The Death of a man at a hospital in Leeds in May 2004

Report by the
Prisons and Probation Ombudsman
for England and Wales

November 2005

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Foreword

This is the report of an investigation into the circumstances surrounding the death of a man on 3 May 2004. The man was taken unwell in his cell at HMP Wakefield shortly after midnight on that date. He was transferred first to a hospital in Wakefield then shortly afterwards to a hospital in Leeds where he died a few hours after admission.

All deaths of prisoners in custody are investigated, including those due to natural causes. The responsibility for carrying out these investigations traditionally fell to the Prison Service but has now been passed to the Prisons and Probation Ombudsman to bring independence and greater consistency to the task. In this case a member of the Prisons and Probation Ombudsman's staff carried out the investigation.

My colleagues and I would like to extend our condolences to the man's family and friends at their sad loss. I would like to thank the Governor in charge of HMP Wakefield at the time of the man's death, and other members of his staff for the assistance they have given to my investigation over many months. I am extremely grateful to Wakefield West Primary Care Trust for leading a wide-ranging clinical review which has obtained information from a significant number of sources.

I hope that the man's family will feel that the questions they asked have been answered as comprehensively as possible. At the end of this report there are some important learning points, both for HMP Wakefield and for the Prison Service generally.

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

Stephen Shaw
Prisons and Probation Ombudsman **November 2005**

SUMMARY

1. The man was sentenced to life imprisonment at Liverpool Crown Court in December 1996 and he transferred to HMP Wakefield in May 1997. He remained at Wakefield until 3 May 2004, the date of his death.

2. The man was 37 years old and his prison medical record indicates that he complained of migrainous headaches on a number of occasions.

3. At 12:30am on 3 May 2004 he was the sole occupant of cell B1-36. He rang his cell bell and the officer who was patrolling on C wing at the time, answered the bell. The man told the officer that he had a very violent headache and that he had lost vision in his left eye.

4. The officer rang the prison's Health Care Centre (HCC) and at 12:50am the man’s cell door was unlocked so that the Health Care Officer (HCO) could examine him. HMP Wakefield is a high security prison and only the Night Orderly Officer, the senior officer in charge of the prison at the time, had the keys that enabled the HCO to make the journey to the man’s cell on B wing.

5. When staff entered the cell at 12:50am the man was found lying under his bed. There was a considerable amount of vomit on his shirt and on the cell floor. He was placed in the recovery position but he began to fit. The HCO decided that an ambulance should be summoned immediately.

6. An ambulance was called by the prison's control room at 12:55am and it reached the front gate of the prison at 1:05am. The ambulance crew arrived at the man’s cell at 1:15am. He was unconscious but the ambulance crew wished to stabilise his condition before transferring him to outside hospital. He was placed in the ambulance at 1:40am and the ambulance left HMP Wakefield just before 1:58am.

7. He was taken first to a hospital in Wakefield and then later in the night he was transferred to a hospital in Leeds General Infirmary.

8. Although the man’s prison record contained no next of kin information, enquiries were made at HMP Wakefield around 8:00am on the morning of 3 May, as a result of which contact was made with the man’s family in Merseyside. His parents, sister and brother were able to reach his bedside by 11:00am and he was pronounced dead at 12:40pm.

9. A post-mortem examination was conducted on the coroner's behalf by a Professor and his report shows the cause of death to be subarachnoid haemorrhage and ruptured aneurysm of the Circle of Willis.

10. A detailed clinical review has been conducted by Wakefield West Primary Care Trust (PCT). A doctor and manager from the Trust made formal contact with the Clinical Director at HMP Wakefield, West Yorkshire Metropolitan Ambulance Service (WYMAS), the Assistant Director Medicines Management at Wakefield West PCT and the Health Care Manager at HMP Wakefield.

11. This report makes a number of recommendations. The recommendations at the end of the PCT's clinical review are endorsed. Additional recommendations are made in relation to the excellent conduct by an officer at HMP Wakefield, the need for reviews at least annually of next of kin details to be used in an emergency and the possibility of introducing a target time for responses by health care staff at Wakefield to night-time emergencies.

INFORMATION ABOUT HMP WAKEFIELD

12. HMP Wakefield is a high security dispersal prison for prisoners convicted of serious offences, most of them sex offences. It was most recently inspected by the HM Chief Inspector of Prisons (HMCIP), between 13-17 October 2003. The introduction to HMCIP's report states:

    "Many of those it holds would pose significant risks to society if released, and it is the prison's task to hold them securely and try to work with them to reduce those risks."

