PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the death of a man at HMP Wakefield in January 2012

Report by the Prisons and Probation Ombudsman for England and Wales

Sep 2012

This is the report of the investigation into the circumstances surrounding the death of a prisoner at HMP Wakefield, who died in hospital in January 2012. The man had a longstanding history of ill health, and was seen regularly by healthcare. The post mortem revealed that he died as a result of a ruptured atheromatous abdominal aortic aneurysm (a rupture in the main blood vessel to the heart). I extend my condolences to his family and friends.

The investigation was carried out by one of my investigators. A clinical reviewer was commissioned to review the clinical care provided to the man. Staff at Wakefield fully co-operated with the investigation.

On 6 January 2012, the man went to see the nurse complaining of pain in his hip. The man and the nurse both believed this was as a result of his arthritis. As a result, the nurse gave him the next available appointment to see a doctor, which was 11 days later, and prescribed him painkillers.

On the day the man died, his pain increased and he was eventually taken to hospital by ambulance. He was diagnosed as having an aneurysm, but his condition deteriorated rapidly and quickly became critical. Treatment was discontinued and the man died not long afterwards.

I agree with the clinical reviewer that, overall, the man received a level of clinical care that was equivalent to that which he might have expected in the community. Although he was seen regularly and frequently by healthcare professionals, it was of concern that a routine GP appointment at Wakefield could take two weeks, which is too long in the prison environment. Better arrangements are also needed at Wakefield to ensure that ambulances are able to leave the prison quickly and there continue to be deficiencies in clinical record keeping which we have identified in previous investigations at the prison. Sadly, it is unlikely that any of these matters would have altered the outcome for him.

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 **Sep 2012**

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SUMMARY

1. The man was sentenced for serious offences. He was moved between various prisons before transferring to Wakefield in October 2010. The man did not have good health. On arrival at Wakefield he was prescribed medication for his heart and arthritis. The man was a smoker and overweight, with a history of spondylosis (degeneration of the spine), and arthritis. In 2002, he had had a quadruple heart bypass. In June 2011, he was also diagnosed with chronic kidney disease. He had regular contact with healthcare and his medication was often reviewed in order to manage his pain and illnesses.

2. Although unwell, the man moved independently around the prison with the aid of a walking stick and worked in the recycling department at Wakefield.

3. On 5 September 2011, the man attended an appointment with healthcare, and complained of groin and leg pain. The nurse recorded that she would book him an appointment to see the doctor the following day. There is nothing in his records to indicate this appointment happened.

4. Between 14 September and the 20 December, the man was examined four times for chest symptoms, including wheezing, coughing and an infection.

5. On 6 January 2012, the man saw a nurse prescriber as he was experiencing pain in his hip. He informed her that he had arthritis, and she attributed his pain to that condition. The nurse said in interview that she booked him an appointment to see the doctor when one was next available which was eleven days later. He was not given an immediate appointment as he was not in acute pain. The man was prescribed Ibuprofen (pain relief medication) to cover the period before seeing the doctor. This appointment is not documented in his medical record.

6. The following day, the man's health deteriorated. He was seen by healthcare and due to his appearance and the pain he was experiencing an ambulance was called. The man was taken to Pinderfields hospital, in Wakefield where he was diagnosed with an aneurysm (balloon like bulge in an artery). His condition quickly deteriorated and hospital staff had to resuscitate him.

7. Although the man was resuscitated, hospital doctors decided that he was not well enough to be operated on. Treatment was stopped and his death was confirmed.

8. We make four recommendations concerning effective record keeping, proper disclosure of test results, reduced waiting times to see a doctor, and facilitating ambulances leaving the prison.

THE INVESTIGATION PROCESS

9. The Ombudsman's office was notified of the man's death on the day of his death. On 12 January, my investigator visited HMP Wakefield to open the investigation. Notices had previously been issued about the investigation to staff and prisoners. These invited anyone who wished to share information about the man's death to make themselves known to the investigator. One prisoner came forward and my investigator met him as part of the investigation.

