PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the death of a man at hospital in May 2012, while in the custody of HMP Dovegate

Report by the Prisons and Probation Ombudsman for England and Wales

May 2013

This is the report of an investigation into the death of a man, a prisoner at HMP Dovegate. He died from lung and heart disease at hospital in May 2012. He was 74 years old. I offer my condolences to his family and friends.

An investigator was appointed and a clinical reviewer conducted a review of the man's clinical care in prison. HMP Dovegate cooperated fully with the investigation. I apologise for the delay in issuing this report.

The man had a history of chronic obstructive pulmonary disease (COPD) for which he had been treated since 2005. In the evening of 18 May 2012, he had a heart attack while being treated in his cell for shortness of breath. He was taken to hospital, where he died a few days later.

The investigation has identified several areas of concern about the man's care at Dovegate. Medical record keeping was below the expected standard and, despite obtaining information from his home GP about his medical history and levels of medication, Dovegate did not follow the advice. This resulted in a misunderstanding about his chronic medical condition, no care plan and incorrect prescribing levels. During the emergency response, key equipment failed and the nurse who attended seemed unclear about the treatment she administered. I am also concerned that the use of restraints on him in hospital was not justified by an appropriate risk assessment. He was in a very weakened physical state following three cardiac arrests and the use of restraints in these circumstances was inhumane treatment of an elderly, dying man,

It is disappointing that this report repeats a number of recommendations that have been raised in previous investigations at Dovegate, including the poor standard of record keeping and weak medicines management. I expect the Director and Healthcare Manager to address these issues robustly.

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 **May 2013**

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SUMMARY

1. The man was convicted of sexual offences on 24 January 2012 and remanded into custody. He was subsequently sentenced to twelve years in prison. He was 74 years old.

2. At his reception health screen, the man told the nurse that he had asthma but medical records which the prison obtained from his community GP show that he had been diagnosed with chronic obstructive pulmonary disease (COPD). Dovegate failed to adjust his medication and treatment to meet this diagnosis and he continued to be treated as though he had asthma rather than COPD. No treatment plans were put in place.

3. In the early hours of 18 May 2012, a nurse went to see the man, who was reported to be having an asthma attack. She noted that he was in respiratory distress and used a nebuliser to regulate his breathing. (A nebuliser is a device to administer medication through mist inhaled into the lungs). This worked well and he recovered.

4. At 8.30pm that evening, the nurse was again called to see the man, who was once more having difficulty breathing. As she had done earlier in the day, the nurse attempted to use the nebuliser, but it failed to work. An ambulance was called but, before it arrived, he had a cardiac arrest (heart attack). Staff attempted cardiopulmonary resuscitation (CPR) and stabilised him until paramedics arrived. On the way to hospital he had a further cardiac arrest and was again stabilised. Shortly after he arrived at the hospital, he suffered a third cardiac arrest.

5. During the journey to the hospital, and immediately after the man's arrival, escort staff did not use restraints. However, after nurses told the escort officers that he had stabilised, they restrained him with an escort chain (a chain with a handcuff at each end attached to the prisoner and an officer) although his condition was still extremely serious. The chain was not removed until two hours after he had been taken to the area of the hospital for patients who would not be resuscitated.

6. The man's health deteriorated and he died a few days later. His family were notified promptly and funeral expenses were offered.

7. The clinical reviewer expressed several concerns about the man's care at Dovegate. It is evident that his existing medical condition was not treated appropriately and that the emergency response lacked coherence. We have made recommendations on the management of COPD, the standard of record keeping, medicine management, the handling of the emergency response, nurses' skills training and the use of restraints.

THE INVESTIGATION PROCESS

8. Notices were issued announcing the investigation to staff and prisoners, asking anyone with relevant information to contact the investigator. No one came forward.

9. The initial investigator visited HMP Dovegate on 29 May 2012. He met the Deputy Director, the investigation liaison officer and the family liaison officer. He also spoke to the wing manager and wing staff, and collected documents about the man. He returned to the prison on 26 and 27 June with the clinical reviewer, to interview staff. This included an interview with a nurse which, unfortunately, was not recorded due to equipment failure. In view of this, additional details were obtained from the nurse by correspondence.

10. Another investigator subsequently took over the investigation when the initial investigator left this office. He visited Dovegate on 14 August 2012 and interviewed four members of staff. Further information was sought in writing from a fifth member of staff. He gave preliminary feedback on the findings of the investigation to the investigation liaison officer at the prison.

