

**Investigation into the circumstances surrounding the
death of a man at
HMP Doncaster in January 2006**

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

March 2007

This is a report into the circumstances of the death of a man on 31 January 2006. The man, who was aged 46, collapsed while having a joke with his friends in the exercise yard at HMP Doncaster just after 1pm. He was pronounced dead in hospital just over an hour later. The man was due to be released three days after he died. The cause of death was coronary artery thrombosis.

I would like to take this opportunity to extend my sympathy to the man's family for their sudden loss.

The investigation was carried out on my behalf by two of my colleagues. A Clinical Review of the man's healthcare and the immediate response to his collapse was undertaken by the Clinical Governance Development Manager at Doncaster Central Primary Care Trust (PCT). I am most grateful to him.

Serco Home Affairs are contracted by the Home Office to manage Doncaster prison. The company conducted its own investigation into the man's death. Regrettably, my investigators have not yet been given access to the investigation report. That said, I would like to thank the Director of Doncaster prison and his staff for their co-operation and assistance with my own investigation.

I make four recommendations. The Clinical Review makes an additional seven recommendations which I endorse.

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

Stephen Shaw CBE
Prisons and Probation Ombudsman

March 2007

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SUMMARY

The man collapsed on the exercise yard of Houseblock 2a at HMP Doncaster at lunchtime on 31 January 2006. He was due to be released three days later. The cause of his death was determined by the post mortem as coronary artery thrombosis.

In November 2005, he had complained of chest and back pains. The man was seen promptly by healthcare staff. The Clinical Review finds that examinations were conducted appropriately, although they were badly recorded on some occasions. The man had no family history of cardiac disease. His chest pain was diagnosed as dyspepsia, which he had suffered in the past. His back pain was diagnosed as muscular and a side effect of dyspepsia.

In January 2006, a week and a half before his release, the man complained of pain in his left pectoral muscle. He was examined the day after he made the medical application. He told healthcare staff that he felt better. Healthcare staff noted his colouring was good and had no further concerns.

A routine pre-release health check took place on 27 January. The doctor who undertook this examination noted pain in the left pectoral muscle. It was diagnosed as muscle strain from the gym. The man discussed this diagnosis with staff on the morning that he died and seemed happy with the doctor's conclusion. Surveillance footage shows the man wandering around his houseblock, holding a cup of tea and smiling. He rubs his upper left arm on one occasion, but does not look in obvious pain.

The man collapsed suddenly while smoking a cigarette and joking with his friends. A radio call for assistance was made promptly. Prisoners and an officer worked together to place the man in the recovery position and make him comfortable. Healthcare staff arrived within five minutes of the response call and immediately started resuscitation efforts. They also requested an emergency ambulance. The Clinical Review says that staff and prisoners are to be commended for their swift response to his collapse. The nature of the man's thrombosis is described by the Clinical Reviewer as 'inevitably fatal'.

The man was transported to hospital, where he was pronounced dead at 2:08pm.

I make four recommendations in this report.

HMP DONCASTER

Opened 12 years ago, this purpose-built Category 'B' large male prison is privately run by Serco Home Affairs. It is made up of three houseblocks, each with four wings. Doncaster's capacity is 1,120 prisoners. As a 'local' prison, Doncaster prison serves local courts and the population is largely made up of unsentenced prisoners.

The prison has a dedicated healthcare unit and has a drug strategy designed to support prisoners with substance misuse problems, such as alcohol dependency. A Community Re-entry team provides advice about resettlement into the community upon release from prison, including housing support.

The most recent inspection of the prison was an announced inspection that took place in November 2005. Her Majesty's Chief Inspector of Prisons, found that HMP Doncaster 'was generally well-ordered'. However, the Chief Inspector expressed concern that 'prison managers had allowed important areas to slip below what is safe and decent', since the Inspectorate's last visit.

The man's death is the second death from natural causes at Doncaster since my office took over responsibility for investigating all deaths in prisons in April 2004.

THE INVESTIGATION PROCESS

Following the man's death on 31 January 2006, my investigators contacted Doncaster prison to request the man's paperwork. It was copied and sent within a week of the request.

Notices were sent to the prison to invite prisoners and staff to contact my investigators if there was anything that they wanted to bring to my investigators' attention in connection with the man's death. No-one responded to this invitation.

