Investigation into the circumstances surrounding the death of a man, a prisoner at HMP Pentonville, at hospital in September 2010

Report by the Prisons and Probation Ombudsman for England and Wales

July 2011

This is the report of an investigation into the circumstances of the death of a man in September 2010 at hospital. I have assumed that he died of natural causes although the post-mortem report has not yet been made available to my investigator.

Very little is known about the man except that he was a 40 year old Lithuanian national. He did not give any next of kin details to prison staff and it is my understanding that all enquiries on behalf of the coroner, the police and the prison to find relatives have been unsuccessful. Nonetheless I give my condolences to his family and friends should they read my report at any time.

The investigation was carried out by my colleague. I am grateful to the clinical reviewer who carried out a thorough and exemplary clinical review. As is often the case in natural causes deaths, my office relies heavily on the quality of the clinical review and she also made enquiries of her own to staff at the hospital. I would also like to thank the Governor and staff at HMP Pentonville, and, in particular, the liaison officer for their co-operation with the investigation.

The man was remanded to prison on 10 September. He arrived at HMP Pentonville at 7.55pm that evening and was booked into reception soon afterwards. It was clear that he was unwell and, after vomiting blood at midnight, the doctor decided that he should go to hospital. Discussions took place between the doctor and the orderly officer about the urgency of getting him there. A miscommunication meant that an ambulance was not called. He was left for 80 minutes, with limited monitoring by healthcare, until a taxi arrived and he was eventually taken to hospital at 1.30am that morning. He died just over a week later, still restrained by an escort chain.

There are questions outside of my remit regarding whether or not the man should have gone straight to hospital from either police or court custody and these will be no doubt be examined at the inquest. Notwithstanding this, I make three recommendations including the use of prisoners as interpreters in medical matters.

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.

Thea Walton
Acting Deputy Prisons and Probation Ombudsman **July 2011**

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SUMMARY

1. The man was arrested at 10.35am on 10 September 2010 for failing to appear at court in relation to an offence of criminal damage. The arresting officer noted that he had a bloated stomach and, upon reception at the police station, he was referred to the forensic medical examiner (a doctor employed by the police). He was declared fit for detention and stable. A Lithuanian interpreter was used through the telephone interpreting service, Language Line.

2. At 2.10pm, the man appeared at Magistrates' Court and was remanded until 13 September so that further enquiries could be made about the best way to proceed. He arrived at HMP Pentonville at 7.55pm, along with eight other prisoners, as HMP Wormwood Scrubs was overcrowded. Upon reception, he was unable to give details about his age and it was recorded that he was "very drunk". Another Lithuanian prisoner was asked to interpret.

3. The man was seen by the nurses in the first night centre who also used the prisoner as an interpreter. His stomach was distended and his complexion was yellow. He was referred to see the doctor who decided that the detoxification wing was the best place for him due to the risk of alcohol withdrawal seizures. He was given some of his medication for alcohol misuse and withdrawal. Almost immediately, he vomited, which contained fresh blood, and the doctor decided that he needed to be admitted to hospital.

4. Through the interpreter, the man had said that he was seen regularly at hospital. The doctor contacted the SO, the night orderly officer, and they decided to refer him to that hospital rather than the local one. The doctor obtained telephone agreement from the hospital that they would admit him and she wrote an accompanying referral letter. She and the SO discussed his transfer to hospital. A miscommunication between the two of them meant that he was transported to hospital by taxi 80 minutes later, once escorting staff had been arranged. The level of medical monitoring during this time was limited. He was placed on an escort chain to one of the officers and struggled to walk to the taxi. He appeared to sleep during the journey to hospital.

5. The man arrived at hospital at 2.00am and remained in the accident and emergency department until his condition deteriorated and he was taken into surgery at 4.45am. His condition remained very serious. On a number of occasions, he became agitated and officers helped the nursing staff to keep him in bed. He died at 2.30am. Following his death it was established that he had not given any details of next of kin.

6. Three recommendations have been made including one regarding the use of prisoners for translating in medical consultations.

7. A copy of the draft report was sent to the Prison Service and their responses to the recommendations are repeated verbatim in the recommendations section.

THE INVESTIGATION PROCESS

8. My investigator collected the documents in relation to the man's death on 23 September 2010. Notices were put up about the investigation and staff and prisoners were asked to contact the investigator should they wish to provide any information for the investigation. No one came forward as a result.