13. HMP Wakefield is a main lifer centre, which means that it accepts men as soon as possible after they have been sentenced to life imprisonment. There has been a prison on the site since 1595. The prison in its current form dates back to 1845 and the wings are arranged in the Victorian style radial system. The prison's certified normal accommodation is 567 and it has an operational (maximum) capacity of 571.

CONDUCT OF THE INVESTIGATION

14. My investigator visited HMP Wakefield on 5 May when he was given a detailed briefing by the Deputy Governor, the Clinical Director and the Health Care Manager.

15. I commissioned a clinical review from Wakefield West PCT. I am most grateful to the Trust for their thorough and professional response to my request.

16. My investigator met with the man's mother, father and sister at the family home. At that meeting the family asked many questions, several of which were of a medical nature and were therefore conveyed to Wakefield West PCT when the clinical review was commissioned on 1 June.

17. My investigator interviewed the three members of staff at HMP Wakefield who were significantly involved in dealing with the emergency very early in the morning of 3 May. These were the Night Orderly Officer, the HCO and the C Wing Night Patrol Officer.

THE EVENTS OF 3 MAY 2004

18. The man occupied a single cell on B wing at Wakefield. Through the night of 2-3 May there was a Night Patrol Officer on B Wing and a Night Patrol Officer on C Wing. The Night Patrol Officer on C Wing heard the man ring his cell bell at approximately half past midnight and since the B Wing Officer was elsewhere at the time the C Wing Officer walked onto B Wing after about 10 or 15 seconds and proceeded to the man's cell on the bottom level of the wing. In interview the C wing Officer explained that the noise of the cell bell was "pretty strident" and carried clearly to him at that time in the morning. The C Wing Officer was confident about the time. His routine, which he again observed this particular night, is to check his watch if such a call is made. In his experience these calls generally signify a medical problem.

19. The C Wing Officer's timing of half past midnight is confirmed by entries in the Wing Occurrence Book (by the B Wing Night Patrol Officer), in the Governor's Journal (entry made by the assistant Night Orderly Officer) and in the HCO memorandum to the Governor of 3 May.

20. When the C Wing Officer reached cell B1-36 (the man's) he opened the observation flap on the cell door and could see that the man was standing at the front of the cell with his face up against the observation flap. The man told the officer that he had a very violent headache and that he had lost vision in his left eye. The two men knew each other, as the C Wing Officer has been an officer at Wakefield for nearly 13 years.

21. After being told the man's symptoms the C Wing Officer rang the prison's HCC and spoke to the HCO who said that he would attend.

22. Wakefield is a high security prison and the HCC is approximately 250 yards from the man's cell. The HCC is double locked at night-time so the HCO had to be collected by the Night Orderly Officer (the most senior officer on duty in the prison).

23. In interview the Night Orderly Officer explained that he was the only person during the night who had access to the major areas of the prison which were double locked so he made his way to the HCC, collected the HCO and the two men returned to the centre of the prison. The HCO indicated that there were nine sets of locks to negotiate on both the outward and return legs of the journey.

24. In interview the HCO explained that the complement of staff in the HCC during the night was himself and an agency nurse. Whilst waiting to be collected by the Night Orderly, the HCO had time to check the man's medical records but he discovered no recent entries of significance.

25. At 00:50am (timing in both the HCO's memo and the Night Patrol Officer's Wing Occurrence Book), an officer who was assisting the Night Orderly Officer, unlocked the man's cell door and the C Wing Patrol Officer and the HCO went inside.

26. The man was found to be lying on the cell floor with his upper body, from his waist upwards, under the bed. The C Wing Officer said there was a lot of vomit on the floor and when he spoke to the man he received no response whatsoever. The C Wing Officer and the HCO pulled the man from under his bed onto an open piece of cell floor and discovered vomit all down the front of his T-shirt and around his mouth.

27. In interview the C Wing Officer said that the man's speech seemed fairly normal when the two men spoke at half past midnight and his estimate was that the vomiting began after he had left the man. He could see no vomit on the man's shirt at 00:30am but there was so much at 00:50am that the two officers removed his shirt.