Having gone through the paperwork, my investigators visited Doncaster on 22 March 2006 to interview staff and prisoners. Some interviews were taped and some interviews were less formally conducted. All staff and prisoners have agreed with our record of the interviews.

The Clinical Governance Development Manager from Doncaster Central Primary Care Trust, attended Doncaster prison with my investigation team. The Manager wrote a Clinical Review, which has contributed vital clinical expertise to this investigation.

KEY EVENTS

The man's time at Doncaster prison

The man was remanded into the custody of Doncaster prison in August 2005. He underwent a First Reception Health Screening, in accordance with standard procedures. It was recorded that he had no concerns about his physical health, despite the man acknowledging that he was an alcoholic. Significantly, it was recorded that he had experienced no problems with chest pains.

A week later, the man had a well man screening, during which he said that he was separated from his wife and had six children. No other indication of this family is to be found in his records. Sadly, my investigation team could locate no further details.

There is a brief note of this screening. Under a section headed 'Medical History', the man was identified as suffering from 'Depression' and 'Alcohol Problems'. The form also noted that he smoked 15 cigarettes a day.

The High Risk Assessment Team is the system used at Doncaster prison for prisoners who have been identified as at risk of attempted suicide or self-harm. A form was raised on 3 September by a member of staff in the healthcare centre. The man had approached a doctor and said that he wanted to die by lethal injection. Two days later, well within 72 hours, the initial case review took place. The man was identified as requiring level three observation. (Level three observation requires staff to visit a prisoner every 30 minutes to check his welfare.) Regular case reviews took place and several entries were made daily, as staff made the half hourly observations.

A Visiting Specialist Registrar in Forensic Psychiatry, assessed the man on 8 September and concluded that there was no evidence of psychiatric illness. During the assessment, the man indicated that he had experienced feeling anxious and 'hot', a feeling which would gradually build up. The registrar recommended that the man be prescribed a small dose of Olanzapine.

There were three Psychological Services Reports prepared on the man on 5, 16 and 29 September. Repeatedly, the brief reports document a sense of hopelessness and lack of self-esteem. Again, the man told the psychologist that he felt his anxious feelings were 'building up'. On 18 September, a note was made on his Clinical Record that the man felt he was 'losing it'.

The registrar in forensic psychiatry reassessed the man on 22 September and concluded that, although he appeared calmer, the man was still presenting with 'acute agitation'. During the assessment, the registrar noticed scratch marks on the inside of the man's arms. He said that there were no evident thoughts of suicide, but that the man was frustrated with being in prison. The registrar was made aware that the man had not taken the medication he had prescribed following his assessment on 8 September. After the doctor

explained to him the benefits of the medication for the treatment of agitation, the man agreed to try Olanzapine.

During the month of October, the man made eight medical applications to see someone about what he perceived to be mental health issues. He wanted to transfer to the healthcare unit for some 'peace and quiet'. A referral was made to the RMN clinic, but he was not transferred. He remained on houseblock 2a.

The man appeared at a Crown Court in November. He was convicted of possession of an imitation firearm and received a prison sentence of one year. By that time, he had already served 103 days at Doncaster. This reduced the amount of time he had left to serve in prison. His release date was set for 3 February 2006.

Two days later, on 18 November 2005, the man made a medical application to see a doctor in relation to chest pain that he was experiencing. A RGN assessed the man that same day and made the following entry in his continuous medical record:

'Chest pain – central epigastric – no radiating pain to left arm – no left chest pain – pulse regular area 85 bpm BP 150/90. Colour good – peripherals well perfused. No breathing difficulty noted. Referred to MO for review 19/11/05.'

According to the Clinical Reviewer, the examination was thorough and the findings well-recorded. All appropriate checks were made.

The man was referred to a doctor who reviewed him the next day. The entry in his medical record agreed that the man was suffering from epigastric pain and suggested he was also suffering from dyspepsia. He had apparently taken strong antacids previously for indigestion and heartburn.

It can be hard to distinguish dyspepsia from the early stages of a heart attack. The man had no previous or known family history of heart failure. The doctor's conclusions could have indicated that the man was suffering from cardiovascular problems. However, the Clinical Reviewer concludes that the epigastric pain episode 'appears to have been assessed and managed appropriately'.

