

**Investigation into the circumstances surrounding the
death of a man, who was a prisoner at HMP Wormwood
Scrubs, on 14 October 2006**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

January 2008

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.

This is the report of an investigation into the death of a man, who was a prisoner at HMP Wormwood Scrubs, who died from natural causes on 14 October 2006. He was 52 years old.

I would like to add my personal condolences to those already expressed to the man's family on behalf of this office by one of my Family Liaison Officers.

This investigation was undertaken by one of my investigators. Both he and I would like to thank the Governor of HMP Wormwood Scrubs, Mr Steve Metcalf, and his staff for their participation in the investigation. Hammersmith and Fulham Primary Care Trust identified a member of their staff to undertake a review of the man's clinical care and I appreciate his assistance.

The clinical review for the man raises a number of learning points that the prison health partnership will need to consider seriously. I urge Hammersmith and Fulham Primary Care Trust in partnership with HMP Wormwood Scrubs to develop an action plan to address them in a timely manner.

This revised version of my report reflects the substantial additional inquiries that have been made following the pre-inquest review, as well as comments received on an earlier draft.

Stephen Shaw
Prisons and Probation Ombudsman

January 2008

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SUMMARY

The man was born in 1953. He was 52 years old when he died on 14 October 2006 at HMP Wormwood Scrubs. According to the post mortem, the man died from natural causes as a consequence of coronary heart disease, with emphysema and tuberculosis being contributing factors.

The man had been received into custody at Wormwood Scrubs on 29 June 2006, after being remanded by a local Magistrates' Court. During his first health screen, the man did not disclose that he had first suffered from tuberculosis (TB) 30 years previously and had received subsequent treatment for tuberculosis twice in the previous six years. This information came to light on 30 June when the man was seen by a senior nurse.

Whilst the man was in custody he was admitted to the local hospital on two occasions, from 7 to 14 July and from 18 to 22 August. On 3 October, the man had a productive cough and complained of having chest pains. The man was seen by a prison doctor who diagnosed TB but no action was taken in relation to his chest pains.

Between 8:30am and 9:00am on 14 October 2006, the man collected his morning medication. At around 11:15am, while prison staff were unlocking prisoners for lunch, they were unable to rouse the man. Staff entered the man's cell. They could not find a pulse and so summoned urgent medical assistance and commenced cardio pulmonary resuscitation (CPR). Staff were joined by the prison doctor and a paramedic crew who continued the resuscitation attempts. The doctor and paramedics were unsuccessful in their attempts. Resuscitation was stopped and the man's death was pronounced at 11:43am.

The clinical review identified issues relating to the provision of care for the man. Although I have no specific recommendations to make, the clinical reviewer highlights areas of practice that could be improved. The reviewer makes a total of 22 recommendations for service improvement. Although few of them have a direct bearing on the man's death, I believe it is important that the prison health partnership consider the findings from this report and develop an action plan to address these learning opportunities.

THE INVESTIGATION PROCESS

1. The investigation was opened on 16 October 2006 when my investigator issued notices announcing the investigation to staff and prisoners. The notices included an invitation to those who had information relevant to the man's death to make themselves known to the investigator. In the event, nobody came forward. My investigator also studied all relevant prison records relating to the man. These included his main prison record, medical records and statements made by staff. My investigator visited Wormwood Scrubs on a number of occasions and discussed aspects of the man's treatment with staff at the prison.
2. Hammersmith and Fulham Primary Care Trust commissioned a member of their staff to lead a panel review of the man's clinical care. I am grateful that this was undertaken in a most timely manner. My investigator contacted Her Majesty's Coroner to inform her of the nature and scope of my investigation and to request a copy of the Post Mortem report. My draft report was sent to the Coroner to assist in enquiries into the man's death.
3. After a pre-inquest meeting on 11 June 2007 and following instructions from the Coroner, my investigator carried out further interviews with staff at Wormwood Scrubs. My investigator was also instructed by the Coroner to interview the prisoners who had been housed in the cells adjacent to the man. This was not possible as both prisoners were no longer in custody. One of the ex-prisoners chose not to respond to a written request to contact my investigator while the other did not give a forwarding address when he left Wormwood Scrubs.
4. One of my Family Liaison Officers contacted the man's family. This was to give them the opportunity to meet with the investigator to discuss the purpose of the investigation and to raise any concerns or questions that they would like explored and addressed. My Family Liaison Officer and my investigator met with the man's family to discuss their concerns.
 - The family felt very strongly that the man would not have died had he not been in prison. They felt that he had not received appropriate medical care in light of his condition. The family were shocked at the man's death, particularly as he had appeared well and had not shown any obvious signs of deterioration when they saw him two days before his death.
 - The family were also concerned that the man was discharged from hospital for cost related and not medical reasons.
 - The family wanted to know why the man referred to the cells on his wing as "dungeon cells".
 - The family also queried why an air ambulance had been called following the man's discovery.