10. During her visit my investigator met the prison liaison officer, a representative from the Independent monitoring board (IMB), the prison family liaison officer and the healthcare manager, my investigator also visited the healthcare centre and the wing where the man lived. The investigator was given copies of the man's prison records.

11. The investigator contacted HM Coroner for Wakefield to inform him of the investigation and request a copy of the post mortem report. This report will be shared with the Coroner to assist with his enquiries.

12. Another investigator returned to Wakefield in March and interviewed six members of staff. Following the interviews, written feedback was provided to the Governor.

13. An independent clinical review of the man's medical care was completed by the clinical reviewer. Her review is annexed to this investigation report

14. One of our family liaison officers (FLO) contacted the man's wife, as his listed next of kin, to explain the purpose of the investigation and invite her to ask any questions or raise any issues for consideration.

15. All families are offered the opportunity to meet the FLO and the investigator to discuss their issues. We did not have the opportunity to meet the family but our FLO discussed their concerns with them over the telephone. The man's daughter said that they had thought that the officers were "brilliant", and that her father thought highly of them and the way he was treated. However, they also raised the following concerns:

    a) The man had had a urine test, because it had a strong and unpleasant smell. The results were negative but the man's wife wanted to know if anything else had been done to investigate what had caused the problem.

    b) The man had a chest X-ray taken but he was not told the results.

    c) The man complained about his hip and had put in numerous appointments to see the doctor. When he eventually saw the doctor he was prescribed paracetamol but nothing was done to find out what the problem was.

    d) The man had asked to see the prison doctor on 6 January as he was unwell but was told he would have to wait two weeks.

16. We hope that this report gives the man's family an understanding of his time in prison and helps to answer their questions and concerns.

HMP WAKEFIELD

17. HMP Wakefield is a high-security prison for adult men holding up to 740 category A and B prisoners. Category A prisoners are those whose escape would be highly dangerous to the public or to national security and category B are those who do not require maximum security, but for whom escape needs to be made very difficult.

Healthcare

18. Primary health services at Wakefield have been run by Spectrum, a private healthcare service, since April 2011. Nottingham Mental Health Trust is responsible for primary and secondary mental health services. There is a 15 bed in-patient unit. At night there are two members of healthcare staff on duty.

HM Chief inspector of Prisons (HMCIP)

19. The last published inspection report by HMCIP is an inspection in December 2008. The inspection found that, in the five years since the previous inspection, Wakefield had improved considerably.

20. The 2008 report identified some issues with healthcare, including that prisoners had to wait too long to see the doctor. Nurses could arrange an urgent referral to the doctor, but the wait for a routine appointment was ten days, which was too long. In their survey, significantly fewer prisoners than the comparator said that it was easy to see a doctor or nurse.

Independent Monitoring Board (IMB)

21. Every prison in England and Wales has an IMB of unpaid members of the local community, appointed by the Secretary of State for Justice. Their role is monitor day to day life in the prison and ensure proper standards of decency and care are maintained.

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22. In their annual report for the period ending 30 April 2011, the Board reported that overall, the health care unit provided a comprehensive service that met the needs of the prison population to a level equivalent to that available to the general public. There were, however, underlying problems relating to the staff shortages which the Board had also raised in the previous year's report.

Previous Deaths at Wakefield

23. There have been 12 deaths from natural causes at Wakefield since January 2010. The Ombudsman's office has made previous recommendations in relation to record keeping, and we are disappointed to make a similar one again as a result of the investigation into the death of the man.

KEY EVENTS

24. The man was born County Durham. He was sentenced to 12 years imprisonment. He had not served a prison sentence before. He was initially held at HMP Holme House, and in February 2004 transferred to HMP Frankland. In October 2010, he transferred to Wakefield, where he remained until he died.