9. The clinical review was carried out by the clinical reviewer. Two joint taped interviews were carried out and she conducted four interviews on her own. Notes were made of these interviews. My investigator carried out two interviews on her own and provided the clinical reviewer with copies of the transcripts. The clinical reviewer made a number of enquiries of her own which included contacting the clinical lead at the Emergency Services Department of the hospital and the London Ambulance Service about ambulance prioritisation procedures.

10. Statements from the police were provided by the coroner's officer. My investigator's understanding from the coroner's officer is that his enquiries, and the inquest itself, will examine the decisions made by the police, escort and court staff regarding whether the man was fit to remain in custody rather than be admitted to hospital. The coroner's officer has provided some police documents allowing her to outline a time line between arrest and his arrival at Pentonville. I am grateful for his co-operation with my investigation.

11. My investigator contacted the London Probation Service at HMP Pentonville to enquire whether the man was known to them. Having checked their records, they confirmed that he was not familiar to them.

12. Given the absence of any known next of kin, my office has been unable to contact anyone regarding any concerns that they may have had. Regretfully, it has not been possible to gather any basic background information about the man, except that he was thought to be a Lithuanian national and had previous similar minor offences dating back to July 2008.

13. Verbal feedback was given to both the deputy Governor and Governor during and at the end of the investigation.

HMP PENTONVILLE

14. HMP Pentonville is an adult male category B local prison in London holding up to 1,152 remand, trial and short-term convicted prisoners. The last inspection by the former Majesty's Chief Inspector of Prisons took place in May 2009.

15. In the inspection, Lithuanian foreign nationals were one of the three largest groups. The report commented that ”… there had been little use of formal interpreting and translation services, but this was being addressed” (page 39). In relation to foreign nationals, the inspection team commented, ”… foreign national work had strong strategic support and a well attended foreign national committee had a clear action plan … some effective use of made of staff and prisoner translators, but there had been little use of professional services or provision of information in other languages” (page 13). Specifically, the report recommended that ”Interpreting services should be used for confidential medical matters” (page 55).

16. There have been seven deaths from natural causes since this office took up the role of investigating deaths on custody in April 2004. The man's circumstances are unusual in that he was only in Pentonville for five hours. In one previous case, references were made to the arrangements for monitoring prisoners in hospital, known as ‘bed watch’.

KEY FINDINGS

17. According to the police custody records, the man was arrested at 10.35am on 10 September 2010 for failing to appear at court in relation to an offence of criminal damage. He was found by the officers lying on an upturned sofa in the street. Having identified himself it was discovered that there was an outstanding warrant for failing to appear at court. The arresting officer noted that he had a bloated stomach with a growth. The officer told the custody sergeant at the police station about his condition. He was placed in the detention room nearest to the custody desk so that he could be monitored more closely.

18. The police used a telephone interpreting service, Language Line, to speak with the man through a Lithuanian interpreter. A Forensic Medical Examiner, (FME) assessed him at 11.58am and declared him to be “stable, fit for detention and transfer”, but recorded that he would need to see a FME for a review if he remained in police custody after 8.00pm. According to the police report, he was prescribed a dose of Diazepam to be taken at 2.00pm but the medical form was not completed, so it is not known whether or not he was given this medication.

19. The man was taken to Magistrates’ Court at 2.10pm having been deemed fit to be detained by the FME. He was remanded until 13 September. Prisoners are allocated by geographical area and the usual catchment area for the Magistrates’ Court meant that he should have gone to HMP Wormwood Scrubs. However, due to population management problems, eight prisoners were taken to Pentonville. He left court for prison at 4.56pm.

20. The man arrived at Pentonville at 7.55pm and was booked in at 8.30pm. Upon reception, he was interviewed for the personal summary sheet. It is recorded that he was ‘UTA’ (unable to answer) basic questions about his age or date of birth, among other things. Whether this was a language problem or incapacitation through illness or substances, was not clear, although it is recorded that he ”was very drunk”. He was recorded as ‘NFA’ (no fixed abode).

21. A cell sharing risk assessment (CSRA) was completed and the man was identified as dependent on alcohol. It was recorded on the form that it was his ”… first time in prison in this country. Smoker. Little English (Russian/Lith).” Another prisoner was used as an interpreter.

22. In interview, the prisoner said that whilst he was in reception officers asked if anyone could speak Lithuanian and he volunteered. He thought that the man did not seem to understand that he was in prison but thought that he might be in hospital. He was concerned about where he was going to sleep that night. He said that it was clear that the man was unwell as he had “big legs” and a ”big stomach”. He could speak some English and said that he had regular hospital appointments about the ”water inside his body”.