The clinical reviewer and my investigator have explored these points and I hope that this report provides the family with answers to their questions.

HMP WORMWOOD SCRUBS

5. Wormwood Scrubs was built between 1875 and 1891. The population is a mixture of adult male convicted and unconvicted prisoners. The maximum number of prisoners who can be held is 1,256. The prison predominantly serves the West London courts and has a high reception and discharge rate, averaging around 40 new prisoners each weekday.
6. Provision of healthcare is the responsibility of the Hammersmith and Fulham Primary Care Trust. The healthcare centre is located on two floors (H2 and H3). The out-patient and day centre are located on H2. The in-patient unit is located on H3 and has 17 beds, 12 of which are single cells. H3 includes a gymnasium and relaxation room. Healthcare provision includes a 24 hour on-call doctor service, a psychiatrist, a dentist, hepatitis clinic, pharmacy, visiting surgeon (minor surgery only), GP surgeries and nurse triage. More serious and acute conditions are referred to the local hospital.
7. For emergency situations, the prison operates an emergency radio medical code system. This alerts the emergency healthcare responder (Hotel One) to the nature of the emergency they are attending, enabling them to take the correct equipment to help manage the situation. Call sign Hotel One is available 24 hours a day, contactable from the communications room via the prison communication system.
8. Medication is administered on a weekly and/or monthly basis to those prisoners who have been risk assessed as suitable for holding it in their own possession. It is administered on a daily basis to other prisoners when they are considered to be at risk or the medication is considered unsuitable to be held in their possession.

KEY FINDINGS

29 June to 14 October 2006

9. The man arrived at HMP Wormwood Scrubs on 29 June 2006 after being remanded into custody. At his first health screen interview the man did not disclose his full medical history. The next day, a senior nurse discovered that the man had a 30 year history of tuberculosis for which he had received treatment during the previous six years.
10. On 7 July, the man was due to appear via a video link to a local Magistrates' Court. As the man seemed unwell, he was examined by the prison doctor who noted that the man was distracted and emaciated. He decided that the man should be admitted to hospital for assessment. The prison doctor felt the man was possibly experiencing a relapse of his tuberculosis. The prison doctor then gave evidence via the video link to the judge that the man could not appear as he was acutely unwell. The man was admitted to an outside hospital later that same day.
11. By the time of his discharge from hospital on 14 July, the man's condition had been identified as a community acquired pneumonia and he was treated with antibiotics. The man told the hospital staff that the condition had in fact started two days before he was remanded into custody.
12. On 21 July, the man was reviewed by a prison doctor at Wormwood Scrubs, and it was noted that he was continuing to cough. A further course of antibiotics was prescribed. The man was reviewed again on 4 August by a prison doctor. It was noted that the man still had a persistent cough and it was therefore decided to continue with his prescription of antibiotics.
13. On 17 August, the prison received a phone call from the local hospital informing them that the man had suspected tuberculosis. The prison healthcare team were advised to isolate the man, re-admit him to the hospital and to trace people with whom he had been in contact. The man was admitted to hospital the following day and was treated for infectious tuberculosis. It was later discovered that the man did not in fact have active tuberculosis, but rather a bacterial infection.
14. On 22 August, the man was discharged from hospital back to Wormwood Scrubs. He was prescribed anti-tuberculosis medication and antibiotics. The man attended the treatment room on the ground floor of A wing on a daily basis to collect his medication.
15. The man's condition was reviewed on 11 September but it is not clear who carried out the review. The man's medication was reviewed on 15 September and again it is not clear who carried out the review. It was decided to continue with his current regime. On 22 September, the man was given a nebuliser to assist with his breathing which was continuing to give him problems.