25. Staff and prisoners at Wakefield described the man as a friendly man who would help anyone one out when needed. While he was not in good health, the man worked in the recycling shop, which required him to undertake physical work. Officer A (who was based on A wing when the man lived there) said that the man enjoyed his work. He was also a Listener. (Listeners are prisoners who are selected and trained by the Samaritans to provide a confidential emotional support to other prisoners in distress.)

26. During his time in custody, the man had extensive contact with health services and had a number of major and minor health problems requiring medical consultation, nursing care, laboratory investigations and treatment with prescription drugs. He had a history of spondylosis, (the degeneration of the joints between the centre of the spinal vertebrae), arthritis (a form of joint disorder that involves inflammation of one or more joints), and in 2002 he had a quadruple heart bypass (a surgical procedure, to reduce the risk of heart attacks).

27. When he arrived at Wakefield in October 2010; he was appropriately assessed and prescribed medication for his heart and arthritis. The man's records show that he frequently complained of back and other joint pains and was prescribed pain relief, which he continued to take until his death. In June 2011 he was diagnosed with stage three chronic kidney disease (CKD).

28. The man saw prison doctor A, on 27 July 2011 complaining of irritation around the anus. The doctor recorded that the man refused an abdominal examination and did not attend the follow up appointment with her.

29. On 5 September 2011, the man complained of pain in his right groin and testicles. He was examined by a nurse prescriber (a nurse who is qualified to dispense prescriptions), who recorded that she had booked the man an appointment with prison doctor B, the following day. There is no record of this appointment happening.

30. Between 14 September and the 20 December, the man was examined four times in relation to symptoms related to his chest and was diagnosed with a chest infection. Despite having been prescribed amoxicillin (antibiotics), the condition did not improve and further investigations were arranged to check whether the man was suffering with Chronic Obstructive Pulmonary Disease (COPD). (COPD is an umbrella term for a range of conditions related to the lungs and breathing. It is not curable and usually gets progressively worse over time.) A chest X-ray was carried out on 7 November 2011 and the

results arrived on 22 November 2011. The X-ray showed that his lungs were clear, and also showed some other age related changes which did not require further medical treatment. There is no entry in his medical record to confirm that he was told about the results.

31. For reasons of security and safety, staff listen to a percentage of telephone calls that prisoners make. Hand written notes from the man's telephone account show that he spoke to his daughter on 6 January 2012. They record that he was very emotional and described having a 'massive pain'.

32. Later that day he was seen by the nurse prescriber. In interview, the nurse prescriber said that the man complained that he was in pain and that he had arthritis, but that it was getting worse. The nurse said that she attributed the pain to his arthritic problems. She said that she knew he saw healthcare staff often and that his pain relief medication was reviewed regularly. This is evidenced in his medical records. The nurse told us that she could not get an appointment for the man to see a doctor that day, because he had not complained of severe pain. She prescribed Ibuprofen to alleviate his pain. She booked him an appointment with the doctor 11 days later, the standard waiting time at Wakefield being two weeks. The nurse explained to the investigator that the man had not asked to see a doctor, but that she had advised him that if his medication was not controlling the pain, he needed to discuss this with a doctor. The nurse said that the man was happy with this decision.

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33. The following day the man spoke to his wife and told her that he was in pain and had been to healthcare. The records show that he complained that it would be two weeks before he could see a doctor and that he said he thought it would be a waste of time in any case.

34. At 7.00pm, Officer B started a night duty. In interview, she said that she began by carrying out a roll check on A wing. (During a roll check, all the prisoners are checked and counted.) On checking the man, she noticed that he looked unwell but he told her that he was alright. The officer said that he was sitting on his bed, looked uncomfortable and was swaying. Because she knew the man, the officer said that she knew something was wrong with him. She told him that she would finish her duties and then come back to see him. The officer informed Senior Officer (SO) A of her concerns.

35. The man pressed his cell bell and Officer B and SO A responded quickly. The man told them that he had been experiencing pain in his groin and left leg all day. The SO told the man that he would contact healthcare and asked him whether he wanted immediate assistance, or could wait until the nurse did her rounds later that evening. The man said that he was fine and that he would wait. The officer said that she would check on him at intervals and he was advised to let her know immediately if he felt any worse.

