A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at outside hospital in December 2012, while a prisoner at HMP Bedford.

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 investigation report into the death of a man at an outside hospital in December 2012, while a prisoner at HMP Bedford. A post-mortem examination found that he died of myocarditis, an inflammation of the heart muscle. He was 32 years old. I offer my condolences to the man's family and friends.

The investigation was conducted by one of my investigators. A clinical reviewer reviewed the clinical care provided to the man. The prison cooperated fully with this investigation.

The man had been released from a prison sentence in March 2012 and was then recalled to custody in June 2012 facing further charges. He had suffered from brittle asthma for some time, and was being treated by a consultant at an outside hospital when he returned to prison. While at Bedford, he attended the respiratory clinic, but appeared to use his asthma inhalers more frequently than expected.

On 28 December 2012, the man reported having chest pain. A nurse went to see him, and decided to take him to the healthcare centre to conduct further tests. After they arrived there, a doctor saw him and thought that he might have pericarditis, an inflammation of the lining around the heart. An ambulance was called, and he was taken to outside hospital and from there to a further outside hospital. Double handcuffs were used for the journeys and an escort chain in hospital, but there was no risk assessment which took into account how his medical condition impacted on his risk of escape,

The clinical review has identified some room for improvement at Bedford in managing and reviewing medication and arranging hospital appointments. There is also a need for a clear protocol for staff responding to prisoners with chest pain. However, it does not appear that any of these issues directly contributed to the man's sudden death.

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 **July 2013**

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SUMMARY

1. The man was recalled to prison in June 2012. After a stay in HMP Peterborough, he was moved to HMP Bedford on 10 July. He had suffered from brittle asthma for many years and used inhalers and steroids. It was noted that he had an outstanding hospital appointment later in July. No arrangements were made for him to attend the appointment and an appointment was not rebooked. .

2. Over the next few months, the man continued to see healthcare staff frequently. It was noted that he seemed to use inhalers more quickly than he should have done. He also attended a respiratory clinic run by an external specialist.

3. On 28 December, the man pressed his cell bell and told an officer that he had not received his medication. The officer called healthcare staff but shortly afterwards the man pressed his cell bell again and said that he had chest pain. The nurse went to his cell and decided to take him to the healthcare centre to conduct an electrocardiogram (ECG).

4. After the ECG, the nurse spoke to a prison doctor who took the man's temperature and thought that he might have pericarditis. He called an ambulance. When paramedics arrived shortly afterwards, they conducted further tests before taking him to outside hospital. He was only there a short time before he was transferred to a further outside hospital, a specialist heart centre. Shortly thereafter, the man's heart failed and hospital staff were unable to resuscitate him. A post-mortem established the cause of death as myocarditis.

5. The investigation identified a need for some improvements in the management of hospital appointments and long-term use of medication at Bedford. We also recommend that a clear protocol should be implemented for prisoners who report chest pain. Finally, we believe that the level of restraint used when the man was taken to hospital not based on a full assessment of his risk.

THE INVESTIGATION PROCESS

6. Notices were issued announcing the investigation to staff and prisoners at HMP Bedford asking anyone with relevant information to contact the investigator. Two friends of the man asked to meet with the investigator.

7. The investigator visited Bedford on 10 January 2013 and collected the man's prison and medical records. She met the two friends of the man, and also a nurse and a prison officer. The nurse later provided an additional written statement.

8. A clinical reviewer from Bedfordshire Primary Care Trust (PCT) reviewed the man's clinical care in prison.

9. An assistant ombudsman, and the clinical reviewer, interviewed a prison doctor, the Head of Healthcare, a nurse and a residential custody manager at Bedford on 22 March.

10. A copy of this report has been sent to the Coroner.

11. One of the Ombudsman's family liaison officers contacted the man's brother to explain the investigation process and to ask if there were any relevant issues he wished the investigation to cover. His brother explained that he had been unaware that his sibling had been recalled to prison. He wanted to know the cause of his death, which had not been established at that time.

12. The man's family received a copy of the draft report. They asked a number of questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

HMP BEDFORD

13. HMP Bedford is a local prison which holds up to 506 men. The prison accepts sentenced and remand prisoners from Luton Crown Court, Bedford and Luton Magistrates' Courts, as well as sentenced prisoners from London prisons.

