PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man, a prisoner at HMP Isle of Wight, in October 2012

Our Vision

‘*To be a leading, independent investigatory body,*
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision’

This is the report of an investigation into the death of a man, a prisoner at HMP Isle of Wight, who died from lung cancer in October 2012 at hospital. He was 72 years old. I offer my condolences to his family and friends.

The investigation was carried out by an investigator. A review of the man's clinical care in custody was carried out by a clinical reviewer on behalf of the local PCT cluster. HMP Isle of Wight cooperated fully with the investigation.

The man was diagnosed with incurable lung cancer shortly after moving to HMP Isle of Wight (Albany site) in late 2011. The clinical reviewer concludes, and I agree, that he was diagnosed in a timely manner and received good care and support from healthcare staff at the prison. However, I am concerned that on one occasion a planned appointment with a palliative care consultant did not take place because of unspecified security restrictions on the man's wing. I am also not satisfied that the use of restraints when he was taken for a hospital appointment, less than two weeks before he died, was justified by a properly considered risk assessment – a matter I have previously raised with HMP Isle of Wight.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **April 2013**

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SUMMARY

1. The man was sentenced to 20 years imprisonment in August 2011 and went to HMP Isle of Wight (Albany site) shortly afterwards. On 17 November, he reported chest pains. A chest X-ray showed a suspicious mass on his right lung, and a prison doctor made an urgent referral for suspected cancer. He underwent tests and a diagnosis of incurable lung cancer was confirmed at hospital on 24 January 2012. The clinical reviewer concludes that he was referred appropriately and diagnosed in a timely manner.

2. Radiotherapy to control the man's symptoms was recommended and he underwent a week long course in early March. In the weeks before this, his health deteriorated significantly and he was admitted to the prison's inpatient healthcare unit. He became much weaker and was reportedly vague and confused. A referral was made to local palliative care services and an instruction was given that the man should not be resuscitated were he to suffer a cardiac arrest.

3. The man's physical and mental health improved significantly in the weeks after radiotherapy, and he was able to return to his wing and continue with prison life. Despite his improvement, the order not to resuscitate was not reviewed or discussed with him, which should have been done. A palliative care consultant from a local hospice arranged to assess him but was not allowed to see him on the wing because of unexplained security reasons, and the assessment did not happen. We consider such an appointment should have been facilitated.

4. In summer 2012, the man's health began gradually to deteriorate. He continued to work in the prison's charity workshop, but needed a wheelchair to get there from his wing. For earlier hospital appointments no restraints were considered necessary, and we are concerned that for a hospital appointment on 11 October, an escort chain was used. This was after the man began using a wheelchair and was not justified on grounds of risk.

5. One morning in mid October the man was found collapsed on the floor of his cell. After assessment, he agreed to move to the inpatient healthcare unit. Shortly after he got there, his condition deteriorated further. He was admitted to hospital and died that night.

6. The man's final deterioration was rapid, and the speed of his decline meant that an end of life care pathway was not necessary. We conclude that overall, he received care equivalent to that he could expect to receive in the community.

THE INVESTIGATION PROCESS

7. On 23 October 2012, notices were issued announcing the investigation to staff and prisoners, inviting anyone who had relevant information to contact the investigator. No one came forward.

8. The investigator visited HMP Isle of Wight on 25 October. During the visit he saw D wing, where the man lived, and visited the inpatient healthcare unit (IHU) and the charity workshop, where the man worked. He spoke to a senior nurse, one of the prison's family liaison officers, and two prisoners who knew the man well. He obtained copies of the man's prison records, including his medical record.

9. The investigator returned to HMP Isle of Wight on 5 December and 18 December and interviewed four members of staff. A review of the man's clinical care in custody was carried out by a clinical reviewer on behalf of the local Primary Care Trust cluster.

10. On 14 November, one of the Ombudsman's family liaison officers wrote to the man's granddaughter, his next of kin, to explain the purpose of the investigation. The family did not raise any matters for the investigation to address. They received a copy of the draft report as part of the consultation process, and were content with the findings.

11. The investigation has assessed the main issues involved in the man's care, including his diagnosis and treatment, liaison with his family, his location, whether compassionate release was considered and whether appropriate palliative care was provided.