36. Having read over his medical records and assuming that his pains were related to arthritis, Nurse A went to see the man. In interview, she said that he was lying in his bed and was pale, cold, clammy and had been incontinent of urine. The nurse asked SO A to call an ambulance and then went to collect the emergency healthcare bag as she thought that the man was seriously unwell. The emergency healthcare bag was in the primary care centre, at the end of the A wing landings. The SO used his radio to request an ambulance.

37. Nurse A said that during this time the man's breathing became shallow, and his pulse was weak. He was responding to questions and commands, but his responses were slow and sluggish, his hand grip weak, and his pupils were very small (these are all signs that the patient is seriously unwell). The man confirmed that he had not taken any other drugs except his usual medication, and explained that the pain in his leg had worsened over the day. The man said he had been walking that day with the aid of a walking stick. He was able to move his leg freely, but the nurse could not undertake a full examination because he was in so much pain. The nurse placed the man in the recovery position (which is designed to keep the patient's airways clear and help them to breathe) and remained with him until the ambulance arrived. While waiting for the ambulance, the man complained of numbness in his lower leg.

38. The ambulance reached Wakefield. Officer B said that, on examining the man, the paramedics were not sure what was wrong with him and were in some doubt about whether to take him to hospital. However, they eventually decided to take him to hospital because he was complaining of such severe pain. The man was taken to Pinderfields hospital. His condition began to deteriorate and he was moved to the resuscitation room.

39. The man was restrained by an escort chain (a length of chain with a single handcuff at each end, one attached to the officer and the other to the prisoner).and accompanied by Officer B and Officer C.

40. Unfortunately, the man deteriorated further and required resuscitation. The escort officers contacted the prison's emergency control room and the duty Governor authorised the escort chain to be removed for treatment.

41. The man was critically ill and all medical treatment was stopped. The man did not regain consciousness and was pronounced dead by a hospital doctor. Officer B remained with the man until he was moved from the resuscitation room.

Contact with The man's family

42. The hospital requested that the man's next of kin be informed and Duty Governor requested that Officer D, the prison's family liaison officer, telephone the man's wife. Officer D made contact and kept the man's wife informed of the events as they unfolded. She gave the man's wife the hospital's direct telephone number, told her of his critical condition and

advised her to go to the hospital as a matter of urgency. The man's wife spoke to the hospital and was waiting for information from the doctor but the man died before his family was able to get to the hospital.

43. On his reception at Wakefield, the man said that he wanted his wife, who lived in Cleveland (some distance from Wakefield), to be contacted in the event of an emergency. After he got to the hospital, Officer D telephoned the man's wife and remained in contact with her. As she was aware of his rapid deterioration and critical condition, the officer also informed her of his death, by telephone. Officer D and Officer E visited the man's family the following day. In line with Prison Service policy, the prison remained in contact with the family and assisted with funeral arrangements and expenses.

Support for staff and prisoners

44. Officer B said that when they returned to the prison in the early hours of the 8 January, all staff who had been involved in the emergency response attended a hot-debrief chaired by a Governor. SO A explained that staff who were involved but not available for the hot-debrief, were seen on a different occasion. (A hot-debrief should focus on reassurance, information sharing, normalisation and how staff can support each other and provides an opportunity for all those involved to discuss their experience and gain support where needed.) Staff who were interviewed during the investigation all spoke positively about the support they were offered by managers at Wakefield, and said that they knew where to obtain further support if they felt necessary.

45. Prisoners were told of the man's death by way of notice from the Governor, this note provided information about where to access support. A friend of the man on his wing said that officers had told him personally that the man had died. He was aware of the support available to him if needed.

