PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the death of a man in hospital, while a prisoner at HMP Wymott, in July 2012

Report by the Prisons and Probation Ombudsman for England and Wales

November 2012

This is the report of an investigation into the circumstances of the death of a man, a prisoner at HMP Wymott. He died of ischaemic heart disease at hospital in June 2012. He was 69 years old. He had no known family, but I offer my condolences to those affected by his death.

An investigator conducted the investigation. The local Primary Care Trust (PCT) commissioned a clinical reviewer to provide a clinical review of the standard of healthcare the man received when he was at Wymott. The prison cooperated fully with the investigation.

The man was an older prisoner who had known heart problems but he did not always cooperate with the treatment he was offered. He often did not attend appointments and he declined referrals to specialists, although he sometimes agreed to emergency hospital treatment.

I consider that the clinical care the man received at Wymott was appropriate and at least comparable to that he could have expected in the community. However, I am concerned that when he was taken to hospital two days before he died, restraints were used without an appropriate risk assessment which took fully into account his age, health and mobility.

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 **November 2012**

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SUMMARY

1. The man died in July 2012, aged 69, in hospital. The primary cause of death was a coronary artery atheroma (hardening of the arteries) because of ischaemic heart disease.

2. In September 2009, the man was sentenced to six years imprisonment for rape. It was his first time in custody. He transferred from HMP Manchester to Wymott on 19 October 2009.

3. The man had been diagnosed with a number of health problems. He had cataracts in both eyes, which were removed shortly after he arrived at Wymott. He also had brittle bone disease and used a walking stick to aid his mobility. In April 2012, he had a heart attack and received treatment at two hospitals. He did not always comply with the advice of medical staff and, on a number of occasions, he discharged himself from hospital and refused treatment.

4. We conclude that the man received appropriate and timely medical care at Wymott, equivalent to that he could have expected in the community.

5. On 29 June 2012, the man was admitted to hospital with chest pains. Initially, he expected to remain in hospital for just a few days to recover from pneumonia. However, his condition deteriorated and he went into cardiac arrest one morning in July. He was unable to be resuscitated and pronounced dead twenty minutes later.

6. The man went to hospital in an emergency ambulance, escorted by two prison officers. The risk assessment completed by staff before he left the prison indicated that he was low risk on all factors except for the nature of his original offence. In spite of this, he was restrained with an escort chain for the journey to hospital and throughout his admission until his cardiac arrest. We consider that the level of escort and restraint did not properly take into account his health condition, age and mobility.

7. Despite extensive efforts by the prison, police and probation services as well as the Coroner, no relatives of the man were traced. The prison arranged his funeral.

THE INVESTIGATION PROCESS

8. An investigator carried out the investigation. On notification of the death, he contacted HMP Wymott and arranged for copies of the man's prison and medical records to be made available. Notices were issued, informing staff and prisoners at Wymott of the investigation. He visited Wymott on 3 July 2012, to meet staff, prisoners and collect the documents.

9. On 31 July, the investigator returned to Wymott to conduct interviews. Afterwards he gave both verbal and written feedback to the Governor.

10. The local Primary Care Trust commissioned a clinical reviewer to conduct a review of the man's medical care.

11. We were unable to speak to any of the man's family as efforts to find any next of kin were without success.

12. The investigator informed HM Coroner of the investigation and requested a copy of the post mortem and toxicology reports, which confirmed that the man had died from ischaemic heart disease.

HMP WYMOTT

13. HMP Wymott is a large category C prison holding up to 1,174 adult male, sentenced prisoners including vulnerable prisoners, mainly sex offenders. The separate vulnerable prisoner side of the prison includes I wing, where the man lived, a specialist unit for older prisoners. Prisoners on this wing are given additional support to help them with their social care needs.

14. Healthcare services at Wymott are commissioned and provided by the local Primary Care Trust. The healthcare centre is centrally located. A private company provides general practitioner (GP) services, and clinics are run every weekday morning and two afternoons each week. The same company provides out-of-hours medical cover. There are no inpatient beds, but nursing cover is provided 24 hours a day.