HMP ISLE OF WIGHT

12. HMP Isle of Wight is an amalgamation of three prisons, Parkhurst, Camp Hill and Albany. The man was at the Albany site, which holds up to 567 sex offenders and vulnerable prisoners in five cell blocks.

13. Health services at HMP Isle of Wight are commissioned and provided by the local Primary Care Trust (PCT). An Inpatient Healthcare Unit (IHU) was opened in October 2009 at the Albany site. It has 18 beds and caters for prisoners with a wide range of mental health, general medical, rehabilitative and health-related respite needs.

HM Inspectorate of Prisons (HMIP)

14. HMIP conducted an announced full follow-up inspection of HMP Isle of Wight in May 2012. They found that health services had improved considerably from their previous inspection, although there were some delays in accessing primary care services for prisoners at Albany. Inspectors also found that there were good care arrangements for men with palliative care needs.

Independent Monitoring Board (IMB)

15. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. The most recent IMB annual report for HMP Isle of Wight noted that the opening of the IHU had reduced the number of prisoners staying as inpatients in outside hospital. They also noted that they ageing population at Albany led to increased waiting lists for some health services.

Previous deaths at HMP Isle of Wight (Albany)

16. We have investigated a number of previous deaths at Albany, most of which were of older prisoners. Many of the men who died at Albany had serious medical conditions and a number had been diagnosed with cancer. The man was the 12th of 13 men to die at Albany since January 2011. Four of these previous deaths were attributed to cancer. Our investigations into these deaths found that the men in question received healthcare equivalent to that they could expect to receive in the community, and we commented on the high standard of palliative care provided to one man. In a number of cases we were concerned that restraints were used for hospital appointments without proper justification.

ISSUES

The diagnosis of the man's terminal illness

17. The man was born in October 1939. He was remanded in custody to HMP Bristol on 1 November 2010. At the time of his imprisonment, he had been taking painkillers for a number of years due to a nerve injury to his left arm. He had also been diagnosed with high blood pressure, chronic kidney disease and arthritis. The man had restricted mobility and used a walking stick. He was allocated a ground floor cell at Bristol.

18. The man was convicted of serious offences on 17 August 2011. Two weeks later he was sentenced to 20 years in prison. He transferred to the Albany site at HMP Isle of Wight on 3 November 2011.

19. At Albany a routine appointment was booked for 9 November with a prison doctor. The man did not attend and a further appointment was arranged for 17 November, at which he told a prison doctor that he had experienced chest pains over the previous few months. The doctor referred him to hospital for a chest X-ray.

20. The X-ray took place on 1 December, and the results, which were sent to Albany on 8 December, showed that there was a mass (possibly of cancer cells) on the man's right lung. The radiologist recommended a CT (computerised tomography) scan. The next day, 9 December a prison doctor made a referral to the hospital's respiratory clinic under the two week rule (a national target for patients with suspected cancer to be seen by a consultant within two weeks).

21. On 22 December, the man was seen by a consultant at the hospital respiratory clinic who examined him and discussed the results of the X-ray. The consultant requested an urgent CT scan and biopsy.

22. The CT scan took place on 5 January 2012, and the biopsy one week later. On 24 January, the consultant informed the man that he had inoperable and incurable lung cancer which had spread to other parts of his body.

23. The clinical reviewer notes that prison doctors referred the man appropriately under the two week rule. We agree with her conclusion that his diagnosis was made in a timely manner.

Informing the man about his condition and treatment

24. On 13 December, a prison doctor explained the referral and potential outcomes. He recorded that the man took the news as "matter of fact" and said he would deal with whatever came his way. The respiratory consultant explained the possible implications of the referral again, at his appointment on 22 December.

25. Over the following weeks, the man had several conversations with prison healthcare staff about the tests and the potential outcome. The respiratory consultant informed him of the outcome of the tests and confirmed his diagnosis

on 24 January 2012. Two weeks later, the man returned to hospital to see a consultant oncologist to discuss his treatment options and the aims and potential benefits of radiotherapy.