11. The local Primary Care Trusts (PCT) requested a clinical reviewer to review the man's clinical care in prison. She was given all the relevant documents to assist her review. The final copy of her report was received on 17 October, 2012.

12. We are sorry for delay in issuing this report which was caused by staffing changes during the course of the investigation and a backlog of cases, which we are striving to clear.

13. This investigation report has been sent to the Coroner.

14. One of our family liaison officers contacted the man's nominated next of kin, a friend, to explain the purpose of the investigation and invite them to identify any issues they wished the investigation to consider. We did not receive a reply.

HMP DOVEGATE

15. HMP Dovegate is a category B prison in Staffordshire for up to approximately 1,100 adult male remand and sentenced prisoners. The prison is managed by a private company, which also provides the healthcare services. Unlike public sector prisons, the local PCT is not responsible for commissioning health services but provides support for clinical guidance. The prison's healthcare centre provides 24 hour cover and has an 11 bed inpatient unit.

HM Inspectorate of Prisons (HMIP)

16. HM Inspectorate of Prisons (HMIP) last inspected Dovegate in October 2011. This was an unannounced short follow-up inspection. Inspectors found that the prison had made good progress addressing the healthcare related recommendations made after the previous full inspection in 2008. HMIP commented on the good partnership between prison and healthcare staff. The inpatient regime had improved, as had mental health services, which were now well regarded.

Independent Monitoring Board (IMB)

17. Each prison in England and Wales has an Independent Monitoring Board made up of unpaid volunteers from the local community who monitor standards to help ensure prisoners are treated fairly and decently. The most recent published IMB annual report for Dovegate covers the year to 30 September 2011. About health services the Board noted that a new Assistant Director for healthcare had been appointed. Nursing staff were given responsibility for a specific house block and the dispensing of medication on each house block was closely monitored. Staff were better organised and supported by primary care staff where necessary. The IMB were confident that the healthcare services had improved over the previous twelve months.

Previous deaths at HMP Dovegate

18. We have investigated a number of deaths at Dovegate. There have been two deaths since January 2011, both from natural causes, of which the man's was the second. A number of the recommendations in this report have been made in earlier investigations, including about the standard of record keeping and the management of medicines.

KEY EVENTS

19. The man was born in September 1937 and lived in the Congleton area of Cheshire. He was remanded into custody by Magistrates' Court for sexual offences on 23 January 2012 and taken to HMP Dovegate.

20. When the man arrived at Dovegate, a nurse carried out an initial health screen. She noted that he had suffered two strokes in the past and used a walking frame. She made a comprehensive list of the medication that he was taking at that time. This included Seretide 500 (Seretide 500 is a combination inhaler used to treat COPD sufferers).

21. The next day, 24 January, the man appeared again at the Magistrates' Court. It was noted that he refused his medication while at court. When he returned to the prison, a nurse and doctor assessed him in reception. A doctor prescribed Seretide 100mg but noted that this prescription needed to be clarified with his community GP before being issued.

22. On 25 January, a healthcare assistant requested the man's community medical records, which were received on 7 February. The records showed that he had a number of pre-existing medical conditions. The list of prescribed medication indicated that his dosage of Seretide should have been 500mg, but there is no evidence to indicate that the dosage was increased from the 100mg initially prescribed by the doctor, to the 500mg advised by his GP.

23. The man had no further recorded contact with healthcare staff until 4 and 5 March, when he reported shortness of breath on both days and was seen by two nurses respectively. The medical records do not indicate what, if any, treatment was given or any treatment plan.

24. The next day, 6 March, a nurse prescribed the man antibiotics. She did not examine him, but used another nurse's notes from the previous day.

25. While issuing the man with his evening medication on 7 March, a nurse noted that he was breathless and his skin was grey. She called an ambulance and he was taken to hospital, where he was admitted for observation and treatment. He was restrained during this stay, and for later outpatient appointments, by an escort chain. He remained in hospital for seven days and was discharged on 14 March. The hospital discharge summary indicated he had been diagnosed with a chest infection, and requested that an appointment be made for a chest X-ray six weeks later. There is no evidence that healthcare staff made this appointment.

26. On 23 March, the man was sentenced to 12 years imprisonment and returned to Dovegate from court. On 10 April, one of Dovegate's GPs reviewed his asthma medication. The doctor noted that, despite his respiratory condition, he continued to smoke six to ten cigarettes per day. He advised him to stop smoking, but there is no record that this was followed up by healthcare staff with any smoking cessation plan.

