PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Preston in September 2013

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, who died of lung cancer in September 2013 at HMP Preston, shortly after he had transferred from HMP Wymott. He was 67 years old. I offer my condolences to his family and friends.

The man received a 12 year prison sentence in 2005 and moved to Wymott in 2010. He had a number of chronic health conditions and lived on a special unit for older prisoners at Wymott. In June 2013, he was diagnosed with incurable lung cancer.

The investigation found that several potential opportunities to diagnose his condition earlier were missed. In particular, an X-ray report received in October 2012 recommended further tests or a referral to a specialist, but healthcare staff at the prison did not follow this up.

After his diagnosis was confirmed, the man received appropriate care and support from staff at Wymott and then at Preston for the last week of his life. However, I am not satisfied that the use of restraints during radiotherapy treatment was justified by a properly considered risk assessment.

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 **March 2014**

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SUMMARY

1. The man was sentenced to 12 years imprisonment in November 2005. He transferred to HMP Wymott in February 2010. At that time his medical conditions included angina and osteoarthritis. He needed a walking stick to get about.

2. The man had a chest X-ray on 27 September 2012, after he had reported coughing up blood. The radiologist's report, which was received on 8 October, indicated an area of inflammation, said that a tumour could not be ruled out and recommended referral to a chest specialist or that there should be further tests. Prison doctors, including the doctor who made the initial referral for an X-ray, saw the man a further three times in October, yet these recommendations were not followed up. Had this been done it is possible that his cancer would have been diagnosed at an earlier stage. We recommend that radiology reports are assessed and followed up in line with recommended action.

3. A second X-ray referral was made on 29 April 2013, when the man again reported coughing up blood. A social care worker on his wing had monitored his weight regularly and recorded that he had lost a lot of weight in recent months, but the doctor was unaware of this and accepted his account that his weight was stable. The doctor said that, had he known of the extent of his weight loss, he would have made an urgent two week referral for suspected cancer at that stage. We recommend that records of weight which are kept on the older prisoners' unit are made available to prison doctors.

4. On 15 May, a nurse reported the man's weight loss to the doctor, who then made an urgent referral for suspected cancer. An X-ray on 17 May showed a potentially cancerous tumour and further tests over the following month confirmed that he had incurable lung cancer. A specialist explained the diagnosis and treatment options to him on 25 June. We found that the man received good support from prison staff after his diagnosis.

5. The man had a two-week course of palliative radiotherapy in mid-July. Despite his age, poor mobility and terminal diagnosis, handcuffs were used for each appointment and were removed when he was undergoing treatment only on the last three occasions. We recommend that escort risk assessments appropriately take into account a prisoner's individual circumstances and the actual risk they present at the time, in line with guidance from the courts.

6. In the last week of August, the man's health deteriorated and a move was arranged to the inpatient unit at HMP Preston. An appropriate end of life pathway was opened. A place at a hospice was arranged for him but he died the night before he was due to move.

THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners informing them of the investigation and inviting anyone who had relevant information to contact him. No one came forward.

8. The investigator visited HMP Wymott on 11 and 24 October and interviewed five members of staff and spoke to two prisoners who knew the man. He gave the deputy governor initial feedback about the findings of the investigation and followed this up in writing. The investigator obtained copies of the man's prison medical records and relevant prison records.

9. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison. The clinical reviewer joined the investigator for the two visits in October.

10. The investigator informed HM Coroner for Preston and West Lancashire of the investigation and the Coroner provided the cause of death. The Coroner has been sent this report.

11. One of the Ombudsman's family liaison officers contacted the man's daughter, his nominated next of kin, to explain the investigation. She did not have any specific issues that she wanted the investigation to cover.

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

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

HMP WYMOTT

14. HMP Wymott is a category C prison holding up to 1,176 adult male, sentenced prisoners. The man lived on I wing, a specialist unit for older prisoners who are given additional support to help them with their social care needs. Healthcare services at Wymott are commissioned and provided by Lancashire Care NHS Foundation Trust. A private company provides GP services and out of hours medical cover. Clinics are run every weekday morning and two afternoons each week. There are no inpatient beds, but there is nursing cover 24 hours a day.

15. Under a local agreement with HMP Preston, Preston provides up to five inpatient beds for prisoners from Wymott who need them. Wymott retains responsibility for all offender management arrangements.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Wymott was in November 2011. The Inspectorate found considerable improvement in the care of older prisoners, with formal care plans introduced for those who needed them. However, they criticised the long wait that some prisoners experienced to see a GP.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. In its most recent annual report for 2011/12, the IMB were concerned that more support was needed for older and disabled prisoners. They also considered that the number of locum prison doctors employed meant that prisoners did not receive consistent care.