26. Shortly after his diagnosis, the man began attending a monthly support group led by the prison's palliative care nurse, for prisoners with a terminal illness. He saw nurses every day when he collected his medication and had the opportunity to ask any questions about his diagnosis and treatment.

27. We are satisfied that the man was appropriately informed of his diagnosis and the treatment options. We agree with the clinical reviewer that he received good support from prison healthcare staff after his diagnosis.

The man's medical appointments and treatment

28. At his appointment on 7 February, the oncologist explained to the man that radiotherapy was the best treatment option and that the aim of the treatment was to control his symptoms rather than cure the cancer. A radiotherapy specialist at hospital assessed him on 10 February and noted his recent symptoms including general weakness and difficulty in walking. He said he would accept radiotherapy treatment if it was offered and the radiotherapist arranged a further assessment for 16 February.

29. On 16 February, the man had a brain scan, which showed the cancer had not spread to his brain. The specialist agreed that radiotherapy was appropriate and that he would return for a one week course of daily treatment starting on 5 March.

30. In the three weeks before he started radiotherapy, the man's health worsened considerably. His mobility deteriorated, his behaviour was sometimes described as bizarre and he became confused and vague when speaking. A referral was made to local palliative care services. (See later section on palliative care plans.)

31. The man's radiotherapy treatment took place from 5 March to 9 March, at hospital. He was reported to have tolerated the treatment well. Because of his recent deterioration, the consultant asked that the man return for an MRI (magnetic resonance imaging) scan as an additional check for brain metastases (spread of the cancer to the brain). The scan was originally booked for 29 March, but was twice postponed and eventually went ahead on 30 May. The first postponement was made by the hospital, because of a faulty scanner. The second time he had not got ready to leave for his appointment at the time arranged.

32. In the weeks following radiotherapy, the man's health greatly improved. His mobility was much better, he became coherent and lucid again, and he was able to return to his wing and continue working in the charity workshop. He went to hospital for a review with a Macmillan nurse on 18 May. The nurse reported that he had few symptoms, although he felt weak at times.

33. The man returned to hospital on 30 May for his MRI scan, which indicated no signs that the cancer had spread to his brain. At his next review with the Macmillan nurse, on 13 July, he showed some sign of deterioration. The man said he was now breathless on exertion and had experienced some headaches.

34. In August, the man reported increasing aches and pains, and blood tests taken at the prison indicated that his disease was progressing. On 8 August he was given a wheelchair to help him get from his wing to the charity workshop.

35. An appointment for the man to see the Macmillan nurse at hospital on 14 September was cancelled by the hospital, as was a rescheduled appointment for the following week. The appointment eventually went ahead on 11 October, when it was combined with a review with the consultant oncologist. The oncologist wrote that the man's cancer was "fairly stable". The man said he was experiencing some additional chest pain and tiredness, and the consultant gave advice on changes to his medication. The consultant asked that he return for a CT scan to assess the disease progression and any future treatment options. This was subsequently booked for 30 October.

36. On 19 October, a prison doctor reviewed the man, who said he had experienced some chest pain in the last day, which had since settled. The doctor arranged for an electrocardiogram to check whether the man might have experienced a heart attack. This showed no evidence of acute heart damage. The doctor offered the man admission to the inpatient healthcare unit (IHU), where he could be monitored more closely by healthcare staff. He declined this offer.

37. At around 6.45am one morning in mid October, the man was found collapsed on the floor of his cell by the night patrol officer. He and a Senior Officer (SO) opened the cell and helped him to his feet. He told them that he did not know how long he had been on the floor. A nurse from the IHU examined him and found no injuries. The morning duty nurse checked him at around 7.15am. Based on her previous experience working with the lung cancer specialist at a hospital, she thought that he was now approaching the end of his life. The man moved to a room in the IHU just before 8.00am.

38. After his arrival at the IHU, the man's condition deteriorated further. An ambulance was called and he was admitted to hospital. His condition quickly deteriorated and he died at 11.15pm that night. A post-mortem report established the cause of death as cancer of the right lung which had spread to other organs of the body.