14. At the time of the man's death, Bedfordshire Primary Care NHS Trust (NHS Bedfordshire), commissioned healthcare services at Bedford which were provided by Bedfordshire PCT. The team provided diagnostics including blood services, in-patient care, and an integrated drug treatment service (IDTS), as well as other primary care services. The healthcare unit can accommodate up to 13 in-patients.

15. Since this office began investigating deaths in custody in April 2004, there have been 15 deaths at Bedford. Two of these, including that of this man, were from natural causes. We have previously made a recommendation about the management of chronic conditions.

HM Inspectorate of Prisons

16. HM Inspectorate of Prisons conducted an unannounced short follow-up inspection in May 2011. The inspection report noted

> "Bedford continued to be a generally safe prison, despite the many challenges posed by its population. There was still scope to improve aspects of the management of early days in custody…Staff-prisoner relationships remained good, supported by improved consultation arrangements. Bedford faces all the typical challenges of a crowded and largely Victorian local prison, including limited accommodation, a rapid turnover of prisoners and a vast array of risks and needs to manage."

17. The healthcare environment was described as poor, but the services were satisfactory.

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure proper standards of care and decency. In their most recent annual report for the year to December 2012, the IMB commented that they were "deeply worried" about healthcare, which had experienced severe difficulties following changes in management: The IMB was concerned that a culture of form-filling had become more important that the care of the patients. However, they also noted that they were impressed that staff delivered "impressively professional services" despite the poor environment.

KEY EVENTS

19. In April 2004, the man was sentenced to 12 years and six months imprisonment, for robbery, drugs offences and escaping lawful custody. He was released on license on 1 March 2012.

20. Three months later, on 27 June 2012, the man was recalled to prison after being charged with violent offences and breaching a non-molestation order. (These charges were later dropped, and a Parole Board hearing had been scheduled for January 2013 to consider the possibility of the man's release.) He was taken to HMP Peterborough. A prison GP saw the man and noted that he was being treated for brittle asthma (a difficult asthma, often unstable and unpredictable), had been on steroids for the previous seven years and used a combination of inhalers (salbutamol, flixotide and titropium), which he was allowed to keep in his cell to self-administer. The doctor noted that the man had been taken to casualty the day before, and was under the care of a consultant at outside hospital. His next appointment with the consultant was on 17 July. He was placed in the healthcare centre overnight so his condition could be monitored.

21. The next day, the man twice said that he had suffered an asthma attack. He was given a nebuliser and his blood pressure, pulse and oxygen saturation levels monitored. Another prison GP assessed that he was fit to go to a standard prison wing.

22. On 29 June, the man complained to a nurse that he was asthmatic and she referred him to the doctor. That evening, he asked another nurse for a salbutamol inhaler. The nurse checked the prescription chart and noticed that he had been issued an inhaler just two days earlier. The nurse thought that he had overused the medication and, after consulting a colleague and the clinical lead, declined to issue another inhaler. The nurse noted that the man became angry but spoke in full sentences with no sign of his breathing becoming laboured. Over the next two days, he twice complained of chest pain and breathing problems. On one occasion he used a nebuliser, but he refused it the second time. He was advised to keep his inhaler with him when on the wing.

23. The man saw a chiropodist on 6 July, to have an ingrowing toe nail removed. That night, he pressed his cell bell complaining of shooting pains and numbness in his left leg. He demanded to go to hospital, but a nurse said that she would refer him to the prison GP. She gave him paracetamol, and noted that he became "uncompromising and combatant". She monitored him throughout the night. A prison doctor saw him the next day and prescribed tramadol, a pain killer.

24. On 9 July, another GP examined the man and could not find any cause of pain in his legs. The man said that he wanted to reduced his steroid intake, and the doctor agreed to reduce the steroids to 25mg for one week, and then to 20mg. He prescribed an antibiotic as the man's toenail had become infected.