Previous deaths at HMP Wymott

18. Two prisoners died of apparent natural causes at HMP Wymott earlier in 2013. In one investigation, we found that the man who died did not receive the standard of care he might have expected to receive in the community. Two other prisoners from Wymott died in the inpatient unit at Preston. In one of these cases, we found that Wymott used restraints inappropriately in hospital on an older, extremely frail prisoner.

HMP PRESTON

19. HMP Preston is a local prison holding up to 842 adult male prisoners. Health services are provided by Lancashire Care Foundation Trust. The healthcare unit has an inpatient unit for up to 30 prisoners which is used as a regional facility. Patients from other prisons remain the responsibility of their original prison for all issues except healthcare.

20. There is a full-time doctor covering the inpatient unit and primary healthcare between 9.00am and 5.00pm Monday to Friday. Between 5.00pm and 8.00pm there is a doctor in the drug dependency unit. At night and weekends there is on-call cover.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Preston was in April 2012. The Inspectorate found that an appropriate range of health services were provided and that inpatient services were satisfactory.

Independent Monitoring Board

22. In its annual report for 2012/13, the IMB reported that healthcare staff provided a caring and committed service but that low staffing levels affected the operation of some services.

Previous deaths at HMP Preston

23. Two other prisoners from Wymott died in the inpatient unit at Preston in 2013. Our report into the first of these deaths recommended that healthcare staff at Preston should be trained to provide end of life care.

ISSUES

The diagnosis of the man's terminal illness and informing him of his condition

24. The man was sentenced to 12 years imprisonment in November 2005. He transferred to HMP Wymott in February 2010. At that time his medical conditions included angina and osteoarthritis, which meant he walked with the aid of a walking stick. He had previously been diagnosed with prostate cancer which was successfully treated with radiotherapy in 2004. The man had appointments with a number of healthcare staff to manage his conditions over the next two years.

25. On 20 September 2012, the man told a prison doctor that he had recently been coughing up blood. She referred him for a chest X-ray, which was carried out on 27 September. The X-ray result was received at the prison on 8 October. The radiologist highlighted an area of probable inflammation and commented that he could not rule out the presence of a tumour. He recommended prison doctors either arrange further tests or a referral to the chest clinic, depending on the man's presentation.

26. Although prison doctors saw the man three more times in October, the radiologist's recommendations were not implemented. The doctor saw him on 15 October for a pre-booked appointment for a skin condition. There is no record that his chest condition or X-ray referral and the result were discussed. At interview, the doctor said that her appointment list would have highlighted the skin condition as the reason for the appointment and she did not remember that she had recently referred him for X-ray.

27. On 23 October, the man told a prison nurse at the prison's chronic heart disease clinic that he was feeling increasingly short of breath and was coughing up dark coloured, sometimes bloody, phlegm. A prison doctor examined him that afternoon and diagnosed a chest infection and prescribed antibiotics. Again, there was no reference in the records to his recent chest X-ray, although the doctor recorded that he would require a follow-up X-ray if the antibiotics were ineffective.

28. The first doctor examined the man again on 30 October, recorded that his chest was clear and advised him to book another appointment if he felt any worse. As previously, no reference was made to the recent chest X-ray. The doctor said she could not remember if she had looked at the X-ray results during this consultation.

29. The man had no further significant contact with prison healthcare staff until 22 December, when he told a prison nurse that he had coughed up blood. He thought that this was linked to a recent throat operation. A prison doctor examined him the next day and recorded his chest was clear, but prescribed a course of antibiotics. The doctor noted that he had reviewed the man's previous notes, but he did not refer to the X-ray results.

30. The man's next significant contact with healthcare staff was on 14 March 2013, when he complained of a cough. A doctor examined him, found that his chest was clear and noted that no treatment was required. An electrocardiogram (ECG, a test of the electrical activity of the heart) was taken and another prison doctor reviewed the results three days later. The doctor noted that the results were consistent with a history of heart disease and advised him to continue with his current medication.

31. The man saw a doctor on 29 April and said he felt tender in his lower chest and had coughed up green phlegm and blood. He told the doctor that his weight was steady, although records kept by a social care worker on his wing showed that his weight had fallen from 77kg in August 2012 to 67kg in April 2013. The doctor did not have access to these records. He referred the man for a chest X-ray.

32. On 15 May, a prison nurse noted the man's recent weight loss and that he was feeling more unwell. She arranged for a doctor to see him the next morning. Because of his weight loss and continuing symptoms, the doctor made an urgent referral for suspected cancer under which a specialist is expected to see the patient within two weeks. The doctor told the investigator and clinical reviewer that he had explained the urgency of the referral to the man and that he had understood this.

33. The chest X-ray requested on 29 April took place on 17 May. The results were available on 21 May and showed what appeared to be a lesion (a group of abnormal cells that needs further examination and will often represent a cancerous tumour). The radiologist recommended urgent referral to the chest specialist. No additional action was taken at the prison because a two week referral had already been made. There is no indication in the notes that these results were discussed with the man at the prison.