39. The clinical reviewer notes that there is a national target for 85 per cent of patients referred with urgent suspected cancer to have their first treatment within 62 days of receipt of the referral. This target date for the man was 9 February 2012, but he did not begin radiotherapy until 5 March. He was able to attend all tests and planning appointments before his treatment, and there is no suggestion that his status as a prisoner had any bearing on his treatment. The clinical reviewer comments that earlier radiotherapy would not have made any difference to the final outcome for him.

40. The clinical reviewer further comments that there is evidence of good communication between prison healthcare and hospital staff and that the man received commendable care in the periods he spent in the prison's IHU. She concludes that he received care equivalent to that he could expect to receive in the community.

Palliative care plans

41. On 22 February 2012, a referral was made to local palliative care specialists at a hospice. Due to an apparent administrative error, the referral was not sent until 29 February. A consultant in palliative medicine at the hospice arranged to visit the man on 23 March. On the morning of the visit the prison telephoned to say that the man had returned to his wing from the IHU and a visit was not possible because of "security arrangements". There is no record of who from the prison telephoned the consultant that morning and it is not satisfactory that the consultant was unable to see him because of unspecified security problems. If there were genuine security reasons why the man could not have been seen on the wing then a suitable alternative arrangement should have been made.

    The Governor and Head of Healthcare should ensure that all planned assessments with visiting health specialists are appropriately facilitated.

42. Following his aborted visit, the consultant spoke to a nurse at the Albany site who explained the improvement in the man's condition since radiotherapy. The consultant then decided that this improvement meant he did not need to visit the man at that stage. He wrote to the prison to ask that they make a further referral should he require it.

43. The man attended regular clinics with a Macmillan nurse at the hospital from diagnosis onwards, as well as the monthly support group with the palliative care nurse.

44. When the man's health deteriorated in February 2012, a prison doctor completed a 'do not attempt cardiopulmonary resuscitation' (DNAR) order[1] as he believed that resuscitation was unlikely to be successful because of the man's advanced and inoperable lung cancer. Because of the man's confusion and bizarre behaviour at the time the doctor decided not to discuss this with him. The clinical reviewer judges that this was reasonable in the circumstances.

45. The man's physical and mental health improved considerably after his radiotherapy treatment and he was able to return to his wing and continue with prison life. The clinical reviewer considers it would have been good practice to review and discuss the DNAR order with him at that stage, but there is no indication this happened.

[1] A DNAR order means that in the event of cardiac or respiratory arrest no attempt at resuscitation will be made. All other appropriate treatment and care will continue to be provided.

The Head of Healthcare should ensure that 'do not attempt cardiopulmonary resuscitation' orders are reviewed if the patient experiences a significant improvement in health.

46. Terminally ill prisoners at HMP Isle of Wight can be placed on the Liverpool Care Pathway aimed at providing the best quality of care for dying patients in the last hours or days of life. The clinical reviewer comments that the man's final deterioration was so rapid that an end of life pathway was not necessary. We are satisfied that he received appropriate palliative care.

The man's pain relief and medication

47. Before he was diagnosed with cancer, the man took medication to treat high blood pressure and chronic kidney disease. He also took the painkillers paracetamol and ibuprofen for arthritis and a long standing nerve injury to his left arm.

48. After his two week referral appointment, the man complained of considerable chest pain. He was prescribed tramadol (a painkiller for moderate to severe pain) on 23 December 2011, and the dose was increased on 4 January 2012, when he said that his pain had increased. This change in dose was initially effective, but the man's medication was changed to morphine sulphate (a strong painkiller used for prolonged relief of severe pain) two weeks later when he experienced further pain.

49. The man continued to take morphine sulphate for the next two months, and the dose was increased twice more when he experienced additional pain. There was one period of four days when he went without this medication after a pharmacy mix up when he was discharged from the IHU on 8 February. On 19 March, the man was given a fentanyl patch to replace morphine sulphate tablets when he returned to his wing after a period in the IHU. (A fentanyl patch provides continuous pain relief over a period of 72 hours.)

50. The man continued to use fentanyl patches for the remainder of his life. The strength of the patch was increased five times as his pain increased. He also continued to take various other medications, including dexamethasone, a steroid used to relieve sickness and boost appetite in cancer patients.