46. In line with Prison Service policy, all prisoners on self-harm and suicide monitoring were reviewed.

Results of the post mortem

47. The post mortem confirmed that the man died as a result of a ruptured atheromatous abdominal aortic aneurysm. An aneurysm, is a localised, blood-filled balloon-like bulge in the wall of a blood vessel. An aortic aneurysm occurs in the main artery carrying blood from the left ventricle of the heart.

48. Abdominal aortic aneurysms are most usually caused by atherosclerosis, a fatty deposit of the inner lining of the arteries.

ISSUES

Clinical care

49. The clinical reviewer noted that the man had attended 50 healthcare appointments in the last 12 months of his life. The clinical reviewer concluded that his access to primary health care services was equitable with that he could have expected to receive in the community.

50. The man was sentenced in December 2002 and when he transferred to HMP Wakefield in October 2010, he was placed on medication for his heart condition and arthritis. The man's records show that he complained of back and other joint pains frequently and needed constant pain relief. In June 2011, he was diagnosed with chronic kidney disease.

51. The clinical reviewer states that the man's medical conditions were not neglected. He had regular appointments, was appropriately prescribed medication and monitored and investigated throughout his sentence.

Whether the aneurysm could have been diagnosed earlier

52. The man died of a ruptured abdominal aortic aneurysm (AAA). The clinical reviewer states that had the aneurysm been found earlier, it might have been treatable, but in the majority of cases ruptured AAAs are fatal.

53. The clinical reviewer comments that AAAs tend to be symptom-less, although pain can be caused to the abdomen, chest and lower back (due to pressure on the surrounding tissue), or in the legs or testicles (due to disturbed blood flow). She says that they are often found accidentally during abdominal examinations as a result of other symptoms. In July 2011, the man declined an abdominal examination during his appointment with prison Dr A when he presented with symptoms of an un-related nature. He did not attend the follow up appointment with her. The clinical reviewer comments that it is possible that if he had been examined at this point the aneurysm might have been found.

54. The man did complain of some of the associated symptoms of AAA, notably back and groin pain. However, such pains were a regular occurrence in the man's life, as they were associated with a long term and well documented disorder of his spine.

55. The clinical reviewer comments that the man had a number of risk factors for AAA being a man in his 70's (AAA is most likely to occur in men aged between 65 and 70 years). He had atherosclerosis (hardening of the arteries) was a smoker and was overweight. He was also a chronically sick man, whose long term symptoms of back and joint pains, heart and circulatory disease, chest infections and dizziness could have masked new symptoms relating to the AAA.

Record keeping

56. The clinical reviewer concludes that the man's electronic record was adequate and met the standard of record keeping required by professional bodies. However, there is some evidence that relevant information is missing from his medical records. In September 2011, the man attended an appointment with a nurse prescriber and she recorded that she would book him an appointment to see prison Dr B the following day. There is no evidence in his medical records that this appointment happened. The clinical reviewer notes that if a patient's appointment is changed by a member of staff, or if they do not attend, that this should be recorded on every occasion and where possible a reason given.

57. The man's family were concerned that he had a chest X-ray and had not been given the results. The clinical reviewer comments that there is no evidence in the man's medical records that results of blood tests or X-rays had been either read or acted upon if required. The clinical reviewer adds that patients should be informed of laboratory and X-ray results, whether normal or otherwise, and that this should be recorded in the medical records.

58. All healthcare staff, irrespective of grade, including agency staff have a duty to ensure that accurate and comprehensive records of contacts with patients are entered on the computerised record. Record keeping has been identified as a problem in previous investigation reports into deaths at Wakefield. It is regrettable that this is still an issue.

The Head of Healthcare should ensure that all healthcare staff comply fully with the requirements for accurate and contemporaneous record keeping in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.

The Head of Healthcare should ensure that prisoners are told the results of health tests and this should be recorded in their medical records.

Appointment waiting times

59. The man's family said he had had difficulty making appointments to see a doctor and, when booked, he had to wait a long time before he was seen. The man's records generally show no indication of delays in receiving appointments.