27. The man had no further significant contact with healthcare staff until the early hours of 18 May when Nurse A went to see him as he was reported to be having an asthma attack. She noted that he was breathless and administered a salbutamol nebuliser to moderate his breathing. (Salbutamol is used to treat acute asthma attacks.) The nurse recorded that the nebuliser gave 'good effect'.

28. Once he recovered, the man informed Nurse A that he had previously developed pneumonia and was concerned that, if he did not receive a course of antibiotics, it would recur. She noted in his medical records that she would request a doctor's appointment but there is no record that this was done.

29. The medical records show that at 8.30pm that evening, Nurse A went to see the man again as he was having difficulty breathing. The nurse described him as suffering from "respiratory distress". As she had done earlier, she administered a salbutamol nebuliser in an attempt to stabilise his breathing. However, the nebuliser device failed to work and his condition worsened. She noted that he was cyanosed (blue discoloration of the skin, fingernails, and mucous membranes caused by a deficiency of oxygen in the blood) and that his breathing was extremely laboured and his veins were engorged. She later told the investigator that she then administered oxygen using an oxygen mask.

30. Nurse A was interviewed and also provided additional information in writing. Key aspects of the latter contradicted the nurse's earlier explanations. She said, "The nebuliser failing hampered me greatly but the oxygen and mask was enough to hold the man's breath until the paramedics arrived". She told the clinical reviewer that she had monitored his oxygen saturation level (a measure of the concentration of oxygen in the blood) when she first went to the cell. She said she did not give him oxygen at that point as she was concerned at his condition. She was also concerned that her skills were limited and she thought he might go into respiratory distress with oxygen. She considered he needed his nebuliser. She explained to the clinical reviewer that she became aware he was cyanosed when he was using his own salbutamol nebuliser after the nebuliser machine the nurse had brought failed to work. The clinical reviewer said she would have expected him to have been given oxygen at that point.

31. At 8.58pm, the night orderly officer (the most senior member of staff on duty at night) asked the communications room to request first response assistance but the man's condition deteriorated quickly and two minutes later at 9.00pm, they asked for an emergency ambulance to be called. At 9.05pm, while in the recovery position, he suffered a cardiac arrest. Staff attempted cardiopulmonary resuscitation (CPR), a series of chest compressions and rescue breaths aimed at keeping blood and oxygen circulating in the body, and used a defibrillator to administer two electric shocks in an attempt to restart his heart. This was successful and he began breathing unaided. At this point oxygen was administered to him at a concentrated level of 15%.

32. Paramedics arrived at 9.33pm and stabilised the man. They transferred him to the ambulance at 10.30pm to take him to hospital.

33. An escort risk assessment is completed when a prisoner goes out of the prison to determine whether handcuffs or other restraints should be used. The risk assessment should consider factors such as the risk of escape and the risk of harm to the public and hospital staff. It should be based on an assessment of the prisoner's actual risk at the time, taking into account his health and physical condition.

34. Prison staff conducted a risk assessment for the man's transfer to hospital. The officer who completed the initial information on the form described him as unconscious, and also ticked the box on the form to indicate that restraints should not be removed for treatment. The senior manager who authorised the risk assessment decided that double handcuffs were to be used, but could be removed for medical treatment. (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.) The form was annotated:

> "To be double cuffed at all times, escort chain may be applied and in the hospital ward – cuffs not to be applied until stable due to medical advice, as he has arrested at least 5 times and this could cause delayed treatment. Duty mgr [manager] to be updated every hour."

Because of his condition, restraints were not used during the journey to the hospital.

35. During the journey to hospital, the man had a second cardiac arrest and after he arrived, he had a third. Hospital staff resuscitated him and described his condition as critical. Initially, he was unable to breathe without the aid of a ventilator. (A ventilator machine is used as life support and breaths for patients who cannot breathe for themselves.) It was noted in the Person Escort Record (PER) that accompanies prisoners travelling to and from prison, that at 11.56pm, nurses informed the escort officers that he was "very unwell and has a high chance of passing away within the next 60 minutes".

36. After the man was taken to hospital, a debrief was held at the prison with the staff involved in the emergency. The staff noted that the nebuliser machine did not work correctly, there was no oxygen mask in the emergency bag and the one bottle of oxygen on the wing ran empty just as the paramedics arrived. Nurse A later said that there was one oxygen mask and that there had been sufficient oxygen to continue oxygen therapy until the paramedics arrived.