25. The next day, 10 July, the man was transferred to HMP Bedford. He was prescribed medication before he left Peterborough, and a nurse checked that he had his inhalers. When he arrived at Bedford, a nurse carried out a health screen. The nurse noted his history of asthma and his steroid use and that he had an outstanding appointment at an outside hospital on 15 July (although the Peterborough doctor had noted it was 17 July). A prison doctor saw him next and recorded that the man was aware of his medical needs and that his asthma was well controlled. He noted that he should be seen on a review basis. The man saw another nurse the next day for a secondary health screen. There were no concerns about his mental health, use of alcohol or compliance with medication.

26. The man did not attend his appointment at the outside hospital on 15 July. There is no mention in the medical record why this was or that a different appointment had been arranged. On 17 and 25 July, healthcare staff assessed him as fit for court hearings. On 24 July, a prison doctor prescribed a fluticasone inhaler.

27. On 26 July, a prison doctor reviewed the man and maintained the level of prednisolone (the steroid). He also prescribed co-codamol, for back pain. The next day, the doctor completed a referral to the prison's respiratory clinic and noted that the man had made a complaint about his medication when he arrived at Bedford on 10 July.

28. A nurse saw the man on 1 August after he asked to see a member of the mental health team. He said that he was under a lot of stress as he had recently completed a 12 year sentence and had been recalled to prison for something he had not done. He was due to see his legal team on 3 August and hoped to speed up his release from prison.

29. On 8 August, the man attended the respiratory clinic, which was run by a specialist nurse. She noted that the man was under the care of a consultant at an outside hospital, and was "followed up monthly". She also noted that he needed to go to the gym to help prevent osteoporosis (a weakness of the bones that can be caused by prolonged use of steroids) and to help a trapped nerve. A prison doctor sent a referral letter to the PE department later that day.

30. The next day, a prison doctor saw the man, who had complained of pain in his hip. He diagnosed possible osteoarthritis and prescribed a pain killer, nefopam. However, the medication was not dispensed that day. The doctor reissued the prescription on Friday 10 August but the pharmacy department was not open over the weekend and the prescription was not processed until 13 August.

31. During the night of 10 August, the man pressed his cell bell and complained of pain which he could not control with co-codamol. He saw a nurse at the wing treatment hatch on Sunday 12 August and complained that he had not received nefopam as prescribed. He also said that he was due to receive his

steroids. The nurse established that the steroids were ready to collect, but he did not issue them as it was not clear whether he was allowed to have his medication in possession.

32. On 22 August, a prison GP noted that the man seemed to be using an excessive amount of inhaler, but the specialist nurse saw him later that day and noted that his medication was well controlled. He told her that he was using his combination of inhalers because the consultant had found that his asthma could be controlled using them without increasing his steroids. The specialist nurse chased up his gym referral.

33. The man did not attend the next respiratory clinic on 29 August and the clinic for 5 September was cancelled because of staff shortages. On 12 September, he told a nurse that he was concerned about his access to healthcare staff if he became unwell at night, and said he needed individual transport to court as he suffered from anxiety and hyperventilation when in confined spaces. The nurse said that she would discuss this with the governor. On 15 September, a prison doctor re-prescribed nefopam, but said that he needed to see a GP again in two weeks if the prescription was to be extended.

34. A prison doctor saw the man on 19 September who remained concerned about the long-term use of steroids and the side effects. She noted that he was under the care of a consultant at an outside hospital, and that he was expecting to find out within the next month if he was to remain at Bedford. She discussed this with a nurse and they agreed to re-refer the man to the consultant at an outside hospital if he was still at Bedford in a month's time.

35. A nurse went to see the man on the wing at 4.30am on 25 September after he complained of shortness of breath. She did not find any signs of shortness of breath and measured his oxygen saturation levels as 99%. She checked that he had his inhalers available. A prison GP re-prescribed nefopam on 2 October. The next day, after he attended the respiratory clinic, the specialist nurse and a further nurse agreed that the man should receive inhalers every two weeks.

36. On 16 October, the man saw a prison GP, who noted that his inhaler technique was good. He maintained the prescription of prednisolone, with four 5mg tablets to be taken each morning.