HM Inspectorate of Prisons

15. The most recent inspection of Wymott was a short follow up inspection in November 2011 of a full inspection in October 2008. Inspectors commented that:

> "There had been considerable improvements in the care of older prisoners and those with disabilities. I wing continued to operate as a specialist unit, and older prisoners and those with disabilities were supported by health services staff and specialist social care workers. Formal care plans were drawn up for those who needed them and a range of adjustments had been implemented as required. A day care centre had been developed and provided a range of activities for older prisoners and those with disabilities."

16. In relation to healthcare inspectors noted:

> "There had been good progress against our recommendations across health services. Staffing levels were sufficient to meet the workload, and cancellation of clinical activities owing to staff shortages was rare. All clinical areas had been subjected to an infection control audit and were generally fit for purpose. There had been little progress in reducing waiting lists, and prisoners waited too long to see the GP and dentist. A system of timed appointments had been introduced but escorting practices remained unchanged, which meant that prisoners waited for extensive periods in the waiting rooms in the health centre after their appointments."

Independent Monitoring Board (IMB) report

17. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who monitor day-to-day life in the prison to help ensure that proper standards of care and decency are maintained. In their annual report for 2010/2011, the IMB commented about I wing and the care of older prisoners:

> "… The Board considers I Wing accommodation to be generally unsuitable for elderly and some disabled prisoners, particularly for the many who spend a considerable amount of each day within its cramped confines. However, the opening of the day care centre during the previous reporting year provides an excellent area for out-of-cell recreation and relaxation. Wing staff also try to ensure that prisoners have access to the exercise yard throughout the day and not simply during the prison's defined association hours. ..The Board is dismayed that the care and welfare of elderly and disabled prisoners is not yet of concern to Adult Social Services. The Prison therefore has had to assume this role together with its other financial demands."

Previous deaths in custody at Wymott

18. Since the Ombudsman took responsibility for investigating deaths in custody in April 2004, we have investigated 33 deaths at Wymott, of which the majority were due to natural causes. This is, in large part, due to its older population profile compared to most prisons. In a report into a death at Wymott, published in November 2011, we made a recommendation about the use of restraints for seriously ill or dying prisoners. A similar issue arose in this investigation.

KEY EVENTS

19. The man was remanded to HMP Manchester on 28 August 2009, charged with rape. It was his first time in prison. He was 67 years old at the time.

20. A nurse assessed the man on his arrival at Manchester and recorded that in the community he had drank heavily and smoked up to 40 cigarettes a day. Before he went into prison, he had been homeless. He told the nurse that he had not had contact with his family for many years. He was asked to provide the name and address of his next of kin and anyone else he would wish to be notified in an emergency. He gave the first name of a woman as his next of kin, but no address. He also nominated another person at an address in Manchester as someone he would wish to be contacted.

21. The man had brittle bone disease and he used a walking stick. He also had psoriasis (dry skin). Due to his age, he was seen in the older persons' clinic, where it was recorded that he was unkempt and under weight, associated with many years of excessive drinking and a transient lifestyle.

22. On 1 September 2009, the man was convicted and sentenced to six years imprisonment. He transferred to Wymott on 19 October 2009.

23. A nurse assessed the man. There were no immediate concerns about his health and no known heart disease or breathing conditions. She noted that he was a heavy smoker with a history of alcohol abuse. Following the reception process, he was given a cell on I wing, a residential unit for older and disabled prisoners. Carers help prisoners on I wing but there are no nurses permanently based there. He was allocated a carer to assist him with tasks such as washing and making his bed.

2010

24. The man's first contact with healthcare staff, after his reception, was on 18 February 2010, when he was assessed in the lifestyle clinic. He told them that he had no problems with his health. In March 2010, he was seen by the GP as he was experiencing problems with his vision. He subsequently had an operation for the removal of cataracts. Around the same time, the GP requested a chest X-ray, as he was concerned that the man was losing weight. He refused to attend.

25. On 24 September, wing staff asked a Staff Nurse to see him as he had back and chest pains. When she arrived, he told her that the pain had eased. She checked his blood pressure and pulse rate, which were normal, and told him to report any recurrence of the pain to healthcare staff immediately. She asked him to provide a sample of sputum to rule out any infection. During her assessment, she noted that he had white circles in his iris and requested blood tests to check his cholesterol and troponin. Troponin tests are carried out to evaluate whether people with chest pain have had a heart attack or other damage to the heart.