37. At 1.45am on 19 May, hospital staff disconnected the ventilator and the prison escort staff noted on the PER that his condition had improved slightly. The man moved to the emergency assessment ward. The officers rang the prison and gave an update to the night orderly officer. After this discussion, an escort chain was applied to him. It was not until an hour later, at 2.45am, that

he was reported as being ‘conscious and talking’.

38. At 9.15am the escort log records that the man complained to the escort staff that his handcuff was too tight. The officers recorded that the cuffs were checked and secure and “the prisoner challenged about manner in which he engages with officers, no concerns with cuffing”.

39. At 2.50pm, the man developed further breathing difficulties. Nurses informed the escort officers that due to his deteriorating condition his next of kin should be contacted. Just over an hour later, at 3.55pm, he was moved to ward 6, designated as a ‘do not resuscitate’ ward. The escort chain was removed two hours later, at 5.50pm.

40. At 6.00pm, the prison’s family liaison officer went to the home of the friends that the man had nominated as his next of kin. She told them about his condition and drove them to the hospital to spend time with him. They arrived at 7.50pm.

41. By 9.15am the man could no longer take medication orally and was given pain relief through a drip. At 4.00pm, the nurse attending to him informed the escort officers that they should contact his friends as his condition was worsening. He died at 4.26pm before this was done.

42. The family liaison officer attended the man’s funeral on 12 June. Help with funeral expenses was offered to his next of kin.

43. The post-mortem report states that the man’s death was due to:

Pulmonary congestion and oedema
Ischaemic heart failure
Coronary artery atherosclerosis
Chronic bronchitis and emphysema

ISSUES

Clinical care

44. The clinical reviewer makes a number of observations and recommendations on clinical matters. We have reflected many of her concerns but have not repeated them all.

45. When he first arrived at Dovegate on 23 January, the man had an initial health screen which recorded that he had asthma. His community medical records were obtained on 7 February which clearly indicated that he had COPD and Seretide 500 mcg, an inhaler for COPD, was noted on his prescription chart when he first arrived. There was no evidence that he had previously been treated for asthma. Throughout his time at Dovegate, there was no formal treatment plan for COPD.

46. The clinical reviewer highlighted the absence of chronic disease pathways at Dovegate and said in relation to the man:

> "The lack of multidisciplinary working and personalised care plan in relation to his COPD was detrimental to his health and well-being. The healthcare records fail to identify his acceptable oxygen saturation levels, and the care required if his oxygen saturations decreased."

She concluded:

> "…it is evident there were shortfalls in his care… the lack of ownership of his care and the lack of a care pathway for Chronic Obstructive Pulmonary Disease, led to documentation/ information received from other health care establishments not being acknowledged and utilised."

We therefore endorse her recommendation, slightly recast:

The Healthcare Manager should ensure that prisoners with COPD have a personalised careplan and that healthcare staff are given clear instructions on identifying acceptable oxygen saturation levels in patients suffering from COPD, and the frequency with which those saturation levels should be monitored and recorded.

Medicine management and record keeping

47. On 24 January, the day after his initial health screen, a doctor prescribed 100 micrograms of Seretide. He asked that this dosage be clarified with the man's GP before dispensing it, but it is unclear from the medical records who he expected to take this action. Information about the man's previous prescription for Seretide was already available to the doctor at the time of the consultation as it was included in the list of medication compiled by the reception nurse.

48. The next day, the prison checked by telephone with the man's GP that the dosage of Seretide was 500 micrograms. There is no evidence in his medical records that healthcare staff acted on the information from the GP. As a result, the dose of Seretide given to him was not increased from 100mcg to 500mcg. Although staff rightly requested information from his GP, we are concerned that they did not take account of his previous prescription and there is nothing in the record to explain why a lower dosage was prescribed.

The Healthcare Manager should ensure that advice about dosage from a patient's GP is taken into account when prescribing medication for new arrivals.

49. The man's prescription chart shows that on 14 March, after he returned from hospital, he was prescribed Seretide 125. However, the discharge summary recommended an increase in dosage to 250mcg, as well as a chest X-ray six weeks later. There is no evidence that healthcare staff at Dovegate contacted the hospital to confirm the correct dosage or that they made the appointment for the X-ray.