Just two days later, the man made a further application to the healthcare centre, this time regarding back pain. The nurse offered him pain relief but he refused, preferring to see a doctor. The doctor saw and assessed him and concluded that the man was suffering from mechanical back pain. In his Clinical Review, the reviewer recognises that:

'back pain can occur as a consequence of epigastric pain or as a separate muscular-skeletal problem.'

The next day, the prison's doctor, wrote that the man should be referred to a physiotherapist, although there is no evidence that such a referral took place.

On the same day, the man received a letter from a Trainee Probation Officer from the South Yorkshire National Probation Area. She introduced herself as the man's Probation Officer for the duration of his sentence and wrote that she would continue his supervision upon his release, if he chose to return to the Sheffield area.

The man was again examined by a doctor on 25 November, to determine the cause of his back pain. The back pain was diagnosed as muscular.

The man made a couple of further applications in relation to earache and a dentist's appointment over the following weeks. Significantly, on 24 January 2006, a week before he died, the man wrote:

'Could I please see the doctor as I have got a pain in my left side. Thank you.'

A nurse wrote on the application under 'Assessment / Action taken', "See on wing and assess". Similarly, on the man's Continuous Clinical Record, the Nurse wrote, "See on wing and assess." There is no outcome of the assessment noted on the man's file. In fact, it is not possible to determine, from the records whether the man was assessed by any member of staff at all.

However, during interview, the nurse who made that entry recalled receiving the man's application. Following a medical application, initial triage assessments of a prisoner's condition are carried out by a nurse on the houseblocks. The nurse will determine whether it is necessary to refer a prisoner to a doctor for further examination or treatment. Despite there being no record of the assessment, the Nurse assured my investigators that he visited the man on houseblock 2a the day that he received the medical application. The man told the nurse that he felt better and that it might have just been indigestion. The nurse was satisfied that the man's appearance and colour were not a cause for concern. He did not check the man's vital signs, and he did not refer him to a doctor because he concluded that his condition had improved. Furthermore, he made no written record of the consultation or assessment.

In the week before a prisoner leaves Doncaster prison, they are assessed by a doctor. A doctor examined the man on 27 January, one week before his release date. The doctor recorded:

'left pectoral muscle – at night & now on resisted action Δ strain.'

In his Clinical Review, the reviewer writes that the diagnosis of strain was logical, given that there was no record of the pain radiating either in the man's neck or arm.

31 January 2006

On the morning of Tuesday 31 January 2006, a Prison Custody Officer (PCO) was working the dayshift on houseblock 2 with two more PCOs. The prisoners were woken as normal at 8am. Prisoners can then fetch their breakfasts from the hotplate. All prisoners are unlocked from their cells for 30 minutes for a period of association at 10am.

Two PCOs were sitting at the desk on houseblock 2a, during the morning association period that Tuesday. One of the PCOs said of the man:

'He seemed very excited about his imminent release ... Despite the man's good frame of mind, he spoke about chest pains and swung his left arm around whilst holding his chest with his right hand.'

The man approached the desk where the officers were sitting and told them that the doctor had recently said that he had pulled a muscle. It seemed to the PCO that the man was happy with this diagnosis.

The prisoners had their lunch as usual, from 11:45am, sitting together on the houseblock. After lunch, the prisoners were locked in their cells while the staff had their lunch. When the staff came back on duty, the prisoners were unlocked for a further association period and exercise.

During this period of association on 31 January, a fellow prisoner, recalled the man lying on the floor at around quarter to one. In the statement that he gave to Doncaster police, the prisoner said that an officer approached the man as he lay on the floor and asked him what he was doing there. In the prisoner's recollection, the man's response to the officer was: 'I'm getting pains in my chest.' The prisoner could not identify the officer but remembered that he was male. After he had spoken to the man, the officer 'just walked on'.

Doncaster prison has a camera surveillance system which monitors the interior of the whole prison. My investigators examined the available footage. The man is visible on the camera on a number of occasions wandering around the houseblock. He holds and rubs his upper left arm on one occasion. However, he presents as happy and was chatting with fellow prisoners. He drank a cup of tea. There was no footage to verify the suggestion that the man was lying on the floor at any time.

At the end of the association period, prisoners can make their way onto the adjoining exercise yard. Prisoners are entitled to one hour's exercise outside a day.