28. The two officers tried to put the man into the recovery position but he started to fit and it was difficult to hold him in the recovery position. When the HCO observed the first fit he decided that an ambulance must be called. The log maintained by Control Room staff at the prison indicates that an ambulance was called by them on the HCO's instructions at 00:55am. This time is confirmed in a letter written to the PCT by the Acting Chief Executive of West Yorkshire Metropolitan Ambulance Service (WYMAS). The WYMAS letter establishes that the ambulance crew arrived at the outer gates of the prison at 1.05 am. They reached the man's cell at 1.15am.

29. While the HCO and the C Wing Officer were waiting for the ambulance to arrive, they observed the man fit on a significant number of occasions (between six and 12 according to the HCO). The two men did their utmost to maintain an airway and to maintain the man in a safe environment where he could not cause himself injury. The C Wing Officer explained how they made the man as comfortable as possible by putting a pillow under his head and covering him with a blanket. The HCO constantly tried to talk to him but received no response. The man was moaning a lot but was unconscious.

30. According to the C Wing Officer the paramedics who attended wanted to get a cannula (thin tube) into the back of one of the man's hands so that they could administer a sedative to calm him down because he was continuing to fit. This was achieved but then the man had another fit and inadvertently ripped the cannula out. The memorandum submitted by the HCO states that the man was stabilized at 1:40am and the ambulance left for Pinderfields Hospital, Wakefield 15 minutes later. The Control

Room log times the man’s removal to Pinderfields as being at 1:58am. The WYMAS timing is identical.

31. During the night the man was transferred from Pinderfields to Ward 6, the Neurology Unit at a hospital in Leeds. At the request of the hospital the prison supplied a contact telephone number for the man’s parents and family members who were able to make their way from their home to be at the man’s bedside before he passed away at 12:40pm on 3 May.

CONTACT WITH THE MAN’S FAMILY ON 3 MAY 2004

32. When the man first came into HMP Liverpool on 17 August 1996 he gave his home address. He was asked for the name and address of his next of kin and the answer given was "states none". He was also asked for the name and address of any other person to be notified in an emergency and again the answer was "states none". There is no evidence that the man was asked at any stage during the next seven and a half years whether he wished to supply such information.

33. There is clear evidence in the man’s prison record of regular contact with his family before his death. A probation officer contributed in January 2004 to the man’s Sentence Planning and Review Board. In the section headed 'outside contacts with family' the probation officer wrote that the man "has some good external support from his family. They maintain contact via the telephone". Two Visiting Orders, issued just weeks before the man’s death, provide even clearer evidence of the strong relationship with his family. The Visiting Orders were issued on 4 March and 6 April 2004 with visits paid by two family members (according to the orders) on 18 March and 23 April 2004.

34. On the morning of 3 May 2004 it was clear that the man was very seriously ill, but making contact with his family was a difficult exercise in view of the absence of information on the first page of his prison record. Thanks to the determination of medical staff at Leeds General Infirmary, a phone call was made to the prison by one of the two prison officers accompanying the man at the hospital. Records of the man’s phone calls were studied and the prison was able to give the necessary information to nurses. At 8:25am a nurse informed one of the escorting officers, that the man’s next of kin had been contacted. The Escort Record kept by this officer shows that the man was visited at his bedside by his parents, brother and sister at 11:00am. The man was pronounced dead less than two hours later.

35. It was thanks to some quick and humane thinking by both prison and medical staff that the man's relatives were able to be with him before he passed away. Contact with the relatives would have been much easier if next of kin information had been contained in the man's record. It is not completely surprising that the man did not wish to supply such information when he first arrived at HMP Liverpool in August 1996. At that time he was very unsettled and he had been charged with serious offences. There are some prisoners who have no next of kin, or who remain adamant that they do not wish to supply contact information, even for use in an emergency. The man was a lifer whose progress through his sentence was reviewed annually.

Recommendation

I recommend that the Prison Service should devise a method of updating next of kin information on long term prisoners on at least an annual basis.

FOLLOW UP TO THE MAN'S DEATH

36. The man's parents, brother and sister were at his bedside when he died. 3 May 2004 was a Bank Holiday and the following day the Governor at Wakefield published a Notice to Staff and a separate Notice to Prisoners in which he announced the man's death with deep regret.

37. Subsequently the family accepted an invitation to visit the prison when items of the man's property were handed over and the family had an opportunity to see the areas where he had lived and worked. They also spoke with both staff and prisoners who had known the man well.