26. A doctor saw the man the next day to follow up the nurse's assessment. He recorded that the man had no history of ischaemic heart disease. He examined him and diagnosed an inflammation in the chest muscles and prescribed paracetomol and anti-inflammatory medication. The doctor recorded that he should be reviewed in 7 days. He did not feel that the pain was cardiac in origin and therefore made no hospital referral.

27. On 28 September, the doctor reviewed the man's blood results, which indicated that his troponin levels were not within the normal range and he needed to be seen by a GP. Another doctor examined him and concluded that he was now stable but had suffered a myocardial infarction (heart attack) and should have gone to hospital when the results were known two days earlier.

28. The man was escorted by two officers to the accident and emergency (A&E) department at hospital for assessment later that day. He was restrained by a single handcuff, the standard level for a category C prisoner. He discharged himself from hospital the same day. The escort staff were given post myocardial infarction medication for him, which he refused to take. Healthcare staff were informed on return to the prison and arranged for a GP to see him.

29. The man continued to refuse to take the medication. On 8 October, wing staff asked a nurse to see him as he was complaining of pain in his right shoulder. She visited him and he told her about the pain, which was worse when he lay down. He said he had no pain in his chest or down his arm. The nurse recorded that his colour was good and that he was talkative and happy. He refused pain relief medication. He did not attend a GP appointment on 11 October and he declined a flu vaccination, offered on 10 November. He had no further contact with nurses during 2010.

2011

30. On 3 March 2011, a nurse visited the man on I wing, at the request of his carer. He told her that he had chest pain that had started the previous night, as well as pain in his left arm and down his back. She offered him glycerol trinitrate (GTN) spray, used to treat both angina and heart failure. He declined and refused to go to hospital despite being told of the possible implications of not doing so. He signed a medical disclaimer to this effect. She recorded that she would speak to the GP and arrange an electrocardiogram (ECG) that afternoon, if he agreed.

31. The prison GP was not able to be contacted until 1.00pm and, in the meantime, the nurse arranged to take blood from the man to check troponin levels. He refused to have this done, but agreed to the ECG, which showed abnormalities consistent with an anterior infarction (heart attack of the front part of the heart). The nurse spoke told a doctor about his test results and that he was refusing treatment. The doctor advised her to call an ambulance. He was taken to hospital again restrained by a single handcuff. He discharged himself and returned to the prison later that evening. The hospital

doctor advised the escort staff that he did not think there had been any changes in his condition since his last myocardial infarction.

32. During April 2011, the man did not attend three medical appointments for blood tests and the chronic heart disease clinic.

33. A nurse examined the man at the request of wing staff on 28 June. The nurse recorded that he was complaining of pain in his groin area and that his foot was discoloured. He refused pain relief. She discussed his symptoms with a doctor, who noted that he had a scheduled GP's appointment the next day, but if his leg went white then he would need to see him.

34. Another doctor visited the man on the wing on 29 June, and recorded that he was having pain in his left thigh. She found no evidence of deep vein thrombosis or infection. She advised him to stop smoking and to walk a little each day. She also requested a blood sample, but he refused. For the remainder of 2011, there were no further significant contacts with medical staff, but it is recorded that he remained uncooperative with medical advice and did not attend medical appointments.

2012

35. On 8 April 2012, the man was taken by emergency ambulance to hospital after becoming unwell. He was again escorted by two members of staff and restrained using a single handcuff. He refused treatment in the ambulance and after arrival at hospital he was examined and transferred to another hospital for further treatment. He initially refused this treatment and returned to the first hospital. He then changed his mind and went back to the other hospital where he had an operation to increase the blood flow to his heart. During the operation, restraints were temporarily removed. He remained at hospital until 21 April, when he returned to Wymott. While admitted to hospital, an escort chain was used in place of the standard handcuffs.

36. The man was discharged with medication to treat pneumonia and had been started on medication to help thin his blood, which would require regular monitoring. A doctor visited him on the wing on 23 April and recorded that he was mobile and his lungs were clear; he advised him of the importance of complying with his medication. Medical staff made regular checks on his blood and he was cooperative.

37. Over the next two months, the man had regular check ups. It was recorded that he was becoming breathless and was only eating small amounts of food. However, he was drinking plenty of fluids as well as nutritional supplement drinks to help increase his weight. In May, healthcare staff liaised with a cardiac rehabilitation nurse to arrange an appointment with a specialist. She advised that, in the meantime, his medication could be altered and, if he became unwell, he should be sent to hospital immediately.