Two prisoners and the man who died made their way into the exercise yard together at 12:45. One of the prisoners started walking laps of the yard and the other prisoner and the man who died stood on the steps smoking cigarettes and chatting. The first prisoner described this as their usual routine. A third prisoner was in another part of the exercise yard, walking around talking to another prisoner.

A PCO had been detailed to supervise the exercise period. He described his duty as supervising prisoners while they walked around the yard and some prisoners had cigarettes. As a matter of routine, his colleague remained in the houseblock. He was the only officer in the exercise yard. The PCO remembers the man walking around during the exercise period, holding his upper left arm. Following the discussion that the man had with previously with the PCO that morning, he believed that the man was holding his arm because of a gym injury.

The prisoner taking exercise remembered that the man was 'his normal self' whilst they were outside. He was in a jovial mood, chatting with fellow prisoners. While he was in conversation with a prisoner at around 1pm, this prisoner turned away briefly to talk to another prisoner. When he turned back to the man, he saw him standing on a step. The prisoner recalled that the man went into a crouching position and fell face first onto his head.

The prisoner saw the man's fall in the corner of his eye and turned to see the man hit the ground face first with a 'thud'. The prisoner immediately shouted to the PCO, 'he's having a fucking fit'.

My investigators spoke to one of the prisoners on the exercise yard at the time that the man collapsed. In that prisoner's recollection, the PCO continued to talk into a radio that he was using at the time and did not immediately run to the man's assistance. The prisoner, assisted by another prisoner who controlled the man's head, turned him over into the recovery position. The prisoner holding the man's head was verbally reassuring the man. He could then see that the man's eyes were open. There was a lot of blood from his facial injuries. Orange bile came out of the man's mouth and he was making gurgling noises. One of the prisoners assisting the man checked for a pulse and pinched him to get a reaction, assuming that he was still alive. In his statement to the police, this prisoner said that this was the point when the PCO came over to the man and started to shake him and feel for a pulse.

The PCO remembered being positioned by the perimeter fence, approximately 30 yards away. He recalled that the movement of the man falling drew his attention. He turned to watch the man fall face first, with his arms by his sides. His face hit the concrete floor. The PCO reported that he ran immediately to his assistance. In the PCO's recollection, the two prisoners who assisted the man were closer to him. They had already knelt by the man's head when the PCO had reached him. As soon as he reached the man, the PCO called for 'First Response' on his radio.

The PCO remembered turning the man over and saw that he had facial injuries. He could also see that he was having difficulty breathing. The PCO again radioed, this time requesting a 'Medical Response'. The two prisoners then held the man's head while the PCO placed him in the recovery position. He recalled the man vomiting and that there was blood coming out of his

mouth. Not long after the man was put in the recovery position, other staff arrived on the exercise yard.

At around 1pm, the Acting Unit Manager (a unit manager is responsible for the day to day running of the houseblock and is expected to attend any emergency call) received a 'First Response' call from the exercise yard, which he recognised as being made by the PCO.

The Acting Unit Manager, made his way from the office on the upper landing to the exercise yard immediately. He was accompanied by an Assistant Director, who happened to be in his office. When they reached the exercise yard, the Acting Unit Manager recalled that the PCO was the only officer in the exercise yard. It had taken him about a minute to get to the yard from his office. The PCO told them that the man had collapsed in front of three prisoners. When the PCO had noticed the man's breathing become laboured, he had called 'Medical Response'.

At Doncaster prison, staff will radio for assistance in the event of an emergency. If the emergency requires additional discipline staff quickly, staff will call for 'First Response'. If the emergency appears medical in nature, the member of staff will call for 'Medical Response'. The PCO told my investigators that he initially called for 'First Response', because he was concerned about the other prisoners on the exercise yard. They needed to be safely returned to their cells. When he had made an initial assessment of the man's condition, he was clear that medical assistance was necessary and he radioed for 'Medical Response'. Healthcare staff will attend all 'First Response' and 'Medical Response' calls.

At around 1.09pm, three medical staff arrived on the exercise yard, two Staff Nurses and a Health Care Assistant (HCA). Upon arrival, one of the nurses immediately noticed that the man was blue and was having difficulty breathing. The officers had not attempted resuscitation at that point. The PCO told my investigators that the man continued to vomit. He was still in the recovery position. While one of the nurses was putting her gloves on, she asked for an emergency ambulance and instructed an officer what to tell the emergency services. An ambulance was called at 1:14pm.