16. On 26 September, a Consultant Physician in Infectious Diseases wrote a letter to Wormwood Scrubs summarising the treatment the man had received whilst in hospital and his prognosis. She confirmed that a Computer Tomography (CT) scan of the man's lung, carried out in August, did not show active tuberculosis. The Consultant Physician said in her letter that the man would need to be reviewed towards the end of the year and a further scan would then be carried out.
17. On 3 October, the man had a productive cough and complained of having chest pains. He was seen by a locum General Practitioner (GP) who continued treatment for tuberculosis. The GP took no action in relation to the man's chest pains. The care plan for the man was to remain in healthcare until the results of sputum tests were known, to remain on his current treatment regime and to be nursed in isolation. A TB specialist nurse on the PCT panel reviewing the man's care after his death, questioned whether the continuation of treatment could have been related to the timing of the man's tuberculosis medication. This is because patients are encouraged to eat after taking their medication as side effects can include indigestion and heart burn. It is important to note that this advice is not documented as having been given to the man and no attempts were made to investigate the cause of the chest pain.
18. The man was admitted to the healthcare centre on 4 October, as he was coughing excessively and he had coughed up blood. Tests were carried out and samples sent to the local hospital. Two days later, after the results of tests did not show active tuberculosis, the man was discharged from the healthcare centre and he returned to A wing.
19. On 13 October, a prison doctor reviewed the man's medication and decided to continue with his current treatment regime.
20. Between 8:30am and 9:00am on 14 October 2006, the man collected his morning medication. Prison Officer A recalled that on his return to his cell the man popped into the wing office to say hello. She then saw the man a little later. He was smoking a cigarette and leaning on the landing rail before he returned to his cell. At around 11:15am, when Officer B was unlocking the prisoners on A wing for lunch, he noticed that the man was lying on his back, with his eyes open and staring at the ceiling. The man's mouth was also slightly open. Officer B could not see if the man's chest was rising or falling.
21. Officer B did not get a response when he called the man's name, so he entered the cell (A2-38) and tried to rouse the man by shaking him and pinching his arm. Officer B then checked for a pulse but could not find one, so he immediately summoned medical assistance and commenced cardio pulmonary resuscitation (CPR). Officer A had been unlocking cells at the other end of the landing. Both she and Senior Officer C immediately went to cell A2-38. Senior Officer C recalled that, when he entered the cell, Officer B was being sick as he had inhaled debris from inside the man's mouth. Senior Officer C reviewed the situation and asked for urgent medical assistance. This request prompted the prison control room to call immediately for an emergency ambulance.

22. The prison officers helped to lower the man onto the floor of his cell before healthcare colleagues continued with the resuscitation efforts. Senior Officer C withdrew from the cell to make room for the healthcare staff and paramedics to carry out their work. Senior Officer C confirmed that at no time during the CPR were staff able to resuscitate the man. Officer A also witnessed the attempts to resuscitate the man. She recalled that the man had obviously been in the process of writing a letter as his notebook was open.
23. A nurse and Healthcare Officer arrived shortly after the urgent medical assistance call. They were then joined by another Healthcare Officer and a Principal Officer. They applied an external automated defibrillator to the man. It did not advise to shock, but rather to continue with CPR.
24. On arrival, the paramedics and one of the prison doctors took over the resuscitation. Despite their best efforts, the team were unable to resuscitate the man. A collective decision was taken by the doctor and the paramedics to stop the resuscitation attempts and the man was pronounced dead at 11:43am.

Events following the man's death

25. A Duty Governor and a member of staff from the chaplaincy visited the man's family to inform them of his death and to offer condolences and support.
26. A Family Liaison Officer was appointed by the prison and he maintained contact with the family. He was able to assist with the arrangements for the funeral and on behalf of the Governor offered financial assistance towards the funeral costs. This was gratefully accepted.
27. The post mortem has recorded the man's death as being due to natural causes. The report gives the cause of death as a consequence of coronary heart disease, with emphysema and tuberculosis being contributing factors.
28. At the pre-inquest meeting on 11 June 2007 with the Coroner, my investigator was instructed to interview staff about whether the man raised issues relating to his health. My investigator was also instructed to interview the prisoners who occupied the cells adjacent to the man's cell.
29. My investigator carried out further interviews with staff at Wormwood Scrubs and asked all of the interviewees whether the man had complained to them of having chest pains. My investigator interviewed a number of Prison Officers and Senior Officers. Three of the officers he interviewed had worked as landing officers on A wing (the man's wing) and had dealings with the man. The Senior Officers interviewed by my investigator had both been responsible for managing A wing. All of the discipline staff interviewed by my investigator said that the man did not complain to them that he had been suffering from chest pains. The officers were quite clear that they would have referred the man to the treatment room on A wing or to the duty nurse if he had been experiencing such pains.