23. According to his medical records, the man was seen by two nurses in the nurses' room on A wing (the first night centre) at approximately 11.41pm. Although it is not entirely clear what their respective roles were, they were both present and reported in interview that the information was uploaded into EMIS (the medical database system). He was one of the last prisoners to be seen by medical staff and he was again accompanied by the prisoner who translated. In interview with the clinical reviewer, the prisoner said that when the man lifted up his jumper, his stomach was "unreal". According to the medical entry, he had no mental health problems, no thoughts of self-harm, drank alcohol and needed to see the doctor. In interview, both nurses said that they were disturbed by his distended stomach and yellow complexion. The assessment finished at 11.44pm.

24. A part-time doctor who regularly carried out reception duties saw the man in the consulting room, adjacent to the nurses' room, at approximately 11.46pm. He was accompanied by the prisoner and both nurses for some of the time. The doctor recorded he was jaundiced and recalled him reporting a daily alcohol intake of a few litres of strong cider and five cans of Strongbow (also cider). He was seen regularly as an outpatient at the hospital for alcohol and liver related problems. He had a distended stomach. She prescribed a number of medications – Omeprazole (for stomach problems), a Vitamin B Compound, Thiamine and Librium (all commonly prescribed for alcohol abuse and withdrawal). Neither the nurses nor the doctor recalled seeing any documentation from the FME which should have accompanied him from police custody.

25. The doctor decided that the detoxification wing (F wing) would be the best place to care for the man for the first night given the risk of alcohol withdrawal seizures. She referred him to the substance misuse service and scheduled a review on 15 September. She concluded the consultation at midnight. After the consultation, a nurse told the clinical reviewer that he gave some of the medication (Omeprazole and Librium) to him (although this is not recorded anywhere). Within minutes, he had vomited and the doctor was immediately called back. There was a large amount of vomit which contained fresh blood and coffee granules (the appearance of blood is altered by contact with gastric acid which causes vomit to look like ground coffee). The doctor did not re-examine him although she saw the vomit.

26. The doctor decided that the man needed to be admitted to hospital. A Senior Officer (SO), the Oscar One (the night orderly officer responsible for the running of the prison at night) was contacted immediately so arrangements could be made to transfer him to hospital. He attended A wing and saw the vomit on the floor. The doctor and SO discussed his transfer to hospital. Given his history at the hospital, the SO suggested that he should go there rather the nearby hospital, where Pentonville prisoners normally go in an emergency.

27. The SO recalled asking the doctor whether it would be suitable to get a taxi rather than calling an ambulance (only used when a situation is urgent). The senior officer said that the doctor agreed this. This took off some immediate

operational pressure as the two accompanying staff needed for the escort did not both have to come from the night staff. Staffing levels at night are significantly reduced and having two staff from this compliment on a bed watch would cause difficulties. However, in interview for this investigation, the SO was adamant that the decision was clinical, and for the doctor, rather than operational, and his own responsibility. If an ambulance had been requested by the doctor, he said that he would have immediately diverted two of his staff to escort the ambulance. The doctor told my investigator that she recalled being asked whether he could wait a bit before going but she took this to mean ten minutes whilst escort officers were arranged and she assumed that he was still going to travel by ambulance.

28. The doctor telephoned the hospital and referred the man to the on-call medial registrar. This is recorded on EMIS at 00.11am. A nurse was present when she made the call. In interview the nurse said that he thought that he heard the doctor discuss him being admitted directly into a ward, bypassing the accident and emergency department. The doctor wrote a referral letter to be taken with him to hospital. She made reference to his alcohol intake, history with the hospital and limited English. She also described her prognosis following her examination and the episode of haematosis earlier that night.

29. Not very long afterwards, the doctor left the prison (a taxi had been called in anticipation of her departure at 11.44pm according to the control room log). The communications log showed that a second taxi was called at 00.20am to take the man to hospital. In the Oscar One log, the SO records events but does not put a time by them.

30. The SO had to make arrangements for two officers to escort the man to hospital. One of these, Officer A, was on duty on the first night centre and recalled him lying on the sofas there and appearing to be asleep. The officer was one of three officers in the first night centre. He told the investigator that at no point did any of the medical team tell them about his condition. The other officer, Officer B, was asked to come in from home and he arrived at the prison at 1.15am.