51. Throughout his time at HMP Isle of Wight, the man collected his medication from healthcare every day. When he did not feel well enough to go to healthcare, a nurse took his medication to his cell for him.

52. The clinical reviewer comments that the man's pain medication was adjusted appropriately and long acting drugs were selected throughout his illness to allow him to receive steady pain relief on the wing.

Liaison with the man's family

53. Shortly after the man's diagnosis was confirmed, a prison chaplain was appointed as the prison's family liaison officer. He telephoned the man's

granddaughter, his nominated next of kin, on 8 February 2012. The man had already told his granddaughter that he had been diagnosed with lung cancer, and the purpose of the chaplain's call was to introduce himself and explain his role as a family liaison officer.

54. The man's daughter telephoned the chaplain later that day to say she wanted to visit her father, and he advised her of the Assisted Prison Visits Scheme, which can help relatives of prisoners with travel costs. The chaplain subsequently arranged for the man's daughter to visit him in the IHU on 11 March, when he was recovering from radiotherapy.

55. When the man was admitted to hospital in October, another prison chaplain visited him. The man told the chaplain that he did not want his family to be informed he was in hospital.

56. After the man's death, later that night, the chaplain contacted a family liaison officer at HMP Bristol (near to where the man's granddaughter lived) and asked him to visit his granddaughter and break the news of the death. The family liaison officer visited the man's granddaughter's home twice on 23 October, without success. He left a message asking her to contact him, which she later did, and he then visited her the next day. He explained the help the prison could provide.

57. The funeral took place on 16 November. A chaplain attended and later arranged for the prison to make a contribution to the cost of the funeral in line with national guidance. A memorial service was held at HMP Isle of Wight for staff and prisoners who knew the man.

58. We are satisfied that the prison appointed a family liaison officer at the appropriate time, and that the chaplain provided good ongoing support to the man's family.

The man's location

59. For most of his time at HMP Isle of Wight, the man lived on D wing on the Albany site. D wing is one of five wings (A to E) which do not have in cell sanitation. F and G wings, which are newer, contain in-cell toilets and sinks.

60. When undergoing the tests that led to his diagnosis, the man was offered admission to the prison's inpatient healthcare unit (IHU) for monitoring and support, but he preferred to remain on his wing. After his health deteriorated in February 2012, he agreed to move to the IHU. When his health and mobility improved in the weeks after his radiotherapy, he returned to his wing. The man had no further admissions to the IHU, until the day of his death, although he was offered a move earlier in October when his mobility worsened.

61. As his health worsened in February, the man was recommended by healthcare staff for a move to F and G wings. He was initially keen on the move, but his

personal officer[2] said he subsequently changed his mind and decided that he preferred to stay on D wing. A prisoner who knew him said the man did not mix with much with others much and spent most of his time in his cell. His personal officer said that he was happy doing this and had a couple of friends who would go to see him in his cell.

62. Most days, unless he was feeling unwell, the man went to work in the prison's charity workshop. Workshop instructors told the investigator that he enjoyed his work and continued to attend until the day before his death. As his health deteriorated, he was given a wheelchair to help him get to the workshop and to healthcare to collect his medication. Another prisoner who worked with the man volunteered to push his wheelchair on these journeys. He was also given help with everyday tasks, such as cleaning his cell, by a prisoner who was employed as his 'buddy'.

63. We are satisfied that the man apparent wish to remain on the wing for as long as possible was respected. Although he was terminally ill, he was able to continue to be involved in prison life through his regular attendance at the charity workshop. The man was helped with everyday activities and getting around the prison when his health deteriorated.

Compassionate release

64. Early release on compassionate grounds (ECR) is a means by which prisoners who are seriously ill can be permanently released from custody before their sentence has expired. The criteria for early release for determinate sentenced prisoners are set out in Prison Service Order (PSO) 6000 and prisoners are usually expected to have less than three months to live. The criteria include that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) within the National Offender Management Service (NOMS).

65. An application for early release was initiated in February 2012, shortly after the man's diagnosis. It was decided not to progress the application at that stage as he did not have a prognosis of less than three months and had only recently been sentenced to 20 years for very serious offences. We note that at that time the man had yet to undergo radiotherapy and his prognosis was unknown. We are satisfied that it was reasonable not to pursue an application for early release at that time.