37. On 5 October, the man provided a sample for a mandatory random drug test. On 9 October, it was confirmed that the sample was positive for cannabis. Following a hearing on 17 October, he was given ten days cellular confinement, and was taken to the segregation unit. (The segregation unit provides temporary accommodation for prisoners who are violent or disruptive, have committed offences against Prison Rules or require protection if they are under threat from other prisoners.) A nurse saw him in his cell, and the man said that he was concerned that his asthma might deteriorate if he remained in the segregation unit. The nurse told him that he

would be monitored each day and that if he thought his asthma was deteriorating, he should discuss this with the nurse in charge.

38. The next day, a prison GP saw him in the afternoon. The man told her that his breathing had deteriorated as he had not received prednisolone or nefopam that day. The GP discussed this with a nurse, and they noted that he had been issued 28 tablets on 17 October, and should therefore still have some. The GP prescribed further prednisolone to be issued to him daily, and recommended that he be reviewed by the respiratory nurse on 22 October. He was given nefopam and prednisolone the next day as prescribed.

39. A prison GP saw the man on 22 and 23 October in the segregation unit. He complained of having a bad chest, but the GP noted that he could not find any signs of respiratory difficulty. He moved to C wing on 23 October. On 24 October, a nurse was called to see him on C wing, and he told her that he was stressed as he wanted to return to a cell with his former cellmate. The nurse discussed this with a senior officer (SO), who agreed to look into a cell move.

40. The man attended the respiratory clinic on 7 November. A nurse noted that he was happy with his medication regime, although was concerned about having access to a nebuliser at night. He said that he had been denied access a couple of times at night after pressing his cell bell. The nurse thought this might have been because he had recently moved wings and that C wing staff were not aware of his requirements. He said that he sometimes passed out when his breathing became difficult, which they agreed was more likely to be caused by hyperventilation rather than asthma. He said that he recovered shortly afterwards. He also said that he had not yet had a date, but thought he might be released in early December and had not had an appointment with the consultant at an outside hospital. The nurse noted that he would ask administration staff to book an appointment for him with the consultant after his expected release date so that he would benefit from an early consultant review. There is no evidence in his medical record that this appointment was made.

41. Over the next month, the man continued to be prescribed inhalers and prednisolone. He saw a prison GP on 23 November, complaining of ongoing back pain. He said that nefopam did not work, but declined paracetamol. The GP noted that the man was hoping to leave prison after a hearing in a few weeks and decided to review him after that hearing. In the meantime, he advised the man to return if his symptoms changed.

42. The man had a flu vaccination on 29 November. He asked to see a nurse on 1 December, but was at the gym when the nurse went to the wing. He saw a prison GP on 4 December, after reacting to the flu vaccination and also complained of further back pain and numbness in his leg. He told the GP that his main problems were a fear of dying or of being severely disabled by his respiratory problems and his back pain. The GP noted that the man now had a possible release date of 14 January and prescribed paracetamol for the pain and re-prescribed his inhalers and prednisolone.

43. By 15 December, the man's prescription for paracetamol had expired. He was given paracetamol on an ad-hoc basis by nurses before being re-prescribed by a prison GP on 17 December. On 20 December, a further GP prescribed co-codamol for the pain and agreed to refer him to an orthopaedic specialist. The GP who had originally re-prescribed paracetamol, re-prescribed co-codamol on 24 December.

44. On 28 December, at approximately 5.15pm, the man told an officer that he had not collected his medication that day and wanted to complain about it. There is no indication why he had not attended to collect it. He then pressed his cell bell again and complained of having chest pain. Healthcare staff were asked to attend at approximately 5.45pm. A nurse passed a prison GP on his way to the wing and explained that the man was short of breath and reporting chest pain. When he examined him in his cell, the nurse decided to take him to the healthcare centre to conduct an electrocardiogram (which measures the electrical output of the heart). The nurse told the investigator that the man was able to walk unaided to healthcare.

45. A nurse was in the healthcare centre at the time. He recalled that the man had a high temperature, was ashen in complexion and had difficulty in standing upright. When interviewed, he said that he thought an ambulance should have been called immediately. An ECG was completed.

46. A prison GP was asked to look at the ECG printout. He also noted that the man's temperature was high and thought that this might indicate pericarditis (an inflammation of the pericardium, the fibrous sac surrounding the heart) rather than a heart attack. He immediately decided that the man needed to go to hospital and asked for an ambulance to be called. A nurse said that the ambulance was called "within moments" of the ECG printout being available but the prison did not record the time. Ambulance service records show that the call was received at 7.09pm, and a first responder paramedic car was dispatched one minute later. While waiting for the ambulance, healthcare staff gave him oxygen and 75mg of aspirin. The first responder car arrived at the prison at 7.18pm. A second ambulance was called at 7.38pm, and arrived at the prison at 7.50pm.