38. The family were originally advised by the prison to make a claim for a Social Fund Funeral Payment to help with funeral costs. The family were not sure how to access such a payment and explained their concern to my investigator when he visited them on 25 May 2004. My investigator wrote to the Deputy Governor about this and related matters and the Governor then made an ex gratia payment to the funeral director towards the funeral costs which had been incurred. The family are most grateful to the Governor for his response.

THE QUESTIONS ASKED BY THE MAN'S FAMILY

39. During my investigator's meeting with the man's parents and sister on 25 May 2004, the family asked nine questions. The most detailed responses that can be given to these questions are as follows:

1) They understood that a doctor was on duty in the prison's HCC throughout each night and they wondered why a doctor did not attend the man when he was taken ill in his cell after midnight on 3 May.

Page 4 of the PCT's clinical review explains that during the night period a doctor is on-call for advice but he/she is at home, not in the prison. The letter from the Health Care Manager to the PCT explains that the two staff on duty in the HCC were the HCO and an RMN. (The RMN had been supplied by a nursing agency.)

2) The family understands that paramedics arrived at the prison at approximately 1:10am and that the man was removed to Pinderfields Hospital at approximately 1:40am. They ask why he was not transferred to hospital sooner.

According to the letter from the Acting Chief Executive of WYMAS, the ambulance crew arrived at the outer gates of the prison at 1:04am. They arrived at the man's cell at 1:15am. The paramedics decided it would be dangerous for both patient and crew to move him before first administering Diazemuls (this is a drug to help the patient stop fitting). The crew arrived back at the ambulance at 1:40am.

The third paragraph of the Chief Executive's letter explains that once back in the ambulance the crew carried out a full routine baseline examination, taking approximately two to three minutes. They passed through a number of security gates and left the prison at 1:57:57am.

*3) The family enquired whether the man suffered an epileptic fit in his cell which induced a brain haemorrhage **or** whether a haemorrhage led to a subsequent fit.*

4) The man's father asked if it was thought that his son had banged his head as he fell in his cell and whether such a fall could have induced a brain haemorrhage.

No information has been made available which supplies definitive answers to these questions.

5) He also asked whether his son was receiving medication at the prison prior to his death.

The Continuous Medical Record section of the man's Inmate Medical Record (IMR) shows that medication reviews were held at regular intervals. The last such review is recorded as taking place on 14 April 2004 when the man was again prescribed paracetamol to have in his own possession. The amount to be taken was one or two tablets 3 times a day.

6) The man's father asked if his son had had bad headaches before going into prison and receiving his life sentence. He asked whether the prison had arranged for any examinations of his son's headache problem and whether the response to the presenting problem(s) had been sufficiently thorough.

7) The man's father said that his son had complained often in phone calls home from the prison about bad headaches and blurred vision in one eye.

The clinical review submitted by the PCT includes notes from a meeting that was held on 10 August 2004 between the Medical Director at Wakefield West PCT, and the Clinical Director at HMP Wakefield. The meeting noted that the man's IMR recorded evidence of a history of migrainous headaches but there was little evidence in the IMR of medical neurological examinations having taken place. There were also scant records of examinations by clinicians in the prison. The last two notes made at the meeting between the two doctors were as follows:

- from the medical record it seems that the man had been appropriately managed and treated at the prison
- The man had been referred to, and seen by, a consultant neurologist with another referral pending.

In relation to clinical management, the relevant section of the clinical review states that there is no evidence to indicate that the clinical management of the man's case was flawed or mismanaged during his custody at HMP Wakefield. Evidence-based guidance for clinicians is that it is not appropriate for a patient to undergo imaging without specific neurological clinical indicators, which were not present in the man's case. In his case there had not been any specific or clinical indicators, other than migrainous headaches, that would have led a clinician (whether a prison doctor or consultant neurologist) to carry out imaging on this patient. Imaging is a medical procedure for scanning or x-raying the part of a patient's body under scrutiny.

8) The family stated that a nurse at the hospital in Leeds had complained to them on the morning of 3 May about the man's remaining in handcuffs.

Wakefield is a high security prison and the prison has local security instructions which indicate that in a medical emergency, where there is no time for a risk assessment, restraints must be applied until a risk assessment is completed.

The Prisoner Escort Record, maintained by staff who escorted the man to hospital, shows that one of the officers who accompanied the man to hospital

rang the prison from a hospital in Leeds at 7:51am on 3 May. He reported that the doctor caring for the man had made a request that the prison staff accompanying him go into a side room so as not to upset other patients on the ward. The request was denied at that time by the Deputy Governor. At that stage he had relatively limited information about the man's medical condition.