66. After his radiotherapy, the man's health improved considerably and he was able to return to his wing and continue working. Although he began to deteriorate in the summer, there was still no prognosis of less than three months. At his last clinic, on 11 October, the consultant oncologist reported that the man's cancer was "fairly stable". Therefore it is unlikely, that an application would have been

[2] Each prisoner is assigned a personal officer, whom thy can approach first with any queries or issues.

successful. His hospital admission in October was recognised as a significant development. A second application was quickly initiated, but the man's death came very suddenly later that day before the application could be completed and submitted. We are satisfied that the possibility of compassionate release was given appropriate consideration.

Restraints, security and bedwatch

67. The Prison Service has a duty to protect the public when escorting prisoners to hospital and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes into account factors such as the prisoner's health and mobility. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion regarding the prisoner's ability to escape must be considered as part of the assessment process. It deemed that handcuffing a prisoner receiving chemotherapy (and, by implication, other life saving treatment) was degrading and that such restraint would be likely also to be regarded as inhumane unless justified by other relevant considerations.

68. The man had numerous outpatient appointments for tests and treatment, including a biopsy and five sessions of radiotherapy, in the first three months of 2012. No restraints were used during any of these sessions. Although he had only recently been sentenced to 20 years imprisonment for very serious offences, we consider this was an appropriate decision in the light of his poor health at the time and the judgement referred to, above.

69. At the time of his oncology clinic on 11 October, the man's mobility had deteriorated and he was now a wheelchair user. A risk assessment was completed before the appointment. In the medical assessment section, a nurse recorded that the man's wheelchair use restricted his ability to escape unaided. The prison's security department assessed that he had medium potential to escape (on a scale of low, medium, high) and was medium risk to staff and the public. However, the officer who completed the section concluded that his overall risk was low, as he was an "enhanced[3] prisoner with no history of escape attempts".

70. The risk assessment was authorised by the Head of Security and Operations at the prison. He assessed that the man should be restrained using an escort chain[4] and accompanied by two officers.

[3] Prisoners are assessed on the 'Incentives and Earned Privileges Scheme', which was introduced as a means to encourage and reward good behaviour in prisons. There are three tiers: basic, standard and enhanced. Key earnable privileges include extra visits, access to in-cell television and more private cash to spend.

[4] An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and another to an officer.

71. Prison Service guidance is that that restraints are not normally necessary on an escort when the prisoner's mobility is severely limited. There is no evidence to suggest that the man presented a risk of escape or to the public that could not have been managed by a two officer escort. And it is very difficult to see why he should have been regarded as a higher risk in October when no restraints were needed earlier in the year when his health and mobility was better. We do not consider that the use of an escort chain to restrain him was justified by a properly considered risk assessment. This is an issue we have raised with HMP Isle of Wight in earlier investigations. We repeat a previous recommendation.

    The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents.

RECOMMENDATIONS

1. The Governor and Head of Healthcare should ensure that all planned assessments with visiting health specialists are appropriately facilitated.

   Accepted - There is not normally an issue with arrangements being made for visiting health specialist to attend patients on wings if the patient cannot attend the Healthcare Centre or if this is otherwise deemed necessary.

   Liaison between the responsible clinician and discipline staff ensures arrangements are agreed. This expectation has been made clear to all clinical staff and prison staff.

2. The Head of Healthcare should ensure that all 'do not attempt cardiopulmonary resuscitation' orders are reviewed if the patient experiences a significant improvement in health.

   Accepted - This is particularly pertinent if such a DNAR order is put in place without the patient's involvement (if the patient's mental state meant that he was able to participate in the original DNAR decision). This has been discussed in a new weekly multidisciplinary team meeting involving GPs, nurses and allied health professionals.

3. The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents.

   Accepted - The Head of Security has reviewed escort risk assessment to enhance the medical contribution section to better inform the decision making process in relation to the appropriateness of restraints. Information has been provided to all Operational Managers to assist them in making decisions with regard to the use of restraints for escorts and bed watches. Additionally this has been added into the Local Security Strategy and a Management check system is now in place.