60. However, we have considered whether it was reasonable, when the man saw the nurse prescriber on 6 January complaining of pain, to wait so long for an appointment to see a doctor. It is accepted that this was regarded as a routine appointment. The clinical reviewer reflects that the 11 days that the man was expected to wait is in line with waiting times in the community. While there is no longer an NHS 48 hour target for GP appointments the suggested standard time of two weeks for a doctor's appointment at

Wakefield is too long in the prison context, where prisoners do not have the other options available to those in the community.

61. The most recent HMCIP report of 2008 commented that 'nurses could arrange an urgent referral to the GP, but the wait for a routine appointment was 10 days, which was too long'. We agree with this view and consider that the time the man had to wait for an appointment was too long, particularly for a man of his age and ill-health, who had no alternative means of seeking a doctor's advice.

The Head of Healthcare should ensure that, except in exceptional circumstances, prisoners are able to see a GP within a week.

The emergency response

62. When Nurse A went to see the man, she immediately asked SO A to call for an ambulance. He radioed the control room, and an ambulance was requested, so there was no delay in the ambulance being called. It arrived promptly.

63. The investigator considered whether there was a delay in the ambulance leaving the establishment, as the emergency services log shows that the ambulance was held for 10 minutes within the secure zone between two gates. The Operational Governor explained the process for escorting a prisoner out of the prison in an emergency and when the prison is in night state. He said the ambulance arrived at Wakefield during the patrol state (the period when all prisoners are locked in their cells, staff numbers are reduced and security is heightened). This occurs before the prison goes into night state, when everything is serviced electronically from the control room.

64. When a vehicle arrives and departs from the prison, the prison's security procedures require, a mandatory check of both personnel and the ambulance to be undertaken before the gate is opened. When the ambulance carrying the man was ready to leave, the prison was in night state. This meant that there were insufficient staff to carry out the checks and open the gates in an efficient and speedy manner, which caused a delay. This is unsatisfactory.

65. This office has raised the issue of ambulances being delayed on a number of occasions. In response, the Chief Executive of the National Offender Management Service (NOMs) and the Director of Offender Health (OH), Department of Health issued at letter in February 2011 reminding Governors to ensure a protocol exists at each prison (regardless of security status) to facilitate immediate access for emergency ambulances. The investigator examined the Wakefield ambulance protocol, dated December 2011. The document contains no reference to arrangements for emergency ambulances leaving the establishment. Our view is that 'access' in such situations includes both entry and exit.

The Governor should ensure that the ambulance protocol at Wakefield includes arrangements for the emergency ambulances to enter and exit without delay.

Restraints

66. On each occasion a prisoner is escorted outside of the prison to hospital a risk assessment should be carried out. The assessment will consider the offences and the risk of further offending, whether there is any danger to the public, likelihood of escape, as well as the prisoner's health and mobility. This assessment informs the decision about the number of escorting officers and type of restraint to be used. It also determines the circumstances and the authority required for the restraints to be removed.

67. In the man's case, no formal risk assessment was undertaken before he was removed from the prison. HMP Wakefield's ambulance protocol dated 9 December 2011, states:

> "When dealing with an emergency escort, the preservation of life must always be the first consideration, and that in critical situations a risk assessment can be completed after the escort has left the prison, and delivered to the hospital at the earliest opportunity within 24 hours".

No risk assessment was completed subsequently as the man died not long after arriving at Pinderfields.

68. Once the decision was made to take him to hospital, the man was restrained by escort chain and accompanied by two officers. The man's condition deteriorated rapidly once he arrived at Pinderfields hospital and the restraints were removed for emergency treatment and not replaced.

69. Although no formal risk assessment was carried out, we believe that the decision to use an escort chain, a relatively low level of restraint for a category B prisoner, was appropriate for the short time it was used and ensured there was no delay.

70. We are satisfied that the restraints were appropriately removed when the man required emergency treatment.

Family Concerns

71. The man's family were concerned that, approximately two weeks before he died, he had provided a urine sample and that the results had come back negative. They wanted to know if anything had been done to further investigate his urinary problems.