47. The man was taken by ambulance to an outside hospital at 8.10pm, escorted by two prison officers. An escort risk assessment deemed him to be a medium risk to the public and of escape. Double handcuffs were used for the escort to hospital, which were replaced by an escort chain when he was examined by hospital staff. (Double cuffing entails the prisoner having his hands cuffed in front of him and then having one wrist attached to a prison officer by an additional set of handcuffs. An escort chain is a length of chain with a handcuff at either end.)

48. The man arrived at the outside hospital at 8.25pm. At 9.38pm, he was transferred to the high dependency cardiac unit at a further outside hospital. The escort chain was replaced with double handcuffs during the escort. He arrived at 10.10pm, where hospital staff suspected myocarditis, a bacterial

infection of the heart muscle. The escort chain was used once the man arrived at hospital.

49. The man was admitted to the high dependency unit at the second outside hospital. Despite receiving further specialist treatment, he died shortly thereafter from heart failure.

50. The man had not nominated a next of kin. His parents were dead and he had not had any contact with his foster family or his brother after being recalled to prison. The prison asked the local police constabulary to inform his ex-partner, which they did later that day. The man's brother was in the armed forces and the telephone number listed on his contact list was an old number and no longer in use. The prison family liaison officer (FLO) managed to get contact details for the man's brother from the army and informed him of his brother's death on 30 December. The prison FLO visited the man's brother on 2 January 2013. The prison contributed appropriately to the costs of his funeral, which was held on 4 January.

51. A post-mortem examination was conducted on 2 January 2013. It was established that the cause of death was myocarditis, an inflammation of the heart muscle, often caused by a virus.

ISSUES

Clinical care

Hospital appointments

52. The man had been ill for some time before he arrived at Bedford. In particular, he suffered from brittle asthma, for which he took steroids and inhalers.

53. Before he arrived at Bedford, the man had been under the care of a respiratory consultant at an outside hospital. His next appointment was due in July (two different dates are noted in the medical record). It is not clear from the medical record why he did not attend the appointment. There are three further references to staff discussing his hospital appointments with him. The specialist nurse who runs the respiratory clinic noted that he was under the care of a consultant at an outside hospital on 8 August. On 19 August, a prison GP and a nurse agreed that they should re-refer the man if he was still in Bedford a month later. Finally, on 7 November, a nurse said that he would ask staff to book an appointment with the consultant in December, by which time the man said he expected he would be released.

54. Although the man died from heart problems unrelated to his asthma, there was a clear break in his care after he was recalled to prison. Healthcare staff at the prison should have ensured that he either attended an appointment with his existing consultant at the outside hospital, or referred him to a respiratory consultant nearer to Bedford. Although the man mentioned that he expected to be released on a couple of occasions, and decisions seem to have been made on this basis, there was no guarantee when, or that he would be released at all. While staff seemed to have been well-intentioned, the effect of this was that he did not see his consultant for over six months after he returned to prison. We make the following recommendation:

    The Head of Healthcare should ensure that prisoners arriving with existing hospital appointments are taken to their appointments or have them rebooked as a priority.

Use of medication

55. The man was prescribed inhalers to treat his asthma. The clinical reviewer has noted that he seemed to use his inhalers more quickly than would have been expected. Although a prison GP also commented on this, no further investigation was made. The clinical reviewer found no documented reason to explain why inhalers were prescribed at the frequency they were, or investigation into why he needed replacements when he did. The clinical reviewer has also pointed out that there are several hospital letters suggesting that his steroids should be reduced but there is no record of any action being taken in response.

56. It is important that prisoners receive the appropriate medication when they require it, but it is also important that the medication is reviewed when necessary. In this man's case, this would have helped determine whether he was using inhalers correctly and allowed a review of the long-term risks in taking steroids. We make the following recommendation:

The Head of Healthcare should ensure that the use of long-term medication by prisoners is regularly reviewed.