31. Unfortunately, it has not been possible to establish exactly what level of monitoring and clinical observations were made whilst the man was waiting to go to hospital. In interview, the nurse recalled checking his blood pressure and pulse and finding them both to be normal; however, the observations were not recorded. He lay on soft seats on A wing. The prisoner said that he was present when the nurse gave the tablets and he vomited. He did not wait for long but said that he was left to sleep on some chairs. The prisoner did not notice whether he was being monitored. The other prisoner is not thought to have been present at this time and was likely to have returned to his cell after the consultation.

32. The nurse did not enquire about the ambulance between 00.11am and 1.15am. He said that the man's clinical observations, that is his blood pressure, pulse and breathing, were stable whilst he was awaiting transfer. He told my investigator that he assumed that his departure was delayed

because of ambulance priorisation procedures and arranging the bed watch officers.

33. When Officer B arrived at the prison he said that he spoke with the nurse, and was told that it was a straightforward transfer to hospital and that he would be going directly into an inpatient ward.

34. Two Prison Escort Record (PER) documents were completed, one at 11.40pm and one at 12.30am and indicated that there was no information on computer regarding risk and that he was to be double cuffed. This is accordance with national security policy for remand prisoners who are always double cuffed. He was cuffed, that is, placed on an escort chain, at 1.15am and finally left the prison at 1.30am on 11 September. Some parts of the risk assessment for the hospital escort/bedwatch form were completed but it is not clear when this happened as it refers to his behaviour in hospital. The front page, which should be completed by prison medical staff, is blank.

35. Officer A said that the man was attached by an escort chain to Officer B. He told my investigator that he was surprised that an ambulance was not requested as he did not appear to be conscious, was stumbling and falling around. He was described by the officers as unsteady on his feet and needing support when he walked to the taxi. According to the bed watch officers, he appeared to sleep on the journey to the hospital.

36. He was taken to the accident and emergency department, arriving at 2.00am. The officers went to the reception desk and gave the sealed letter from the doctor. He was not admitted directly to an inpatient ward. He remained in the accident and emergency department for two hours during which time his condition deteriorated.

37. The man was seen by a nurse at 2.30am. His escort chain was removed after he coughed up a lot of blood in order that the nurses could examine him. At 4.45am, he was taken to theatre for further investigation, and it is recorded that the ”… closeting [escort] chain removed at insistence of doctor prior to theatre; have been informed his chances are 50/50”. He spent some time in the operating theatre and then in the recovery room.

38. One of the bed watch officers noted at 8.05am, that the ”… doctor requested staff presence in recovery area as the man is trying to get off the bed whilst 6 members of nursing staff try to deal with him. He is re-cuffed, which doctors are happy with”.

39. At 12.30pm the next day, 12 September, the cuffs were removed for 30 minutes at the request of the medical team as they tried to treat the man who was in pain. Again, in the early hours of 14 September, he appeared confused and tried to get out of bed. The escort chain was removed at the nurse’s request to allow examination. It was placed back on at 5.10am. He again tried to get out of bed and was recorded to be pulling at the chain at 10.40pm.

40. On 15 September, a tube was placed into the man’s nose to help feed him. The bed watch officer described having to ”hold his arms to stop him pulling the tube out”. Later that day, the staff were advised that he had an infection and they should be vigilant about washing their hands as he was thought to be highly contagious. By this time, he had been placed on a breathing machine.

41. Three days later, on 18 September, staff were advised that the man would remain in hospital for at least another three weeks. However, later that day, he was given a blood transfusion but then deteriorated rapidly. He died at 2.30am. He was still attached to an officer by the escort chain.

42. Following his death, it was established that the man had not given any next of kin details and the prison made enquiries to the police in this regard. Police enquiries were unable to establish any friends or relatives and contact was made with the Lithuanian Embassy for assistance. At the time of issuing this draft, no next of kin have been identified.

ISSUES

43. During his time in the police station, the man was assessed by a forensic medical examiner who would have completed a form outlining their assessment and any medication given. This should have been placed in a sealed envelope and passed firstly to escort staff, then court staff and, upon arrival at Pentonville, should have been handed to nursing staff. It is not known whether this happened but neither the reception nurses nor the doctor recalled seeing the document. Without this, there is no record of what, if any, actions were taken by the medical practitioners in the police station. There is no evidence to suggest that any information contained on this form would have made any difference to the outcome in his case, and it is not clear whether the form reached Pentonville or not. Therefore, I am not minded to make a recommendation but encourage the Governor to share my report with the local police at their partnership meetings.