The other nurse took over from the prisoners in supporting the man's head. A nurse asked for oxygen, which she was told was already on its way. The man then stopped breathing. The nurse could not detect a pulse. She placed an airway into his mouth and instructed the other nurse and the HCA to commence cardiopulmonary resuscitation (CPR). One of the nurses commenced chest compressions whilst the other nurse began mouth to mouth resuscitation.

Several minutes later, the PCO took over from the nurse doing chest compressions. The other nurse began using an ambu-bag and attached a defibrillator to the man. The defibrillator indicated that CPR should be continued. Other medical colleagues got to the yard moments later and assisted with resuscitation efforts.

The ambulance arrived at the prison at 1:24pm and paramedics arrived on the exercise yard at around half past one. The paramedics instructed one of the nurses to continue with CPR, while they used a cannula and a defibrillator machine. The paramedics detected that there was some cardiac output at that point. Once the paramedics had assessed the man's medical condition they transferred him to the ambulance and took him to hospital. The man did not recover consciousness and he was pronounced dead by a doctor at 2:08pm.

Staff Debrief

As soon as the man had been taken to hospital by the paramedics, staff left the exercise yard. A chaplain was made available to speak to staff about their experience. It was explained that they would be interviewed by Serco's Investigation Manager and the police to establish the circumstances of the man's death. Following these interviews, a formal debrief took place, attended by senior management, healthcare staff and all staff involved.

During interview, staff told my investigators that prisoners and staff were all affected by the man's death. He was well-known in the prison and due for an imminent release. There was a collection among staff and prisoners and flowers were bought in his memory. Staff felt well-supported following his death.

One of the prisoners involved in the response efforts following the man's collapse told my investigators he was not particularly friendly with the man before he died, but he was affected by his death. He felt that his efforts were not fully appreciated. The prisoner was told by a nurse that the man had died in the ambulance. He was seen by the chaplain, who offered counselling. He further told my investigators that he did not find the support available helpful to him.

The Man's Family

The man had not listed his mother as next of kin. However, as soon as he died Doncaster prison contacted the police, who began efforts to trace her. The local police broke the news to the man's mother that her son had died.

One of my family liaison officers contacted the man's mother shortly after her son's death. The officer explained the investigation process and asked the man's mother if she had any concerns that she wanted my investigators to look into. She did not express any specific concerns, although she did ask to see a copy of the investigation report on completion.

The Clinical Review

The Clinical Review was undertaken by the Clinical Governance Development Manager at Doncaster Central Primary Care Trust (PCT). The Clinical Reviewer attended interviews with my investigators and examined the man's clinical records.

Significantly, the Clinical Reviewer concludes that:

'The man complained of chest pain immediately before his collapse, and with hindsight, one is inclined to think this may have been an indication of his impending cardiovascular emergency. However at the time given the presenting symptoms, the conclusions drawn would seem to have been logical.'

When considering the response to the man's collapse on 31 January, the reviewer praises staff teamwork. Specifically, he goes on to commend the actions of the man's fellow prisoners who came to his immediate assistance:

'It is clear from the post mortem report that despite everyone's best efforts it would have been most unlikely that staff would have been able to resuscitate the man. His coronary artery thrombosis was so severe as to have been inevitably fatal.'

The full clinical review forms an annex to this report. The reviewer makes seven recommendations, which I endorse:

1. Every effort must be made to ensure good standards of record keeping, e.g. all entries in the medical record are contemporaneous, legible, signed, dated and name printed. It is recommended that a record keeping audit is undertaken of all clinical records at least annually. This is to ensure standards are met and maintained (Nursing and Midwifery Council, 2005, Guidelines for Records and Record Keeping, Department of Health, 2006, NHS Code of Practice Records management).
2. All actions stated within the medical record must include a rationale and be followed up with a review to confirm the action was undertaken and state the outcome of that action.
3. There should be clear standards for correcting or deleting errors within the medical record, compliance against this could be included as part of any record keeping audit.
4. The principle of professionals sharing records or making entries in other records to ensure effective communication is to be supported. Staff must be mindful of the need to ensure entries can be understood by all colleagues and so avoid overly technical entries about which others may have limited knowledge or at least make sure they can be understood with a brief explanation.

