PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man on 23 October 2014 while a prisoner at HMP Peterborough

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 investigation report into the death of a man on 23 October 2014, while a prisoner at HMP Peterborough. He died of a haemorrhage caused by lung cancer. He was 59 years old. I offer my condolences to the man's family and friends.

A clinical review was commissioned to investigate the man's clinical care. The prison cooperated fully with the investigation.

The man was serving a life sentence. He had been in prison since April 2004 and at Peterborough since December 2013. He had little interaction with healthcare staff until August 2014, when he reported that he had been coughing up blood for some weeks. The doctor referred him for hospital tests, but the man was anxious about the possibility of cancer and would not go to his first hospital appointment. He went to hospital as an emergency on 28 August when he had difficulty breathing. The hospital said he should be referred to a specialist and the next day a prison doctor asked for an urgent referral for suspected cancer. This was not actioned and healthcare staff did not note that this had not been done until 15 October. A specialist appointment was then obtained for 29 October. Before this happened, he was taken to hospital as an emergency on 22 October, after he vomited blood. He died in hospital in the early hours of 23 October.

The investigation found that the man's standard of care at the prison was inadequate. In particular, health screening was deficient and there was a delay in processing the referral for suspected cancer, which meant that a possible opportunity for diagnosis and a chance to prolong his life was missed. Recording practices also required improvement. Although it did not affect the outcome for the man, I am also concerned that there was a lack of awareness among staff at Peterborough about emergency procedures.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **May 2015**

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SUMMARY

1. The man had been in prison since April 2004 and at Peterborough since December 2013. He had very little contact with healthcare services. Although a doctor at HMP Garth had diagnosed chronic obstructive pulmonary disease (COPD) in 2012, he had no care plan to monitor this. Initial health reviews at Peterborough noted that he smoked, but identified no significant health concerns.

2. On 15 August 2014, the man told a prison GP that he had been coughing up blood for four weeks. The doctor arranged a chest X-ray at hospital on 19 August, but the man would not go. On 28 August, a doctor sent him to hospital because he had difficulty breathing and a painful cough. An X–ray found no abnormalities. A hospital doctor diagnosed a lung infection and discharged him that day, but recommended that the prison should refer him for tests to exclude the possibility of lung cancer.

3. The next day, a doctor completed a referral for the man to see a specialist urgently. We do not know whether it was sent, but the prison did not chase this up when it did not receive an appointment within two weeks. It was not until 15 October, that someone noted that he had not had a specialist appointment. They then arranged an appointment for 29 October.

4. On 22 October, another prisoner told a tutor that the man had vomited a large volume of blood in the toilets of the education department. Staff asked healthcare staff to attend, but did not radio an emergency code. An emergency response nurse arrived, but no one asked for an ambulance until a senior nurse came. The nurses gave him oxygen, which eased his breathing. He remained conscious throughout and walked to the ambulance. Officers used an escort chain to restrain him.

5. In hospital, the man was in no obvious difficulty and was able to walk and talk with staff. That evening, he appeared to be a little better, but just after midnight he began to vomit blood and later collapsed. The escort officers removed the restraints. Hospital staff administered emergency treatment but could not stabilise him and he was placed on a ventilator. The prison contacted his family and arranged a taxi to take them to the hospital. The man's condition did not improve and he died at 2.30am on 23 October. The prison's family liaison officer went to the hospital to meet his family, who were not able to get there until after his death.

6. The clinical reviewer found that the reception health screen was not sufficiently thorough and, because of the delay with the referral for suspected cancer, the clinical care the man received was inadequate compared to that expected in the community. Someone at the prison should have chased up the referral when an appointment was not received within the expected time. Hospital appointments were not recorded on SystmOne, the computer medical record, which meant that doctors could not easily see whether an appointment had been booked. We are concerned that not all staff at HMP Peterborough were aware of medical emergency procedures. We make three recommendations.

THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at HMP Peterborough informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.

8. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. She interviewed ten members of staff and two prisoners at Peterborough in November 2014. After the interviews, the investigator informed the Director of the initial findings of the investigation.

9. NHS England commissioned a nurse to review the man's clinical care at the prison. She participated in five of the interviews.