The Deputy Governor made two important and humane decisions when he came on duty on the morning of 3 May 2004. Firstly, he made the final decision on a form entitled Risk Assessment for Hospital Escort/Bed Watch about the level of security that was required for the man. He ordered that the handcuffs should be removed and that the man should remain uncuffed while he was unconscious and attached to a life support machine. Secondly, he discussed the case with the Duty Governor at the prison on that Bank Holiday Monday. The Duty Governor was dispatched to a hospital in Leeds with authority from the Deputy Governor to withdraw the staff if he considered that appropriate.

The Prisoner Escort Record shows that a Duty Governor visit was made to the man at a hospital in Leeds at 10:25am. My investigator spoke to the Duty Governor about the visit and he could remember the circumstances clearly. He recalled that the man had been cared for in a small ward at the infirmary and that at the time he arrived there, mid morning, the man was neither handcuffed nor restrained in any way. The Duty Governor was aware that nurses were concerned about the impact of the two prison officers accompanying the man on the remaining patients in the ward. The Duty Governor remembered that the doctor on the ward was very busy indeed, but he discussed the situation with the ward sister and doctor as soon as the doctor was free. The Duty Governor agreed that both the officers who accompanied the man should withdraw from the ward to a small ante-room outside, where they still had sight of the man but were able to give more privacy to his family and the other patients on the ward. The Duty Governor signed a detailed Management Visits Checklist in relation to his visit.

9) The man's sister expressed surprise that her brother had gained so much weight. She enquired as to whether he had gone to the prison gym regularly and asked whether the weight gain had contributed to his death.

My investigator made enquiries at Wakefield as to whether the man had attended the gymnasium regularly, now and then or not at all. A Senior Officer from the Physical Education Department at Wakefield sent an e-mail response stating that as far as is possible he could say that the man did not use the gymnasium at the prison. The clinical review has provided no information as to whether the man's weight gain contributed to his death.

NIGHT-TIME MEDICAL COVER AT HMP WAKEFIELD

40. During the night of 2-3 May 2004 there were two members of staff on duty in the prison's HCC. They were the HCO and a trained nurse supplied by an agency. The HCO received the telephone call from the C Wing Officer at approximately 12:30am and it was he who entered the man's cell, at 12:50am. The letter from the Health Care Manager at HMP Wakefield to the PCT states that the HCO has no formal health care or medical qualifications. The Healthcare Manager also reported that the HCO had not undertaken any formal training or Continuous Professional Development in terms of Emergency Aid, CPR (cardiopulmonary resuscitation) or First Aid.

41. The PCT's clinical review makes it clear that the HCO carried out the appropriate interventions to save life: "This involved maintaining the patient's safe environment, maintaining a clear airway, placing the patient in the recovery position, managing the patient's seizures and taking clinical observations of the vital signs prior to either the doctor or paramedics arriving." The PCT's professional endorsement of the HCO's actions is reassuring, but the Protocol and Training Issues section of the Clinical Review also expresses concerns about the HCO's level of current competence. The PCT has included a most important recommendation about health care staff training which reads as follows:

    "The HCO and all members of the prison health care team should receive regular training, particularly life-saving/emergency aid type training, if they are to competently fulfil the role of being responsible for the health care of the prisoners during the night-time period and competently manage health emergencies. We also recommended that any health care staff at the prison without a professional qualification achieve a minimum of NVQ Care at Level 3."

    Recommendation

    I agree wholeheartedly with this recommendation in the clinical review and draw this matter formally to the attention of the Governor and Clinical Director at HMP Wakefield. I believe this may not be an issue confined to Wakefield and I therefore draw the matter additionally to the attention of the Acting Director of Prison Health, Department of Health.

42. It is of concern to me that 20 minutes passed between the phone call from the C Wing Officer to the HCO and the entry to the man's cell at 12:50am. I am aware that Wakefield holds prisoners of the highest security category and that correct security procedures must be observed

when health care staff are required to see prisoners in the middle of the night. The C Wing Officer estimated that the distance from the HCC to the man's cell was about 250 yards. The Night Orderly Officer stated that he and the HCO had to negotiate nine locked gates when they made that journey. The PCT's clinical review concludes that the time taken for the HCO to reach the man was "within the normal time parameters and without any undue delay".

