in the tea bag workshop and then again on 12 January 2009, that he continued to do such work. In addition on 27 March, he told a nurse that he washed the pans in the kitchen and struggled with the work which involved lifting heavy equipment and increased his "angina pain". The nurse indicated that lighter duties would be discussed with the kitchen, but there was no evidence on the clinical

record that this was done. There were no further references to his employment from the end of March up to his death. However, Officer A's statement suggested that he was still working, although it is unclear exactly what he was doing.

38. The clinical reviewer noted that despite the man being declared unfit for work, he initially worked as a tea bag packer and later in the kitchen. She questioned why he was employed in these jobs given the medical risk assessment. She added that all relevant departments should have been informed about his exclusion and the information should have been "accessibly documented". She concluded that he would not have been employed if other departments had known that he was unfit for work. Although he felt that working had an impact on his health, the reviewer describes this as a "subjective" opinion. The reviewer does not consider that working had a significant negative impact on his health nor contributed to his death. Nevertheless, I am concerned that the doctor's judgement about his fitness for work seems to have been ignored or overlooked, particularly as the work seems to have involved strenuous activity.

The Governor and the Head of Healthcare should ensure that the medical assessment report is fully completed and taken into account when determining prisoners' suitability for employment.

The man's blood tests

39. Over one year after the man's arrival at Wymott, he saw a nurse on 27 March 2009, and asked for his cholesterol to be checked. The nurse noted that there were no previous results and a blood sample was duly taken and sent for tests on 3 April. He had further blood tests, but this was 13 months later in June 2010.
40. The clinical reviewer noted that the man was prescribed a statin when he arrived in prison to either maintain or reduce his cholesterol. She explained that in order to check whether the medication should be increased or reduced, it is suggested that blood tests are carried out regularly. However, she said this was only instigated because he requested one. He had just two blood tests during the 31 months that he was at Wymott. The clinical record did not note any concerns in relation to either of the blood tests that were taken. Although, she found in her review that his cholesterol levels were acceptable, I recommend that prisoners taking statins should have regular blood tests.

The Head of Healthcare should ensure that prisoners who are prescribed statins should have regular blood tests.

The man's clinical records

41. Wymott's healthcare department had two concurrent clinical records for the man. One was the electronic computerised patient record started on 11 February 2008, whilst he was at HMP Liverpool, and continued until he died at Wymott. The second was a handwritten continuous clinical record which was dated from 14 March 2008, almost a month after he arrived at Wymott, to 11 May 2010. It was unclear why the latter was used by healthcare staff given that an electronic system was available. The use of two simultaneous recording systems runs the risk that key clinical information may not be immediately accessible when it is required.
42. The man had a hospital chest x-ray on 12 December 2008, and he twice said that he was waiting for the results. First on 15 December, three days after the x-ray, and then almost a month later on 12 January 2009. This may have indicated that he was anxious about it. Whilst it is clear that a hospital report about the outcome of x-ray was sent to Wymott, the prison did not document when they received it either on the clinical record or through the use of a stamp on the report to show the date of receipt.
43. The clinical reviewer also raised a number of concerns about the standard of recording. She noted that the time that information was entered on the clinical record was not always documented. She did not specify which record this observation related to, but this omission was only evident in the handwritten one. She also noted that the dates when his prescriptions were rewritten by prison doctors were omitted.

The Head of Healthcare should remind all healthcare staff of the importance of accurate and contemporaneous record keeping in accordance with the standards of the Nursing and Midwifery Council and the General Medical Council.

CONCLUSION

44. The man was sentenced to nine years imprisonment on 8 February 2008. He was initially remanded to HMP Liverpool and later transferred to HMP Wymott on 20 February. At both establishments a healthcare screen was completed. These identified that he had angina, osteoarthritis, chronic heart disease and hypertension and he was prescribed medication for his conditions.
45. Prison healthcare staff saw the man on a number of occasions about unrelated complaints. The clinical review found that his medical care in custody was appropriate and this was supported by my investigation. Despite the doctor's assessment, he continued to go to work. He found it strenuous and, although he asked to be relieved of his duties, there is no evidence that this happened. Although the clinical reviewer does not think that working contributed to his death, I suggest that more attention should have been given to the doctor's assessment that he was not fit enough.
46. The man's death was sudden, unexpected and could not have been foreseen. However, there were some aspects of his clinical care for his pre-existing conditions that could have been better. This is reflected in my recommendations for routine blood tests for prisoners prescribed statins, as well as implementing both the local protocol for high blood pressure readings and the outcome of medical risk assessment reports. My final recommendation relates to improving record keeping.

RECOMMENDATIONS

1. The Head of Healthcare should review the use of the local protocol for prisoners who have an initial blood pressure reading of 149/90, to ensure that it is implemented and reflected in the clinical record.

The recommendation was accepted:

*"A Hypertensive lead nurse has been appointed.
A call / recall system is in place for patients who have hypertension and a fortnightly hypertension clinic is also in place in line with NICE guidance."*

2. The Governor and the Head of Healthcare should ensure that the medical assessment report is fully completed and taken into account when determining prisoners' suitability for employment.

The recommendation was accepted:

"A review of prisoner suitability for employment policy will be carried out, with a particular check on health recommendations."

3. The Head of Healthcare should ensure that prisoners who are prescribed statins should have regular blood tests.

The recommendation was accepted:

"The list of all current patients prescribed statins will be reviewed and be subject to the call and recall process for blood checks annually, with medication review where required."

4. The Head of Healthcare should remind all healthcare staff of the importance of accurate and contemporaneous record keeping in accordance with the standards of the Nursing and Midwifery Council and the General Medical Council.

The recommendation was accepted:

*"Recent locally implemented record keeping training has taken place.
All staff are aware of nursing and midwifery council (NMC) and local requirements for record keeping.
Staff mentoring and shadowing has been introduced.
Internal audit procedures will form part of the training process and 5% of clinical records will be reviewed by the Head of Healthcare each month."*