10. We informed HM Coroner for Peterborough of the investigation, who provided the post-mortem report. We have sent the Coroner a copy of this investigation report.

11. One of the Ombudsman's family liaison officers contacted the man's brother, his nominated next of kin, on 19 November, to explain the investigation. He wanted to know why the man's death was so sudden and why the healthcare staff had not been aware of the extent of his poor state of health.

12. The man's family received a copy of the draft report. They pointed out some factual inaccuracies. This report has been amended accordingly. The prison has also submitted an action plan detailing what they have done to address the issues we raised and this is included at the end of the report.

HMP PETERBOROUGH

13. HMP Peterborough is a local prison privately operated by Sodexo Justice Services. It holds both men and women in separate sides of the prison. It has 24-hour health care provision. Cambridge and Peterborough NHS Foundation Trust provides a seven-day mental health service.

HM Inspectorate of Prisons

14. The most recent inspection of the men's side of HMP Peterborough was in April 2011. The Inspectorate found that schemes introduced to tackle non-attendance at healthcare appointments had not been successful, but consultation with older prisoners about their needs was better. There was a range of clinics equivalent to those in the community and emergency resuscitation equipment was available on each block.

Independent Monitoring Board

15. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its report for the year to March 2014, the IMB commented that there had been a shortage of nursing staff which had caused problems, but there had been an increased use of healthcare assistants to help overcome this.

Previous deaths at HMP Peterborough

16. The man's was the fourth of seven deaths from natural causes since January 2012. There were no significant similarities between this and the previous deaths.

KEY EVENTS

17. The man was convicted of violent offences in April 2004 and received an automatic life sentence, with a minimum period to serve of two years and one month before he could be considered for release.

18. In May 2012, a GP at HMP Garth diagnosed the man with chronic obstructive pulmonary disorder (COPD - the name for a collection of lung diseases, including chronic bronchitis and emphysema, which cause difficulty breathing due to the narrowing of airways.) He had no treatment or care plan for this condition.

19. Prison records show that, throughout his sentence, the man often did not attend healthcare appointments. He transferred from Garth to Blundeston on 30 July 2013 and then to Peterborough on 3 December 2013.

20. A healthcare assistant at Peterborough carried out an initial health screen on 3 December and a nurse conducted a more detailed health screen the next day. The man reported no issues and said he needed no medication. He refused a vaccination for flu. The nurse recorded that the man had no disabilities, smoked 30 cigarettes a day and had no physical or mental health concerns. His physical observations were normal. She did not note any evidence of COPD or refer to his earlier diagnosis. She booked a routine appointment for a wellbeing review in April 2014. (He did not attend and there was no follow up.)

21. At Peterborough, the man helped in education classes and the library. Staff and prisoners told the investigator that they had had concerns about his health because his breathing became more difficult over time, especially after he walked up the stairs to the education department. However, there is nothing significant recorded in his wing or healthcare records until 15 August 2014. That day, a nurse booked him an appointment with a doctor, because his friend on the wing had asked her to help him persuade the man to see a doctor. The man told the doctor that he had coughing fits and had been coughing up blood for four weeks. The doctor recorded that the man's chest and heart sounded normal, but requested blood tests and referred him for a chest X-ray. When interviewed, the doctor said that the man was anxious that his symptoms might indicate cancer and the X-ray was the only procedure that he would agree to at the time.

22. A doctor reviewed the results of the blood tests on 18 August and diagnosed a chest infection. On 19 August, the man refused to go to hospital for his X-ray and staff could not persuade him to go. He signed a disclaimer form to say this was against medical advice. He did not attend two GP appointments on 20 and 26 August arranged to discuss this. On 27 August, at the request of a doctor, a nurse saw the man in his cell. He complained of a cough and not feeling well. He told her that he had panicked about going to the hospital and was afraid. The nurse booked a GP appointment for the next day.

23. At an appointment with a doctor on 28 August, the man again said he had a painful cough which had produced blood. He told the doctor that three of his brothers had died of cancer and he had refused to go for the chest X-ray because he was afraid of the outcome. He said he could not eat or sleep,

was vomiting three of four times a day, and had lower chest and back pain. The doctor recorded the man's oxygen level as 92% (below normal range), heart rate 99 (at the top of normal range) and blood pressure 140/99 (high), with a temperature of 37.5 (normal). She diagnosed difficulty breathing and haemoptysis (coughing of blood from the respiratory tract) and sent him to hospital as an emergency. Hospital staff detected no chest abnormalities, but found that the man had abnormal breathing sounds and diagnosed a chest infection.