38. The man's personal officer on I wing told the investigator that he engaged well with staff and was a popular prisoner whose conduct never gave cause for

concern. She said that, at times, he moved around the wing quite well, but when he had a bad day his meals had to be taken to him in his cell. She said that this was quite normal with the elderly population on the wing.

39. At 8.15pm on 29 June, a nurse attended I wing to see the man after an emergency code blue call was called over the radio to indicate a prisoner with respiratory problems. He said that he was feeling sick and had vomited that morning, but had not told anyone. He felt cold and his face was pale. Initially, he said that he had no chest pain, but then described having a weight on his chest. She asked for an ambulance to be called so that he could be taken to hospital for assessment.

40. When a prisoner is taken outside prison a risk assessment is completed to determine the level of escort and restraints required. The first part of the hospital risk assessment requires details of the prisoner's medical condition and any concerns of which escort staff need to be aware. The nurse wrote, "has some medical issue – has the ability to escape".

41. The investigator asked the nurse about her experience of completing the risk assessments and her knowledge of the man. She said that before the emergency call, she knew that he had heart problems and was frail. Nurses would take his medication to the wing, as he was quite frail and unable to get upstairs. She was asked about her entry on the risk assessment and whether this was specific to him or a general phrase that she used when completing such forms. She replied that she generally used the phrase on all risk assessments and it was not individual to him. She could not recall being asked to provide more information in addition to her standard phrase.

42. The nurse said she had never been given any training in risk assessments but had been advised when she first started working at the prison that, if a prisoner is breathing, they have the ability to escape. She confirmed that regardless of a prisoner's age, infirmity or medical condition she would always write the same on every risk assessment. She said that she could not envisage an occasion when she would say that restraints should not be used or were unnecessary and that "while a patient is breathing then I've got to follow the protocol".

43. The remainder of the risk assessment is usually completed by the duty manager or security staff and countersigned by the duty manager, who will make the final decision on strength of the escort required and level of restraints to be used. The risk assessment also provides details on the level of risk the individual poses to children, the public and hospital staff, and the risk of hostage taking and potential to escape. These are rated between low, medium, high and very high. The man's risk assessment indicated that he was low risk on all factors apart from children, due to his index offence. Despite all but one of the security risk factors being considered low, an operational manager and the assistant duty manager on the day, countersigned the risk assessment indicating that two members of staff were required to escort him and that a single handcuff should be used. This could be removed if medical staff had to give emergency treatment.

44. The Head of Security at Wymott was the duty manager on 29 June. He told the investigator that he had previous contact with the man when he had carried out management checks on earlier hospital escorts. He added that concerns had been raised about him when he had been in hospital previously as he had been "a bit verbal" and "erratic" towards hospital staff and been moved to a side room. However, there was no evidence of any such incidents in his prison or medical records.

45. He explained the risk assessment process at Wymott. He said that, as a category C prison, only a single handcuff is used. This means that a prisoner is attached to an escort officer by a single handcuff attached to their wrist. The person completing the assessment would consider and record the individual's behaviour in custody, previous escapes or absconds, as well as risk to escort staff and the public. A manager agrees the risk assessment. He said that medical advice would be sought and an escort chain would be used if treatment had to be given or where the individual's mobility meant that a standard handcuff could not be used.

46. In relation to the man's risk assessment, the Head of Security said that, if he had seen it, he would have asked for more information from the nursing staff and would have expected his colleagues to do the same. But he agreed that what the nurse had written appeared to be a standard line used on all risk assessments. He also admitted there were no "tangible escape issues".

47. In further discussion, the investigator again asked him under what circumstances prisoners would leave the prison without restraints. He replied that all prisoners have to leave with a restraint on, whether a simple handcuff or an escort chain, depending on medical considerations. To sanction not doing so, he would require evidence that applying a restraint would be either not decent, because of the person's condition, or it was unsafe to do so for medical reasons. Otherwise, he would always expect a prisoner to be sent out in with restraints.

48. The man was taken to hospital by emergency ambulance, escorted by two officers and restrained by an escort chain. After assessment in A&E, he was admitted and doctors told the escort staff that he was likely to remain in hospital while antibiotics for pneumonia started to work.