Emergency response

57. When the man was taken ill on 28 December, there was a delay before he was taken to hospital. He pressed his cell bell at 5.15pm, but an ambulance was not called until 7.09pm. It took a nurse 20 minutes to go to the cell, as he was not told that the man needed to be seen urgently. The nurse then decided to take him to the healthcare centre to conduct an ECG. A prison GP saw the man after his ECG and decided that he needed to go to hospital. A nurse told the investigator that he thought that he should have gone to hospital as an emergency. While it does not appear that the delay in getting him to hospital affected the outcome, in other circumstances, such as in a heart attack, a delay of this length could make a significant difference.

58. While waiting for the ambulance to arrive, the prison GP gave the man 75mg of aspirin. He said, at interview, that this was his standard practice. The Resuscitation Council guidelines states that 300mg of aspirin should be given for suspected cardiac events.

59. We consider that practice at Bedford needs to improve when a prisoner shows signs of cardiac distress. An ambulance should be called without delay without waiting for the results of an ECG. If aspirin is administered, it should be supplied in the appropriate dose. We make the following recommendation:

The Head of Healthcare should ensure that staff follow a clear protocol, in line with current national guidelines for prisoners, who report chest pain

Restraints

60. The Prison Service has a duty to protect the public when escorting prisoners to hospital, while treating prisoners with humanity and dignity. The level of restraints used should be appropriate to all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public, the prisoner's category and which also takes into account factors such as the prisoner's health and mobility.

61. A judgment 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 judgment

indicated that medical opinion regarding the prisoner's ability to escape must be considered as part of the assessment process. The judgment also required that risks during stays in hospital needed to be assessed separately from travel to and from prison and should be reviewed regularly during a hospital stay or when circumstances changed.

62. The man was restrained using double cuffs and an escort chain when taken to hospital on 28 December. This was reduced to an escort chain in hospital. The medical assessment section of the risk assessment form said that there was no reason not to use restraints. There was no medical opinion of the impact his condition had on his ability to escape as the court judgment requires. The assessment was reviewed on 29 December, but there was still no medical opinion about how his condition impacted on his risk. The escort chain remained in place until very shortly before the man died, when he suffered heart failure.

63. As we cannot be satisfied that the decision to use restraints and an escort chain was based on a properly considered risk assessment taking into account all of the relevant factors, we make the following 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 Head of Healthcare should ensure that prisoners arriving with existing hospital appointments are taken to their appointments or have them rebooked as a priority.

2. The Head of Healthcare should ensure that the use of long-term medication by prisoners is regularly reviewed.

3. The Head of Healthcare should ensure that staff follow a clear protocol, in line with current national guidelines, for prisoners who report chest pain

4. 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.

ACTION PLAN: – HMP Bedford

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that prisoners arriving with existing hospital appointments are taken to their appointments or have them rebooked as a priority.	Accepted	When a prisoner arrives at Bedford and declares that he has an existing hospital appointment, advice will be sought from the relevant hospital consultant on whether the appointment is urgent and should be kept, or re-arranged locally. Patients with an existing hospital appointment should be placed on medical hold to prevent them from being transferred prior to their appointment(s) taking place. This is in line with the local security strategy which complies with the National Security Framework.	Completed and ongoing.	
2	The Head of Healthcare should ensure that the use of long-term medication by prisoners is regularly reviewed	Accepted	Bedford will introduce formal reviews of all long-term medication. These will be implemented using the repeat prescription template on SystmOne. The frequency of these reviews will be decided by the prescriber based	Completed and ongoing.	

			on clinical need.		
3	The Head of Healthcare should ensure that staff follow a clear protocol, in line with current national guidelines, for prisoners who report chest pain.	Accepted	Triage guidelines have been developed to ensure a standardised approach which encompasses chest pain. These guidelines will be agreed at Clinical Governance and all staff will be emailed and given a hard copy of them. Additionally copies of the triage guidelines will be placed with the emergency equipment.	1 October 2013	
4	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 duty Governor now ensures that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents. All risk assessments for escorts which become bedwatches will have a more detailed medical opinion on the need for restraints. For other escorts, a brief opinion on the need for restraints is routinely included.	Completed and ongoing.	