24. Later that night, the man returned to prison and stayed overnight in the prison's healthcare centre. The hospital discharge letter prescribed a course of antibiotics and suggested that the prison refer him for follow up tests to investigate the possibility of underlying cancer. The next day, 29 August, a doctor reviewed the man and discharged him from the healthcare centre. The doctor noted, "Normal X-ray with high clinical suspicion of cancer". He completed a form for an urgent referral for suspected lung cancer, under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks. Staff in the healthcare department said they faxed the referral to the hospital, but there is no record of this and no record that the hospital received it. No one chased it up.

25. There are no further entries in the man's medical record until 1 October, when he told a doctor that his cough had returned and he was coughing up blood. The doctor noted the man's chest was clear and that there was no blood when he coughed during the appointment. (He said that the man had been surprised by this.) However, he noted that an endoscopy of the throat (an internal examination using a thin, flexible tube with a video camera) should be considered. The doctor told the investigator that he had noted a reminder to request an endoscopy if the hospital referral indicated no cancer, but said that he had not checked the outcome of the referral to the specialist. There was no clear system for recording the outcome of appointments at Peterborough. The doctor told the investigator that he often checked by contacting the hospital, but had wrongly assumed that the man was progressing through the system.

26. On 15 October, nearly seven weeks after a doctor had completed the referral form, an entry on SystmOne noted that the man had not attended, or received, a hospital appointment in response to the urgent two-week referral at the end of August. (The record did not show who discovered this and staff we interviewed could not clarify this.) The Head of Healthcare investigated the delay and the hospital stated they had not received the referral, which prison staff said they had faxed on 29 August. The investigator saw the referral form, but there is no evidence that it was ever sent and there was no fax receipt.

27. Healthcare staff amended the date on the original referral, faxed it to the hospital and received an appointment for 29 October. When interviewed, two doctors said that a nurse had spoken to them about resending it, but the signature on the form is unclear.

28. At about 1.40pm on 22 October, the man went to the education department. He immediately went to the toilet and vomited a large volume of blood. A prisoner alerted one of the education staff. The member of staff went to see

the man, who told him he could breathe all right and he had no problems talking. The staff member asked a prisoner to keep an eye on the man while he went to get help. He asked an officer to radio for healthcare assistance. He did not use an emergency code. The communications room radioed for the duty nurse and a prison manager. The staff member and officer then stayed near the man until nurses arrived.

29. At the same time, another prisoner told a tutor in the library, that the man was in the toilet vomiting blood. She ran to the staff room opposite the library and asked a colleague to ring healthcare staff for help. No one answered the phone, so the colleague went downstairs to the healthcare department below, to get a nurse.

30. The emergency healthcare first responder that day, a nurse, said she did not get a call for assistance over the radio, but went straight to the education department within a few minutes of being asked for help. She took basic medical equipment with her. A nurse accompanied her. It is not clear how long it took nurses to respond (there was no CCTV in that area). Some staff thought it was quick and within five minutes, but others thought it was longer.

31. The first responder told the investigator that when she arrived she telephoned for the lead nurse in the prison that day. The lead nurse thought that she had received a radio message from the communications room (not a telephone call) and had no details of the nature of the incident. She went straight to the education department and immediately asked staff to call an ambulance when she saw the man and how much blood he had vomited. The ambulance service log shows that the prison called an ambulance at 2.03pm. The nurses gave the man oxygen (his level was low at 84-86%) and his breathing became easier. He remained conscious at all times. Paramedics arrived at 2.11pm. They offered to help him to the ambulance but he chose to walk himself.

32. When prisoners have to travel outside of the prison to a hospital or hospice, prison staff carry out a risk assessment to determine the nature and level of any security arrangements, including any restraints. A prison manager, whose signature is illegible, authorised that the man should be restrained by an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). Escort officers applied the escort chain before he left the prison and he remained restrained in hospital.