72. The man's medical record shows that when he initially complained of this problem in March 2010, examinations were undertaken and he provided a urine sample. While his initial results were negative, in June 2010 a urine

sample provided a positive result for a urinary tract infection, for which he was prescribed amoxicillin (antibiotic). There is no further mention of urine problems until 2011, when prison Dr A requested a urine test as part of a series of tests. On 1 July 2011, an entry was made that a urine sample was returned as it was not in the correct bottle. A sample in the correct bottle was provided but there is no follow up entry about this. When he was examined in September 2011, an entry records that the man was passing urine 'as normal' and he did not raise this as a problem during any GP appointments after June 2010.

73. The man's family have had an opportunity to read the report. Having considered the findings of the investigation, they remain concerned that the man missed hospital appointments because no one was available to escort him.

CONCLUSION

74. The man arrived at Wakefield in October 2010 and had a long standing history of ill-health. During his time in custody, he attended regular appointments with healthcare.

75. Between 14 September and the 20 December 2011, the man was examined four times as a result of a chest infection. Additionally, he was seen for joint and back pain regularly and his medication was continually reviewed. An abdominal aortic aneurysm while often symptom-less, can cause pain in the abdomen, chest and lower back. As the man had had problems with pain in his back and joints for some time, healthcare staff, not unreasonably, attributed these to his arthritic problems.

76. On 6 January 2012, the man attended healthcare complaining of aches in his legs and groin area. The Nurse decided that he should have a non-urgent appointment to see a doctor, and booked him in 11 days later, prescribing him ibuprofen as an interim measure for his pain relief.

77. On 7 January, during roll check, a member of staff noticed that the man was looking unwell. It was agreed by the man that he would wait for the nurse to do her rounds of the wing that evening. When she attended, the man seemed very ill, and an ambulance was requested. The man was taken to Pinderfields hospital, and was diagnosed with an AAA. The man's condition deteriorated rapidly and he died shortly after.

78. We agree with the clinical reviewer that the man's care was of a standard equal to what he might have expected in the community, but routine GP appointments take too long in the prison context. Systems need to ensure that there is no delay in ambulances entering or leaving the prison. Some deficiencies in medical record keeping were identified, including noting whether prisoners are informed of test results.

RECOMMENDATIONS

NOMS responses to the recommendations are in italics below

1. The Head of Healthcare should ensure that all healthcare staff comply fully with the requirements for accurate and contemporaneous record keeping in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.

This recommendation has been accepted. NOMS write that "The prison has ongoing training sessions via an outside provider, Meades and Associates. All services providers are using them to train in use of SystmOne. There are also regular updates in staff training sessions facilitated by Spectrum. The next training session will specifically focus on areas identified in this report"

2. The Head of Healthcare should ensure that prisoners are told the results of health tests and this should be recorded in their medical records.

This recommendation has not been accepted. NOMS write "All pathology and other test results are reviewed automatically before these are filed electronically into the patients' medical record. Any abnormal results are flagged and an appointment is made with the patient to discuss this further. However, in GP practices, all 'normal' tests results are not routinely discussed with the patient unless this is specifically requested by them".

3. The Head of Healthcare should ensure that, except in exceptional circumstances, prisoners are able to see a GP within a week.

This recommendation has not been accepted. NOMS write "GP appointments for routine reviews are running at 12 days currently. However there are identified emergency appointments which can be accessed daily Monday to Friday. At weekends there is an emergency on call service whereby if the healthcare staff requires a GP, an on call GP will attend the prison. This is the equivalent service available in the community. There is also qualified nurse cover 24 hours a day".

4. The Governor should ensure that the ambulance protocol at Wakefield includes arrangements for the emergency ambulances to enter and exit without delay.

This recommendation has been accepted. NOMS write "The ambulance protocol will be reviewed to ensure that, accepting the inherent security implications associated with a High Security establishment, emergency ambulances are expedited both in and out in a timely fashion".