50. In the discharge summary, the hospital had also drawn attention to the man's poor inhaler technique. The National Institute for Health and Clinical Excellence (NICE) guidelines recommend that patients' inhaler technique is checked regularly and that relevant vaccinations are given. His medical records do not show whether staff at Dovegate assessed his inhaler technique, which we would expect to be part of a personalised care plan, the lack of which is referred to above. There is no record that prison healthcare staff checked whether he had been given anti-pneumonia or anti-influenza vaccinations.

The Healthcare Manager should ensure that all prisoners diagnosed with COPD or asthma are offered anti-pneumonia and annual anti-influenza vaccinations.

51. The clinical reviewer had concerns about the standard of medicine management and said there were a number of occasions when the prescribing and recording of medication was not of an acceptable standard. She noted that the man's prescription chart was very difficult to read as Dovegate do not use a conventional system of recording. Instead of each column representing a single date, numerous dates were recorded in each vertical line. The clinical reviewer considers that this could easily lead to confusion, or a prescribing error, when administering medication.

52. The clinical reviewer noted about recordkeeping:

- Entries made by healthcare staff were inclined to be very short with very little detail.

- It was unclear from the records whether the consultations held with patients were face to face or if the patients had not been seen.

- Staff inaccurately referred to the man's diagnosis as asthma and not COPD.

- Staff failed to document observations, all activities and interventions.

53. The clinical reviewer concludes that, "unfortunately the standard of record keeping falls below that which would be expected of qualified nursing and medical staff". We are aware that electronic prescribing will be introduced but in the meantime, improvements should be made to the current system. We therefore make the following recommendation:

The Healthcare Manager should ensure that medicine management, the completion of prescription charts and record keeping comply with the code of conduct for the administration of medicines and the standards of record keeping specified by the General Medical Council and the Nursing and Midwifery Council.

Emergency response

Equipment failure

54. In the early hours of 18 May, Nurse A was called to the man's cell after he was reported to be suffering from respiratory distress. She used a salbutamol nebuliser which she reported as having 'good effect'.

55. Later that day, at 8.30pm, the man again had breathing difficulties. Nurse A took the same emergency resuscitation bag that she had used to assist him earlier in the day. She used the nebuliser but he did not respond to it as he had done previously. She soon realised that the equipment had failed. She told the investigator that the failure of the nebuliser had hindered her efforts to treat him, but that she had given him oxygen as she considered it sufficient to sustain him until the paramedics arrived. It is understandable, that having used the nebuliser earlier that day, the nurse would not have expected it to be defective, but it is essential that emergency equipment is functional at all times.

The Healthcare Manager should ensure that staff check emergency response equipment regularly and after each use and that the checks are recorded.

56. Nurse A's administration of oxygen to the man was not documented and, during the investigation, she gave different accounts. The clinical reviewer considers that the decision not to administer oxygen at the appropriate time was an error which contributed to his deterioration and raises concerns about her skills. The clinical reviewer also commented that the level of oxygen administered to him, 15%, was too low for a patient in his condition. The nurse herself cast doubt about her own skills to deal with the situation and we consider that this indicates a need for professional development.

The Healthcare Manager should ensure that all nurses working in the prison have appropriate skills and have training plans to address any assessed training needs.

Restraints

61. 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.

60. 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 restraining by handcuffs of 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.

62. The man was a 74 year old man in poor health. He moved around with a walking frame and had been diagnosed with a respiratory condition. On the occasions that he was taken out of Dovegate, staff used an escort chain. On 18 May 2012, after his collapse and subsequent cardiac arrest, he was taken by emergency ambulance to hospital. The risk assessment indicated that double handcuffs should be used but an escort chain could be applied in a hospital ward. No restraints were used but he was accompanied by two escort officers. He suffered two further cardiac arrests, one on the way to the hospital and the other shortly after his arrival at the accident and emergency department. At this stage, he was unable to breathe without the assistance of a ventilator.

63. Nurses advised the escort staff of the gravity of the man's condition and the possibility that he might die. Yet, when a slight improvement was reported and the ventilator was disconnected, an escort chain was applied. His condition at that stage was still critical. At 3.55pm that day, his condition had deteriorated to the extent that he was moved to a ward for patients who are not to be resuscitated. He was still restrained by an escort chain and remained so until 5.50pm, when the duty director gave permission to remove restraints. It is not clear from the PER what time the escort staff made the request, or if there was any delay in communicating that decision.