30. My investigator also interviewed the nurses who had worked in the treatment room on A wing. When interviewed, Nurse D recalled that the man did not appear unwell but was a very thin man who was fairly active (going up and down stairs, collecting his food from the servery). Nurse D said that the man was respectful to staff and complied with the regime.
31. Nurse D said that he saw the man on a daily basis when he collected his medication and when he attended appointments with the prison doctor. When the man collected his medication, Nurse D would ask how he was. He remembered advising the man to give up smoking as he had a persistent cough and suspected tuberculosis. Nurse D did not recall the man ever raising specific health issues with him. He did recall discipline staff asking advice about the man when it was suspected that he had tuberculosis. Nurse D advised them that it would be a good idea if the man had a single occupancy cell. This was for the safety of other prisoners and also to avoid causing them anxiety over the possibly of contracting the condition. Nurse D said that at no time did the man complain to him of having chest pains.
32. When interviewed, Nurse E recalled that, although the man was not a talkative prisoner, he did not complain and was compliant with his medication. He said that the man was a very lean, emaciated man who had been receiving treatment for tuberculosis during the period he had known him. Nurse E explained that he would see the man at least twice a day when he collected his medication and when he attended appointments with the prison doctor. Nurse E said that he did not recall a month going past without the man having an appointment with the prison doctor or outside hospital, and he recalled that the man was also admitted to the healthcare centre on at least two occasions. Nurse E remembered the man complaining about losing weight and his tuberculosis. Nurse E also recalled an occasion when he sat in on one of the man's appointments with the prison doctor. The doctor advised the man that he should give up smoking as this might help his tuberculosis.
33. My investigator asked Nurse E if he remembered whether the man had ever complained to him of having pains in his chest. Nurse E replied that at no time did the man complain to him of having chest pains. Nurse E said that, if the man had complained of having chest pains, he would have made an immediate referral to the prison doctor. Nurse E confirmed that the man was receiving specialist care from the local hospital and his prescription for his medication came from the hospital.
34. My investigator was unable to interview the prisoners who had been located in the cells adjacent to the man as they had both been released from custody. One prisoner had not given a forwarding address to the prison and the other did not respond when my investigator wrote to ask him to contact my office about the investigation. His contact details were passed to the Coroner at her request.

CONCERNS RAISED BY THE FAMILY

35. The man's family had a number of concerns relating to his treatment while in custody. The family felt very strongly that the man would not have died had he not been in prison. The man had lived with tuberculosis for over 30 years, but died after spending just four months in prison. They felt that the man had not received appropriate medical care in light of his condition. The family was also shocked at the man's death, particularly as he had appeared well and had not shown any obvious signs of deterioration. His wife had seen him two days before his death and thought he looked well. They had also spoken on the day before the man's death.
36. The clinical review draws attention to the limitations of the clinical care provided to the man whilst he was in custody. When interviewed, Officer A was asked for her recollection of the man. She recalled that he was not a well man, as he had to take a lot of medication, but she thought he was very sociable. Officer A said that the man was someone who took pride in his appearance and did not complain about the limitations caused by his poor health. The man spoke fondly of his family and wrote to them often. Officer A also said that the man had a positive approach. He attended meal times, liked chocolate and was known to be a regular smoker.
37. The man's family were concerned about the man's discharge from hospital, querying whether financial savings had been motivating factors. There was no evidence that this was the case. When active tuberculosis was ruled out, the man no longer required to be kept in isolation and no longer needed the services of an outside hospital. He was therefore transferred back to Wormwood Scrubs as a result of his medical condition.
38. The family also queried why an air ambulance had been called following the man's discovery. They felt that valuable time was wasted waiting for an air ambulance, particularly when the prison is right next door to the local hospital.
39. The Ambulance Service confirmed that a call was received at the Emergency Operations Centre (EOC) at 11:18am. Two ambulances and a Fast Response Unit (FRU) were assigned. An air ambulance doctor and team were also assigned and they travelled in a car.
40. The family also queried why the man described the cells on his wing as "dungeon cells". When interviewed, Senior Officer C was asked why the man would have described the cells on A wing as "dungeon cells". Senior Officer C explained that the cells on the two upper floors of the wing (the 3s and 4s landing) had poor lighting and were also double cells. This had led to some prisoners nicknaming them as "the dungeon". Senior Officer C confirmed that the man was located on the first floor (2s landing), so that he could have a single occupancy cell. It also facilitated easier access to the healthcare centre, which was just next door to the man's wing.