5. It is recommended that the prison consider, as part of the medical record, adopting the use of a care plan. Elsewhere within nursing this is accepted and recognised as an invaluable tool with which to plan, review and evaluate care (Nursing and Midwifery Councils Guidelines for Record Keeping, 2005). This would ensure any plan of action or treatment is clearly documented and evaluated providing evidence that it has been undertaken.
6. It is suggested a review is undertaken of the response call system to ensure the nature of the incident is communicated as effectively as possible, ensuring the appropriate staff attend and have the right equipment for the task.
7. In addition to the above recommendation, the prison may wish to consider strategically positioning essential first aid equipment throughout the prison to facilitate its availability in the event of a medical emergency rather than being only located within the Healthcare unit.

FINDINGS

The man presented to fellow prisoners as a jovial, chatty character who was excited about his imminent release. In contrast, staff observed an anxious man, often displaying bizarre behaviour and repeatedly requesting psychological support. Staff struggled to manage his disruptive behaviour, as the man found compliance with rules difficult. The reason he gave for his index offence - a desperate attempt to secure accommodation - had not been resolved.

Within two days of being notified of his release date, the man experienced pain in his upper abdomen. The week he was due to be released, he suffered a fatal coronary artery thrombosis.

All of the man's medical applications were efficiently and appropriately dealt with. The conclusions drawn by medical staff were within the bounds of reasonableness. However, records of these assessments were not well-kept and, on some occasions, they were made some time after the assessment took place. The reviewer makes the following crucial recommendation in his clinical review:

'Every effort must be made to ensure good standards of record keeping, e.g. all entries in the IMR are contemporaneous, legible, signed, dated and name printed. It is recommended that a record keeping audit is undertaken of all clinical records at least annually. This is to ensure standards are met and maintained.'

The Head of Healthcare should implement an annual audit system for clinical records to ensure that records and record keeping are within the standards laid down by the professional bodies.

The medical response to the man's collapse was appropriate. There is no difference between a 'First Response' radio call and a 'Medical Response' in terms of healthcare staff and resources. The reviewer describes the current system as 'ad hoc', and suggests that it might lead to some confusion. It would not have had an impact on the outcome for the man. However, I agree with the reviewer that the system may delay future emergency responses, if not reviewed.

The Director and Head of Healthcare should review the emergency call system, so that all staff are clearer about the nature of the emergency that they are responding to.

As soon as the PCO realised that the man was having difficulty breathing, he called for 'Medical Response'. Healthcare staff arrived quickly, carrying the necessary equipment. The reviewer suggests that the strategic placement of emergency equipment around the prison, including on residential houseblocks, might be helpful for future emergencies. Whilst this eminently sensible suggestion would not have affected the outcome in the man's case, I endorse it.

The Head of Healthcare should consider the strategic placement of emergency medical equipment around Doncaster prison, including on each houseblock, to ensure timely access in the event of an emergency.

The reviewer also recommends further ways to improve clinical records and joined up care. I commend the reviewer's other recommendations as matters of good practice.

The Director and Head of Healthcare should consider the recommendations made in the Clinical Review and develop an action plan to address the identified learning opportunities.

CONCLUSION

The man was receiving medication to manage his stress levels. He had no reported family history of coronary disease. It was in line with reasonable medical practice for him to be diagnosed with dyspepsia.

I have made a number of recommendations alongside those in the Clinical Review, to further improve safety and clinical care at HMP Doncaster. However, overall I judge that the man's care at Doncaster prison was of a good standard.

SUMMARY OF RECOMMENDATIONS

I make four recommendations.

The Head of Healthcare should implement an annual audit system for clinical records to ensure that records and record keeping are within the standards laid down by the professional bodies.

The Director and Head of Healthcare should review the emergency call system, so that all staff are clearer about the nature of the emergency that they are responding to.

The Head of Healthcare should consider the strategic placement of emergency medical equipment around Doncaster prison, including on each houseblock, to ensure timely access in the event of an emergency.

The Director and Head of Healthcare should consider the recommendations made in the Clinical Review and develop an action plan to address the identified learning opportunities.