The use of prisoners as interpreters in medical matters

44. Healthcare staff relied entirely on one prisoner to provide support and translation services whilst they engaged with the man. I do not think that prisoners should be used for translating in medical consultations due to their confidential nature. One of the facilities available in HMP Pentonville is Language Line which provides immediate access to a telephone translator. The HMCIP recommended in her inspection in 2009 that interpreting services should be used for confidential medical matters. The clinical reviewer makes a recommendation about not using prisoners for interpreting medical matters which I fully endorse.

The Head of Healthcare should raise awareness amongst healthcare staff of the need to use professional interpreters, the availability of 24 hour telephone interpreter services, and the problems associated with using prisoners as interpreters.

Communication between medical staff and officers

45. Having recognised the need to admit the man to hospital, the doctor contacted the orderly officer (SO). They had a face to face discussion and it was agreed that he should go to another hospital rather than the local hospital. However, having been asked about the urgency of the referral, the doctor agreed that he did not have to go out immediately. This was interpreted differently by each of them. The SO believed that it was therefore appropriate to arrange escort officers first and that he could be transported by taxi. The doctor, in interview, said that she thought he was going to be taken by ambulance.

46. It is clear that the man’s case is unusual in that he spent so few hours in Pentonville and was not taken ill on a wing. There may well have been a unique breakdown in the understanding between the doctor and the night orderly officer.

47. Nevertheless, the clinical reviewer makes the following recommendation which I endorse:

The Governor and Head of Healthcare should review the arrangements for transport for emergency and urgent hospital admissions to ensure that they are appropriate and timely.

48. It should be noted that the clinical reviewer comments that given his alcoholic disease, the prognosis following an episode of haemetemesis was poor and that he should have been transferred to hospital via an emergency ambulance.

Whether the man was monitored adequately whilst he was waiting to go to hospital?

49. Having made the referral to the hospital, the doctor concluded her duties for the evening. It was a very late evening. It was nearly midnight and she had been scheduled to finish her duties at 9.00pm, albeit with the caveat that she had to remain on duty until all reception prisoners had been seen. The clinical reviewer concludes that the doctor did not conduct or request any observations such as blood pressure reading or pulse. The reviewer says that he should have been kept under observation by healthcare staff whilst he waited to go to hospital. The doctor told my investigator that she was under the impression that he would be leaving relatively quickly for hospital. This did not turn out to be the case and he was left for 80 minutes with little monitoring by healthcare staff and no apparent directions given to the officers in the first night centre.

50. I am surprised that officers did not take the initiative and ask healthcare staff why the man was sitting on the seats, especially given their description of his condition while on the wing. I am also disappointed that healthcare staff did not communicate his conditions to the officers, or effectively record their own observations.

51. One of the nurses said that he took the man's clinical observations but this is not recorded in his medical records. I therefore make the following recommendation:

The Head of Healthcare must remind all staff that all observations must be recorded in a prisoner's medical record.

The use of restraints

52. Restraints are generally used when prisoners are taken to hospital to reduce the risk that they might escape. An assessment should be made of the individual's circumstances and the assessment should be checked by a prison manager every day. The manager should visit the prisoner in hospital to confirm that the level of restraints is neither too low nor too high.

53. The man’s restraints were removed on a number of occasions when hospital medical staff wanted to treat him. According to the bed watch log, staff did this immediately without referring to a manager at the prison. Although this is strictly against the national policy, in the circumstances, I think it was sensible and avoided delaying treatment. The risk assessment form, which was not completed in full, did not give any guidance for staff about the removal of restraints for consultations or treatment.

54. The bed watch log contains no reference to the man’s limited understanding of English and no record of any attempts made by staff to communicate with him. Daily management checks were made but the record is minimal and merely states ”OK” on each occasion. I accept that the records may not be a true reflection of all of the decision-making regarding his restraints. However, given the complicated situation and difficult experience for the bed watch officers, it would have been helpful to indicate that consideration had been given. The risk assessment should have explicitly referred to his lack of English and that staff held him down on more than one occasion.

55. At no point, is there evidence to suggest that staff were asked for the restraints to be removed permanently, even though the man was very ill and attached to an oxygen machine. Neither is there any evidence that either the bed watch officers or the managers took the initiative to remove them as he deteriorated. In other circumstances, I might also have commented that removal should have been considered especially given that he was infectious and prison staff had to take extra measures to reduce the risk of infection.