CLINICAL REVIEW

41. A review of the man's medical care was undertaken on behalf of the commissioning Primary Care Trust (PCT), Hammersmith and Fulham. A panel convened to discuss the review's findings. The clinical review found that the man had suffered from the effects of long-term chronic lung diseases, namely tuberculosis and emphysema. An addendum to the clinical review was completed after the results of the post mortem were known.
42. The reviewer judged that the man's medical records, for the most part, provided a clear account of his care throughout his time in custody. However, he suggested that the prison's medical service should be organised so that it operates like a General Medical Surgery. The panel recommended that medical staff should take a collaborative approach to the care of patients, with the medical officers taking overall responsibility for patients who are unwell. They also recommended that patients are given the tools (literature, advice and empowerment) to enable them to become proactively engaged in their care and to work in partnership with the healthcare providers.
43. The reviewer noted that, after the man completed his course of antibiotics, he was started on other medication. Although multiple sputum specimens had been sent for investigation, there is no documentary evidence to show that the sensitivities of these had been taken into account during prescribing. This is not consistent with current best practice guidance from the National Institute for Clinical Excellence (NICE) for antibiotic prescribing. The panel recommended that communication needed to be improved to support prescribing practices.
44. The clinical review identified issues relating to care provision, namely physical assessment, action planning and referral, communication, and treatment. The reviewer judged that it is paramount that these are addressed with the doctors responsible for reviewing the care provided to the man on the following dates: July 21, August 4, August 22, September 11, September 15, and October 4.
45. It was recommended by the panel that a complete fitness for practice review should be conducted and that this must also review the quality of healthcare delivered. This would consider the competencies of the staff who cared for the man and the healthcare systems that are in place at the prison.
46. The reviewer concluded that it is unknown whether the man's death could have been avoided. The man was considered to be at high risk of developing heart and lung problems. The risk was compounded by the man's smoking, the treatment he had been receiving for his tuberculosis and his pre-existing severe lung problems.
47. The reviewer judged that improved communication and rapport between the man and clinical professionals might have aided the early identification of health concerns and facilitated proactive care planning. The reviewer acknowledged that such an outcome is not easily attained.

48. The reviewer noted that, although the queried tuberculosis diagnosis by the prison doctor on 7 July was handled exceptionally well by the hospital, there were serious failings in the ongoing monitoring and care of the man after he returned to Wormwood Scrubs. The reviewer felt that, if physiological observations were routinely performed and monitored, the man's deteriorating health status would have been identified earlier. Improved communication between all parties would have provided an early warning of the man's deteriorating health problems.
49. The reviewer concluded that the provision of high quality health care within Wormwood Scrubs was compromised by inadequate systems for providing holistic care. He felt that the systems for the management of care provision were in need of a fundamental overhaul. His opinion was that this can be expedited by the installation of an appropriate electronic based healthcare system.
50. In the original clinical review, not a great deal was written about the man's chest pain. When the first review was written, the panel members were particularly focused on issues relating to the man's lungs and tuberculosis and emphysema. It should be noted that a formal post mortem report was not available at that time. The panel was therefore dependent at that stage on the preliminary findings relayed by the Coroner's court. These indicated that the man's lungs were, "... devastated by tuberculosis and emphysema". Once the result of the post mortem report was known, an addendum to the clinical review was completed. This revealed that the man's death was caused by heart disease with tuberculosis and emphysema as contributory factors.
51. Although it is unknown whether the immediate investigation of the man's chest pain would have made a difference to the outcome, the failure to investigate this was a lapse in care. In the addendum to the clinical review it was recorded that, "as a matter of urgency, all clients who complain of chest pain must be immediately referred to the WSBM (Wormwood Scrubs) medical officers. In a community setting patients with chest pain can access their local emergency departments and receive treatment within one hour. This standard of care should be available to those within the prison settings".
52. The prison health partnership must consider the findings of the clinical review and develop a specific, measurable, achievable, realistic and time-bound action plan to address the identified learning opportunities from the clinical review.