43. It seems unlikely that the eventual outcome would have been any different even if the HCO had arrived at the man's cell more rapidly. However I do not take the view that a 20 minute time lag before a prisoner (or member of staff) receives emergency assessment or treatment from a member of health care staff should be accepted as being within normal time parameters.

Recommendation

I recommend that the Governor should review his existing procedures for emergency access by healthcare personnel to cells during the night with a view to providing medical assistance much more quickly than in the case of the man.

CONCLUSIONS

44. The Clinical Management Section of the PCT's clinical review notes that "there is no evidence to indicate that the clinical management of the man's case was flawed or mismanaged during his custody at HMP Wakefield".

45. The Medical Director of Wakefield West PCT did however note during his meeting with the Clinical Director of HMP Wakefield, on 10 August 2004, that there was little evidence in the man's IMR of medical neurological examinations having taken place.

46. The C Wing Officer first became aware that the man was in distress when he rang his cell bell at approximately 12:30am on 3 May. The C Wing Officer remembers looking at his watch at the time because it was unusual for a cell bell to be rung in the middle of the night. The C Wing Officer was an impressive interviewee and I am confident that he rang the HCO promptly after speaking to the man at his cell door. Approximately 20 minutes then passed before the HCO arrived at cell B1-36 where the man was found lying on the floor of his cell.

47. Once the HCO had entered the cell, and assessed the scale of the emergency, he asked immediately for an ambulance to be summoned.

48. The timings supplied by WYMAS show that only ten minutes passed between the call being received and an ambulance arriving at the prison's main gate, one second before 1:05am. There was no undue delay in escorting the ambulance staff to the man's cell but the crew decided it would be dangerous to transport him to hospital immediately. They administered Diazemuls, a drug to help a patient stop fitting, to the man. The evidence given by the C Wing Officer in interview indicates the difficulty experienced by the ambulance crew before they were able to administer the necessary sedative to the man.

49. The crew arrived back at the ambulance with the man at 1:40am and they carried out a full routine baseline examination in the vehicle which took approximately two/three minutes. The clinical review concludes that the ambulance response, and the way the man was treated and managed, was appropriate.

50. The part played during the incident by the C Wing Officer was noteworthy. He answered the man's call for assistance at 12:30am, although he was the patrolling officer on an adjacent wing. He promptly requested medical assistance from the HCO. He remained in the man's cell with the HCO for 25 minutes until the ambulance crew arrived there at 115 am. During that time he helped to remove the man's T-shirt which

was covered with vomit. He did his best to make the man comfortable and tried to maintain him in the recovery position. When the paramedics arrived on the scene he remained in the man's cell and assisted their professional efforts.

Recommendation

I recommend that the C Wing Officer be commended for his actions. They were humane and decent and went well beyond the call of duty.

51. Once the man had been transferred to a hospital in Leeds there was some delay before his family could be notified that he was gravely ill. This complication arose because there was no next of kin information recorded on his prison record. Prison staff and nursing staff at Leeds cooperated effectively to find the necessary telephone number and, as a consequence, the man's father, mother, brother and sister were able to join him at his bedside before he died.

RECOMMENDATIONS

LOCAL

(1) ***The C Wing Officer on duty that night should be formally commended in a way selected by the Governor of HMP Wakefield for conduct that went beyond the call of duty.***

(2) ***The recommendations made at the conclusion of Wakefield West PCT's Clinical Review are endorsed. The Governor, Clinical Director and PCT are invited to establish an action plan for implementation of these recommendations if they are accepted locally***.

(3) ***I recommend that the Governor should review his existing procedures for emergency access by healthcare personnel to cells during the night with a view to providing medical assistance much more quickly than in the case of the man who is the subject of this report.***

NATIONAL

(4) ***I recommend that the Prison Service should devise a method of updating next of kin information on long term prisoners on at least an annual basis***

(5) ***The Prison Service should arrange for prison health care staff to receive regular training, particularly life-saving/emergency aid type training.***

FAMILY RESPONSE TO MY REPORT

In September 2005 the solicitor acting for the man's family contacted my investigator to say that the family considered that doctors at HMP Wakefield should have paid much greater attention to the man's persistent complaints about headaches in view of the serious accident he sustained in 1995, before coming into prison. The family stated that prison doctors were aware of this accident, as indicated by the letter of 8 October 1998 from a Medical Officer at the prison to the Consultant Neurologist at Pinderfields Hospital, Wakefield.