49. At 8.55pm on 30 June, hospital staff told the escort officers that they were going to move the man to a different room as they had concerns about his breathing and had to connect him to a heart monitor. The escort staff contacted the prison and requested permission to remove the restraints from him to allow staff to connect the equipment to him. The Head of Security was still the duty manager. He said that at around 9.50pm that evening he had a telephone call from the orderly officer at Wymott who said the escort officers had reported that the man's breathing had become more erratic. He agreed that if hospital staff wanted the restraints to be removed, the escort officers could do so, but they should update him on the man's condition and let him know if the restraints were re-applied. He said he made it clear to the escort

staff that they should be guided by the nurses and that if they were happy for the man to remain without restraints, the prison staff were permitted to allow this. He telephoned the hospital again at 11.30pm and was told that everything was settled.

50. The man remained unrestrained throughout the night. His heart rate was continuing to cause concern. At 5.20am on 1 July, escort staff recorded that he had been awake most of the night, sitting at the end of his bed struggling to breath. At 6.40am, he vomited as a result of being unable to breath. At 9.00am, it was reported that he was settled and had no restraints. Half an hour later, at 9.30, the Head of Security received a further telephone call from one of the escort officers, who told him that hospital staff had said that the man was settled and that they had no immediate concerns. Based on this information, he told the officer that it was all right to re-apply the escort chain.

51. The officer wrote "… there has been no change in the man's condition of late, will enquire with nursing staff to see if reapplying the cuffs would be detrimental to his health …" The next entry is at 9.40am, " …cuffs reapplied, comms informed …"

52. The Head of Security said he was unaware of the man's difficulties during the night. His decision to re-apply the restraints was made without this information and, if he had known, he would have expected a more in-depth conversation to take place between the escort officers and nurses. He agreed that the evidence suggested that there had been no improvement in the man's condition since the previous evening. He said that either he or another manager would have visited him later that day, as it is normal practice for daily management checks to take place. The condition of the prisoner is reviewed and the risk assessment amended accordingly.

53. The officer was unavailable for interview during the investigation, but the investigator spoke to another of the escort officers. The officer said that, when he arrived for the start of his shift, the man was sitting in a chair, and the staff going off duty reported that he had been poorly all night. At this time, he was not restrained. When asked whether he was mobile, the officer said that he had just sat in the chair, and appeared to have a cough. He did not see him move about. In relation to the telephone call with the prison at 9.30am, the officer said that the prison asked whether the man's condition had improved, as they wanted the restraints re-applied. His condition seemed to improve later on and he became more talkative. It was at this point and on the instruction of the manager at the prison that the escort chain was re-applied.

54. At 11.10am, one officer alerted nurses, as the man had turned very pale. A nurse immediately assessed him and asked the escort staff to remove the restraints, as he appeared to be going into cardiac arrest. They removed the escort chain, whilst the other officer telephoned the prison to give an update on the man's condition. Due to an incident in the prison, this officer was unable to speak directly to the Head of Security when he called. At 11.20am, the man had a cardiac arrest and the emergency resuscitation team tried to

resuscitate him. The Head of Security instructed the prison staff to keep out of the way while the hospital staff acted. At 11.25am, the hospital doctor asked the escort officer for the details of the man's next of kin. He did not respond to the attempts to revive him and was pronounced dead at 11.30am.

Events after the man's death

55. The Head of Security asked the operational manager to try to trace the man's next of kin. After notifying the police, he went to the hospital and officially identified him.

56. The operational manager passed the limited information the man had provided at Manchester to the duty probation officer in the Manchester area and the Manchester police, in an attempt to trace the persons listed. Eventually, the address was found to be a day drop-in centre in Salford. The two names he had given were of nuns who worked at a homeless shelter and not relatives of his. They explained that he had been a regular visitor to the shelter. At this point, the Coroner's officer took on the task of trying to trace his family.

57. The Head of Security and the operational manager held a debrief with the staff who had been involved. They also went to I wing later in the afternoon and spent time speaking to the elderly prisoners and those who had known the man.

58. After unsuccessful attempts by the Coroner's officer to trace any of the man's family, the prison arranged his funeral, which took place on 26 July 2012.