33. At 7.00pm, a nurse telephoned the hospital, who told her that the man would be staying overnight. He felt a little better, but was still coughing blood. The escort staff noted that the man was well enough to chat to them and he was able to get up and go to the toilet when he needed.

34. Just after midnight on 23 October, the man began to vomit large amounts of blood and one of the escort officers pressed the emergency button to alert hospital staff. Nurses attended, but the man stopped breathing and lost consciousness at about 12.20am. The escort officers removed the restraints and hospital staff began cardiopulmonary resuscitation. They took him to emergency theatre, but could not stabilise him for further treatment. The escort officers informed the prison of the deterioration in the man's condition.

Hospital staff moved the man to the intensive therapy unit and placed him on a ventilator.

35. At 12.45am, the prison contacted the man's family to tell them that he was seriously ill. They had no transport and the prison arranged a taxi to take them to the hospital.

36. The prison telephoned their family liaison officer, who went to the prison and learnt that the man's family was not expected to arrive at the hospital until about 4.30am. At 2.10am, the hospital told the escort staff that the man would not survive. He died at 2.30am. The family liaison officer went to the hospital to meet the man's family, who arrived at the hospital after his death.

Support for staff and prisoners

37. The prison issued notices to prisoners and staff informing them of the man's death and offered support to anyone affected. At 6.10am, the escort officers attended a debrief and, at midday, prison managers held a debrief for the staff involved in the emergency response to offer reassurance and support. Healthcare staff did not attend, but said their healthcare colleagues had supported them well.

38. The man's funeral took place on 12 November, and the prison held a memorial service the next day. In line with national guidance, the prison contributed to the funeral costs.

Post-mortem

39. The post-mortem examination found that the man had a history of chronic obstructive pulmonary disorder and a hiatus hernia. He was treated for atrial fibrillation (irregular and fast heart beat) when he was first admitted to hospital on 22 October. Although initially stable, he had a haemorrhage and then a heart attack. The cause of death was recorded as, 1a haemorrhage, 1b carcinoma of the bronchus (lung cancer).

ISSUES

Clinical care

40. The clinical reviewer was concerned that, after the man had a provisional diagnosis of COPD while at Garth in May 2012, no one at Garth, Blundeston or Peterborough put in place care plans or took any other action to monitor this chronic disease. She has made some recommendations, which the Heads of Healthcare at Garth and Peterborough will need to address. (Blundeston prison is now closed.)

41. The clinical reviewer found that the care the man received in prison was inadequate compared to that he could have expected to receive in the community. In particular, the delay in referring him to the specialist for possible lung cancer was possibly a missed opportunity to prolong the man's life.

Reception screening

42. No one identified that the man had a previous diagnosis of COPD. While it is not apparent that the diagnosis was ever confirmed, it was clearly recorded in his healthcare record. It does not appear that anyone reviewed his records or summarised them when he arrived at Peterborough. We were told that there was no time to review records in reception when prisoners first arrive and we accept that this would often be difficult. However, the man had a secondary health screen the next day, which is supposed to be a more in-depth assessment and we would expect nurses conducting these assessments to review a newly arrived prisoner's clinical record.

43. We recognise that the man himself did not identify any specific health problems when he arrived at Peterborough. He was a heavy smoker and had refused advice and help to give up. He often did not attend healthcare appointments and did not attend a wellbeing review arranged for April 2014, which would have been a further opportunity to identify any health concerns. Nevertheless, a more thorough assessment when he arrived at Peterborough should at least have noted the previous diagnosis of COPD and prompted further investigation. We make the following recommendation:

    The Head of Healthcare should ensure that healthcare staff review the clinical records of transferred prisoners to check whether they have previous diagnoses or medical conditions. Those with chronic conditions or other complex needs should have a full assessment as soon as possible after arrival, with a clear and detailed management plan entered in the clinical record.

Referral for suspected cancer

44. On 15 August, a doctor referred the man for a chest X-ray, to diagnose if he had a tumour in his lungs. The doctor told the investigator that the man made it clear he did not want to discuss the possibility that he had cancer and the only investigative procedure he would agree to, was an X-ray. Therefore, the doctor did not refer him to a specialist for suspected cancer at that time. The man refused to attend the X-ray on 19 August and did not attend two

subsequent GP appointments in the prison to discuss this. A prison GP sent him to hospital as an emergency on 28 August and, acting on the advice in the hospital discharge letter, another doctor completed an urgent referral form for the man to be seen by a specialist within two weeks. This was appropriate and timely.