CONCLUSION

53. The man arrived in prison in June 2006, with a history of chronic health problems. He died from natural causes in October 2006. From comments made by staff at Wormwood Scrubs, the man was a respected and well liked prisoner.
54. The man was at high risk of developing heart and lung problems. He was also a smoker who had a history of tuberculosis. It is unfortunate that a thorough investigation did not take place when the man complained of having chest pains in early October 2006. Whether further investigation could have prevented the man's death is not something I can reasonably speculate upon.
55. As the clinical reviewer has said, patients with chest pain in the general community can access their local emergency departments and receive treatment within one hour. I agree with the reviewer that this standard of care must be available to those within the prison setting.
56. In light of the findings of the clinical review, I conclude that the man's medical care was not as good as it could or should have been. The 22 recommendations from the clinical review should be considered by the Hammersmith and Fulham Primary Care Trust in partnership with the Governor of Wormwood Scrubs and an action plan developed to address these in a timely manner.

RECOMMENDATIONS

Medical

- 1. The organisation of the health services should be changed to enable it to operate like a General Medical Surgery practice.**
- 2. Medical officers and nursing staff to take a collaborative approach to the care of their patients; with medical officers taking overall accountability for those who are ill.**
- 3. The patient is given the tools (literature, advice, and empowerment) to become engaged in their care and work in partnership with healthcare providers.**
- 4. A complete fitness for practice review be conducted. This review must also review the quality of healthcare delivered.**
- 5. Adoption and implementation of a robust healthcare IT system that will create 'disease registers' to (i) quantify the number of clients who experience chronic ill health, and (ii) proactively call and recall those who have specific long term needs.**
- 6. There is a need to (i) develop a referral policy for dietetic review; and (ii) a policy to guide the prescription of high energy nutrition supplement.**
- 7. The record keeping policy should be implemented that reflects the completeness, continuity, and quality (including legibility) of entries.**
- 8. HMP Wormwood Scrubs should (i) establish new and strengthen links with specialist peer partners, for example, HMP Pentonville and the prison nurses TB forum; (ii) link with the Health Protection Agency's North West London TB network; (iii) work with the Hammersmith Hospital NHS Trust TB nurses on the creation of 'link nurses' (Nurses With Special Interests).**
- 9. There should be urgent adoption of policies and frameworks for the quantification and emergency intervention for people experiencing angina, chest pain, and cardiac events.**
- 10. Communication improvements to guide prescribing practice and baseline training in physical assessment are to be initiated; followed by regular continuous professional development and peer review.**
- 11. The regular monitoring and documentation of vital signs for patients at risk/or ill.**
- 12. There should be regular monitoring and documentation of vital signs for patients at risk/ or who are ill.**

- 13. An observation chart should be adopted that has confidence levels to facilitate the stepping up of care and referral to healthcare professionals.**
- 14. All prisoners received at Wormwood Scrubs prison should receive urine screening during the reception process to identify (i) drug usage; and (ii) chronic health conditions.**
- 15. The Part Two Health Screen (P2HS) tool should be refined to quantify smoking history, including date started smoking, number per day, and strength.**
- 16. A wall chart describing 'standard units' should be placed in all clinical areas to assist (i) in quantifying the average number and pattern of units ingested, and (ii) the offering of referral to professional support (if indicated).**
- 17. Training is required to address the issues of (i) the subjective nature of assessments, (ii) the lack of exploring issues and (iii) the non referral to specialist review, triage and physical assessment skills. This course must also address action planning and documentation.**
- 18. If patient referrals are made (by staff or prisoners) these must be (i) actioned within an agreed timeframe; and (ii) documented in the patient's medical record. If a referral is later not deemed appropriate, the process for arriving at this decision must be clearly documented in the patient's inmate medical record.**
- 19. The tuberculosis assessment form should be updated to make it more robust by (i) reflecting national guidance; and (ii) being more prescriptive.**
- 20. Care pathways for patients with chronic health conditions should be developed.**
- 21. The Hammersmith and Fulham Primary Care Trust's TB nurse specialist to continue their consultancy role by furthering the strategic direction for tuberculosis care provision within the Primary Care Trust.**
- 22. The prison should foster stronger ties between the acute, community, and forensic setting with the aim of improving partnership working. This may include (i) regular clinical supervision and peer support; and (ii) case conferences for healthcare professionals in these settings.**