ISSUES

Medical care

59. The clinical reviewer reviewed the man's medical records and found the notes about his care to be clear and concise. She considered that the treatment provided to him was appropriate with appointments, referrals and advice made in a timely manner. She concludes that the care and treatment he received was of a standard equal to that which could be expected in the wider community.

60. We agree that his care at Wymott was responsive, prompt and appropriate.

Use of restraints

61. Guidance to prison staff about escorts and bed watches is contained in the National Security Framework (NSF). The NSF provides that a risk assessment to decide the level of escort and restraint required must take place before any prisoner is moved to hospital. The risk assessment must take into account the prisoner's medical condition; security category; the nature of offence; the risk to the public and hospital staff; the prisoner's motivation to escape; and the physical security of the hospital.

62. 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. The NSF also includes guidance on the level of escort and restraint appropriate for seriously or terminally ill prisoners, updated in 2008. The relevant section says:

> "Such circumstances require delicate handling to ensure that not only is the balance between security and the clinical needs of the individual met, but also that the legal test of balance in the decisions reached are also met and supported by fully completed risk assessment documentation. Under such circumstances, individual risk assessments will also require a more frequent level of review … "

63. The man was a frail man of 69 with limited mobility. It was documented when he went into custody that he used a walking stick. Nurses regularly visited him on the wing and took his medication to him, as he was unable to climb stairs. Carers assisted him to complete personal tasks such as bathing and making his bed. The risk assessment indicated that he posed a low risk on all security factors apart from risk of harm related to his offence. The information provided by the nurse did not properly assess his health and how this impacted on his risk and it is a matter of serious concern that the nurse suggested that healthcare staff always assess prisoners at Wymott as a risk of escape as regardless of the prisoner's state of health. Managers were responsible for this approach and it appears that the standard practice at

Wymott when a prisoner is taken to hospital is for a minimum of two officers and a single handcuff or escort chain, regardless of age or health factors impacting on the risk of escape.

64. During the evening of 30 June, the man's condition deteriorated and became critical. He continued to have severe difficulties during the night but the duty manager said that this information was not communicated to him when he spoke to the escort officers the following morning, and the escort chain was re-applied. Despite the seriousness of his offence, we consider that his risk to the public and his risk of escape had significantly diminished due to his age and ongoing chronic health problems yet this had not been properly assessed. As there was no evidence that his condition had improved from the previous evening and in light of his severe lack of mobility and very poor health, we consider that, even if the use of restraints could have been justified earlier, the use of restraints at this point was inappropriate.

65. It is apparent that the prison is reluctant to consider allowing a prisoner out, unrestrained, regardless of age or infirmity. The large elderly population at Wymott is judged in the same way as a physically fit and active younger prisoner and no effective individual assessment is made. We make the following recommendation:

The Governor and Head of Healthcare should ensure that risk assessments for hospital escorts take into account up to date and relevant information, including age, state of health and mobility as well as a meaningful assessment by healthcare staff.

CONCLUSION

66. The man was a 69 year old man who experienced chronic illness for the last year of his life. We are satisfied that he received appropriate and timely medical treatment, as well as support with personal care. When he became ill on 29 June, he was taken to hospital quickly for treatment. Unfortunately, he did not recover.

67. During both the journey to the hospital and his admission he was restrained. There was no appropriate individual risk assessment, which took account of his health and mobility to justify this decision.

RECOMMENDATIONS

1. The Governor and Head of Healthcare should ensure that risk assessments for hospital escorts take into account up to date and relevant information, including age, state of health and mobility as well as a meaningful assessment by healthcare staff.

   Following the consultation period the Prison Service accepted the recommendation and said:

   The Head of Healthcare has undertaken an audit of 10 further risk assessments and PER forms. Following the audit, the Head of Healthcare in consultation with the Head of Security has formulated an action plan which includes raising awareness of healthcare staff via team briefings, the development of examples of completed risk assessments for healthcare staff to refer to for guidance and the reception nurse delivering further training to all nursing staff involved in completing risk assessments.

   Sample checks of completed risk assessments and PER forms will be conducted on an ongoing basis to ensure continued compliance and consistency.

   Decisions to apply restraints are made taking full account of the information contained in the healthcare risk assessment, security information and any dynamic factors that need to be considered at the time.