45. Staff in the prison's healthcare department scanned the referral form onto the man's medical records, but the hospital said they did not receive it and there was no fax confirmation in the records. On 15 October, healthcare staff realised he had not received an appointment and the healthcare manager contacted the hospital. It is not clear who noticed this, but a request for an urgent referral was submitted the same day. An appointment was booked for 29 October, two months after the initial urgent referral, rather than the expected two weeks.

46. The Head of Healthcare told us that since the man's death, they have changed their practices to prevent a similar error in other cases. If healthcare staff do not receive notification of an appointment within ten days of the faxed referral, an administrator now sends a reminder to chase the hospital. The investigator asked whether they had considered emailing referrals which might be less likely to go missing, but was told that faxing was their usual method.

47. We are concerned that doctors did not have a clear overview of hospital appointments at Peterborough. Healthcare staff do not upload appointments to SystmOne (the Prison Service computerised medical record). Instead, they are kept on a separate spreadsheet, managed by an administrator. The Head of Healthcare said it was easier to organise and log appointments on a spreadsheet. She said that doctors had access to the spreadsheet, but those we interviewed were not aware of this. Doctors thought that appointments were not logged on SystmOne for security reasons.

48. Prisons are concerned that prisoners should not learn about hospital appointments in advance in case they use them as an opportunity to escape. However, national Prison Service security guidance is that such cases should be considered individually. We do not consider that generic security concerns are, in themselves, a sound reason for omitting appointments from the SystmOne which would provide an auditable trail. The clinical reviewer agrees.

49. When a doctor saw the man on 1 October, he assumed the referral appointment had happened. He told the investigator that he usually phones the hospital himself to check appointment results, but on this occasion he did not. If appointments were also routinely logged on SystmOne, doctors would be able to see quickly whether an appointment had been arranged or had taken place, without consulting a separate database which is not readily available to them.

50. There was nothing in the man's clinical record to indicate that staff had sent the initial urgent referral to the hospital, or how they became aware of the lack of response. We have been unable to determine who made the second referral on 15 October and there is no record that anyone discussed this with him. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff use SystmOne to record all important information about a prisoner's health including requesting and recording hospital appointments, with a robust system to monitor and chase up appointments as necessary.

Emergency response

51. Accounts indicate that the man vomited a large amount of blood on 22 October. One of the education staff asked an officer to request healthcare assistance and another went to the healthcare centre in person. No one used an emergency code. The first response nurse did not take full emergency equipment as the nature of the incident was unclear at that stage. When she saw the man, she asked the lead nurse to attend, but did not call an emergency code or ask for an ambulance.

52. Peterborough's local emergency protocol is in line with national guidelines (Prison Service Instruction (PSI) 03/2013) and directs the use of codes red and blue. Specifically, code red indicates a severe loss of blood and requires the control room staff to call an ambulance immediately when an emergency medical code is received. Interviews with education staff revealed they were unaware of the medical emergency code system and of how to call an emergency, other than using the general alarm. The lead nurse requested an ambulance when she arrived. When interviewed, she said she would have expected one to have been called already, but wanted to make certain. The first response nurse told the investigator she had not experienced a similar incident before and it appears that she was not confident about the system for radioing an emergency code or requesting an ambulance.

53. We accept that in the circumstances of the man's case it might not have been immediately apparent that an emergency code was necessary. Although he had vomited a significant amount of blood, he was conscious, able to talk and fit enough to walk to the ambulance by himself when it arrived. There was no significant delay in getting the man to hospital, but we are surprised that staff did not use an emergency code, given the amount of blood he had vomited. The lack of awareness of some of the staff, including a nurse, about emergency procedures, is a concern. Education staff who were first on the scene, as would usually be the case for emergencies in the education department, did not know about emergency codes. It is important that all staff know the procedures and are confident in dealing with an emergency and using the relevant code. This should ensure that nurses bring the right equipment to an emergency and that an ambulance is called immediately. Although this omission would not have changed the outcome for the man, it could have a significant impact in other circumstances. We make the following recommendation:

The Director and Head of Healthcare should ensure that all staff working with prisoners understand the local procedures and their responsibilities during medical emergencies so that:

- **Staff efficiently communicate the nature of an emergency;**
- **Staff bring the relevant equipment; and**
- **There are no delays in calling an ambulance.**

Family liaison

54. The prison contacted the man's family within half an hour after his condition deteriorated and, a few minutes later, provided a taxi to take them to hospital. They lived a long distance from the hospital and arrived around three hours after he died. We have considered whether the prison should have notified his family when he went to hospital as an emergency around 12 hours before. Although he had vomited blood and had an outstanding appointment for suspected cancer, he was able to walk to the ambulance and when he arrived at the hospital there was no indication that he was seriously ill at the time or that his condition was life-threatening. When his condition deteriorated rapidly, the prison contacted his family promptly.

55. While we would urge prisons to consider notifying families at an early stage when prisoners are taken to hospital, we accept that this was a judgement call. It is usually preferable to let families know quickly, but we are satisfied that prison staff were not initially unaware of the severity of the man's condition and could not have foreseen his sudden deterioration. Once they became aware that he was seriously ill, they contacted his family and commendably provided transport to take them to the hospital.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that healthcare staff review the clinical records of transferred prisoners to check whether they have previous diagnoses or medical conditions. Those with chronic conditions or other complex needs should have a full assessment as soon as possible after arrival, with a clear and detailed management plan entered in the clinical record.

2. The Head of Healthcare should ensure that healthcare staff use SystmOne to record all important information about a prisoner's health including requesting and recording hospital appointments, with a robust system to monitor and chase up appointments as necessary.

3. The Director and Head of Healthcare should ensure that all staff working with prisoners understand the local procedures and their responsibilities during medical emergencies so that:

    - Staff efficiently communicate the nature of an emergency;
    - Staff bring the relevant equipment; and
    - There are no delays in calling an ambulance.

ACTION PLAN: The man – HMP Peterborough

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and Function Responsible
1	The Head of Healthcare should ensure that healthcare staff review the clinical records of transferred prisoners to check whether they have previous diagnoses or medical conditions. Those with chronic conditions or other complex needs should have a full assessment as soon as possible after arrival, with a clear and detailed management plan entered in the clinical record.	Accepted	Following a prisoner's arrival at HMP Peterborough, healthcare staff will review their clinical records during the reception screening process. Where issues are identified, a GP appointment will be booked for the following day and a full assessment will take place. Joint clinical reviews now take place between GPs, mental health in-reach team (MHIT) and healthcare managers to ensure that a review is undertaken of any urgent referrals and the actions that have been taken. Representatives from the MHIT team now routinely attend the Director's morning meeting to ensure that any urgent concerns about chronic conditions or other complex needs are discussed. Staff have been made aware that should they believe a prisoner requires an urgent referral, the alert should be passed to the GP through the duty orderly officer who will record the referral on the daily briefing sheet. This will ensure that healthcare and the MHIT are alerted to the urgent need to assess the prisoner.	Complete Deputy Director and Head of Health Care

2	The Head of Healthcare should ensure that healthcare staff use SystmOne to record all important information about a prisoner's health including requesting and recording hospital appointments, with a robust system to monitor and chase up appointments as necessary.	Accepted	Refresher sessions for staff and system updates are being completed for SystmOne to ensure that there is improved accessibility and usage to the recognised regional partnership standard. A secondary inmate management system has been introduced to ensure that there is greater monitoring of attendance and communication of appointments for male and female prisoners. This system will improve the accuracy and reporting of appointments on SystmOne.	August 2015 Head of Healthcare
3	The Director and Head of Healthcare should ensure that all staff working with prisoners understand the local procedures and their responsibilities during medical emergencies so that: • Staff efficiently communicate the nature of an emergency; • Staff bring the relevant equipment; and • There are no delays in calling an ambulance.	Accepted	A staff instruction will be reissued to remind staff of the critical elements of a medical response and the immediate actions that should be taken and followed during medical emergencies.	April 2015 Head of Safer Prisons and Head of Health Care