64. The man was convicted of serious sexual offences, committed more than thirty-five years earlier. In the light of his age, physical incapacity, rapidly declining health and poor prognosis it is difficult to see how his risk could not

have been managed by the presence of two escort officers. We make the following recommendation:

The Director should ensure that risk assessments for prisoners taken to hospital fully take into account the individual circumstances, are based on the actual risk the prisoner presents at the time and are reviewed and revised as circumstances change.

RECOMMENDATIONS

1. The Healthcare Manager should ensure that prisoners with COPD have a personalised careplan and that healthcare staff are given clear instructions on identifying acceptable oxygen saturation levels in patients suffering from COPD, and the frequency with which those saturation levels should be monitored and recorded.

   Accepted. "Nice Guidelines 101 (Management of chronic obstructive pulmonary disease in adults in primary and secondary care) state that oxygen therapy should be used with caution in patients with COPD. The Healthcare Manager will ensure that all nurses have signed to say they have read the above guidelines. Since this incident a specific weekly G.P clinic has been allocated for chronic disease management patients. In addition a nurse led clinic takes place twice a month for patients with respiratory disease and on-going care plan."

2. The Healthcare Manager should ensure that advice about dosage from a patient's GP is taken into account when prescribing medication for new arrivals.

   Accepted. "Prior to the draft report being published, The Independent Nurse Prescribers completed further Competency Frameworks as outlined by National Prescribing Centre."

3. The Healthcare Manager should ensure that all prisoners diagnosed with COPD or asthma are offered anti-pneumonia and annual anti-influenza vaccinations.

   Accepted. "Patients on the Chronic Disease Register will be offered vaccinations in line with Nice Guidelines in Management of Asthma and Management of chronic obstructive pulmonary disease in adults in primary and secondary care."

4. The Healthcare Manager should ensure that medicine management, the completion of prescription charts and record keeping complies with the code of conduct for the administration of medicines and the standards of record keeping specified by the General Medical Council and Nursing and Midwifery Council.

   Accepted. "All Nurses working at H.M.P Dovegate are registered with the Nursing and Midwifery Council and are professionally accountable for their actions and omissions. Serco Health Mandatory Training Plan 2013 includes Medicine Management Training for all nurses and healthcare staff. The HCM has ensured that all nurses have read and signed to say they will adhere to the N.M.C Record Keeping (2009) and Serco Health Medicine Management Policy (2012). Failure to comply may result in Performance management. Medical Records audit will be included in the Serco mandatory audit schedule later in 2013."

5. The Healthcare Manager should ensure that staff check emergency response equipment regularly and after each use and that the checks are recorded.

   Accepted. "The emergency grab bags are equipped with emergency equipment in line with U.K resuscitation guidelines. All staff have signed to say they have read and will adhere to Serco Health Emergency Response Policy (2012), which stipulates the process for checking of emergency equipment. Checking of emergency equipment is also part of the Serco Health Mandatory Audit Schedule 2013."

6. The Healthcare Manager should ensure that all nurses working in the prison have appropriate skills and have training plans to address any assessed training needs.

   Accepted. "All Nurses working at H.M.P Dovegate are registered with the Nursing and Midwifery Council and are professionally accountable for their actions and omissions. Serco Health Annual Training Programme (2012) which stipulates all mandatory training, including Medicine Management, Intermediate Life Support, chronic disease management and Record Keeping. Serco Health Appraisal Policy (2012) ensures that individual learning objectives are identified and actioned."

7. The Director should ensure that escort risk assessments and the use of restraints fully take into account the medical condition of the prisoner and reflect the prisoner's actual risk at the time of the hospital admission. The risk assessments should also be dynamic and revised as the prisoner's circumstances change.

   Accepted. "Staff appraised the man's risk at the commencement of the escort and it was decided that due to his condition at that time not to fit restraints. On-going risk assessments are measured throughout every external Serco escort where a prisoner is involved and staff mitigate any perceived risk by use of restraints where they require.
   It is not clear in this case as to why staff perceived that risk had increased and required to be mitigated. Serco has carried out a lessons learned and staff will be reminded to be comprehensively inclusive with risk assessments. The man was a Category B high risk sex offender who had a large amount of his sentence to serve. Decisions were made on the basis that if he had escaped from custody and mixed with others within the hospital grounds or elsewhere, the question that we would have asked ourselves was is he or would he be a risk to members of the public? On this occasion, he was deemed a potential risk. Staff's stance in view of this is to always give consideration to the safety and protection of the members of the public which unfortunately was not evidenced fully in any paperwork."