56. However, I am satisfied that the circumstances were somewhat complicated by the man being almost continually in an agitated state whilst he was in hospital. On occasion prison staff had to help the nursing staff by physically restraining him. He tried to get out of bed on numerous occasions. Nevertheless, I suggest that it would have been appropriate to consider removing the restraints again in his last few hours when he became very ill.

Support for bed watch staff

57. I have found that the circumstances for the bed watch officers were very difficult, given how ill and agitated the man was and the difficulty communicating with him. Whilst this is a voluntary duty, it can be a distressing experience. A staff support officer was allocated after he died and the staff present at the time were contacted. However, there were others who carried out bed watch duties and who may not have been reached via this route. My investigator reported this omission to the Governor who had already put welfare arrangements in place for the staff involved and so I do not make any recommendation concerning the matter.

58. With one exception the bed watch entries are respectful. However, one officer’s language was inappropriate and I would ask that the Governor speak with the individual concerned and consider whether there are any training needs. The bed watch log has many readers and is important evidence of the

way the prisoner is treated. Their dignity should be respected and this should include recording as well as direct contact.

Healthcare internal investigation into the death

59. A copy of the draft internal report by the local PCT was provided to my investigator to aid my own investigation. I understand that it aims to address whether there are any learning points which should be dealt with quickly. Despite the caveat that was carried out quickly, in my view it was a limited report which failed to uncover the details of the care given to the man and no conclusions or recommendations were made. I suggest that the Head of Healthcare should be explicit about the purpose of the exercise so that a sufficiently robust account of events is undertaken.

CONCLUSION

60. The man was a visibly ill man when he arrived at Pentonville and I question whether he should have been admitted to hospital instead. Given his chronic alcoholic disease, the clinical reviewer tells me that his prognosis following the episode of haemetemesis was poor, with a significant risk of mortality or re-bleed. As such, having arrived at the prison, I believe that he should really have been taken to hospital by ambulance.

61. The clinical reviewer, supported by her own enquiries with Clinical Lead for Emergency Medicine at the hospital, concludes that although there was a delay getting him to hospital, a more timely transfer would not have prevented his death. It was unlikely that any treatment and care he received – or did not receive – at Pentonville exacerbated his condition.

62. The man remained in the prison's custody and I have considered how the prison looked after him in the last days of his life. Generally I am concerned about prisoners who are restrained when they die but, on this occasion, I am satisfied that he was agitated for much of the time and his health deteriorated suddenly on 19 September. On this occasion I do not make any recommendations about restraints remaining in place. However, I do make recommendations about using prisoners to translate confidential medical matters, making suitable arrangements to take prisoners to hospital and record keeping.

RECOMMENDATIONS

All recommendations were accepted by the Prison Service. The proposed action is written in italics following the recommendations.

1. The Head of Healthcare should raise awareness amongst healthcare staff of the need to use professional interpreters, the availability of 24 hour telephone interpreter services, and the problems associated with using prisoners as interpreters.

Information regarding the use of The Big Word and NHS interpreting were available at the time of the admission of the man. However, in response to this recommendation instructions of the service and full contact details have been passed to all healthcare staff. Locum staff are to be made aware during inductions. Clear notices have been placed in all areas explaining how to contact interpreting services and making it clear that the use of prisoners is considered bad practice.

2. The Governor and the Head of Healthcare should review the arrangements for transport for emergency and urgent hospital admissions to ensure that they are appropriate and timely.

New guidance has been issued to all healthcare staff that makes it clear that the decision on transport and safe conveyance is the responsibility of the clinical team. The guidance stresses that ambulances must be the preferred method of conveying a patient in emergency situations. It also advises that the process is fully managed by the clinical team and this must include the safe supervision of the patient.

3. The Head of Healthcare must remind all staff that all observations must be recorded in a prisoner's medical record.

The Head of Healthcare has written offering guidance to all staff in October 2010 and May 2011 to reinforce their responsibility under professional codes of practice to record all clinical interventions; including observations. It makes clear the Professional Standards are expected in Record Keeping, Clinical Observations and Duty of Care. Individual staff supervision and appraisals are now requested by the Head of Healthcare to reflect on these areas with all staff in both monthly supervisions and in all staffs year objectives under the organisational scheme. New and adapted regular monthly record keeping audits now undertaken and reported to Healthcare Senior Management team. Performance being addressed vis both staff and management team in healthcare. Internal training sessions have been established each Friday. Record keeping is ongoing and repeated module of training for staff. Incident learning sessions planned for June and July 2011.