34. The man's urgent referral appointment at the chest clinic was on 28 May. He had had a CT scan (a more detailed scan of the organs) which showed a tumour that was likely to be cancer and a respiratory consultant explained this to him at the clinic. The consultant asked that he return for a biopsy to confirm the diagnosis and determine what treatment might be available.

35. In early June, the man spoke to prison nurses about his diagnosis on several occasions. The older persons' lead spoke to him in detail on 4 June about the likely diagnosis and the support they could provide at the prison. Prisoners who were friends of the man said that the two full-time carers on I wing looked after and supported him very well.

36. The biopsy took place on 6 June. The results were available for discussion at the hospital's multi-disciplinary team meeting on 17 June, and confirmed that the man had incurable lung cancer. An appointment was made with an oncologist (a cancer specialist) on 25 June at which the result was explained to him and the treatment options discussed.

37. The clinical reviewer concludes that several opportunities which might have allowed the man's cancer to have been diagnosed earlier were missed. She considers that an urgent two week referral should have been made in October 2012 when the radiologist's report was received. Although the man had three appointments with prison doctors in the month after the radiologist's recommendations were received, including two with the doctor who made the initial referral, no follow up action was taken and it does not appear that the results were reviewed. We make the following recommendation:

The Head of Healthcare at Wymott should ensure that radiology reports are assessed and followed up appropriately in line with recommended action.

38. The clinical reviewer also considers that a two week referral should have been made on 29 April 2013. A doctor told the investigator and clinical reviewer that he would have made such a referral had he realised that the man had lost weight in addition to his other symptoms. The weight recordings from his wing were not aligned to his main medical record and the doctor therefore accepted the man's view that his weight was steady. We make the following recommendation:

The Head of Healthcare at Wymott should ensure that the results of regular weight measurements taken on the older prisoners' unit are included in medical records and that prisoners with significant weight loss are referred to a doctor for review.

39. The doctor told the man about the urgent two week referral and its implications at the time. An oncologist confirmed his diagnosis and explained it to him at a clinic on 25 June. Friends of the man's told us that he received very good support from carers on the unit, as well as from nurses and officers. We are satisfied that he was fully informed of his diagnosis and treatment options and was appropriately supported.

The man's medical treatment

40. Once it becomes evident that a serious medical condition will not be responsive to active treatment, it is appropriate that a palliative care plan is put into place. The NHS document 'The route to success in end of life care – achieving quality in prisons and for prisoners' sets out how an end of life care pathway might be implemented in prisons. Among the benefits of an end of life pathway are that it helps carers plan when and how care will be delivered and helps patients make choices about how they are cared for towards the end of their lives.

41. At his appointment with the oncologist on 25 June, the man was told that his cancer was incurable but that he could have palliative radiotherapy (to help slow the growth of the tumour and relieve symptoms). A two week course, which started on 15 July, was arranged. Before the course he was reported to be in good spirits. His pain was well controlled with codeine (used for mild to moderate pain).

42. The man attended all of his appointments and completed the course of radiotherapy. On 1 August, a few days after finishing radiotherapy, he told a nurse that he was in pain and his medication was no longer sufficient. She spoke to a doctor, who prescribed oramorph (a stronger, morphine based painkiller). She also made a referral to local palliative care specialists and nursing care plans were created to help healthcare staff monitor and support the man in areas such as pain control, personal care, and food and fluid intake.

43. In the next few days, the man said he felt much better and his pain was under control. In the first three weeks of August, he was relatively well but, from 24 August, he began to have difficulty taking his medication and suffered at least two falls. On 27 August, he was referred to the inpatient unit at HMP Preston as healthcare staff were concerned about his safety at night when there were no carers on the wing to help him and there was only one nurse on duty to cover the whole prison.

44. A move to Preston was arranged for the following day, but cancelled as the man was not well enough for the journey. With his agreement, a doctor completed a 'do not attempt resuscitation' order (DNAR), as he considered that resuscitation was not in the man's best interests because of his advanced and untreatable cancer. This meant that resuscitation would not be started in the event of a respiratory or cardiac arrest.

45. In conjunction with staff at a local hospice an end of life pathway was initiated on 28 August. The move to Preston went ahead the next day, as the man had improved slightly. Medication that might be required for end of life care was prescribed in advance so it could be issued quickly if needed, although the man's pain was under control at the time and he remained relatively comfortable.

46. Palliative care nurses visited the man at Preston on 3 September and advised about medication. There was some discussion about suspending the end of life pathway, as it was not clear whether the man met the implementation criteria, but the prison doctor, nurses and the palliative care specialists agreed it should continue.

47. A bed was arranged for the man in a hospice near to where his wife lived. This was available on 5 September and it was agreed that he would move that day. Sadly he died before the move could go ahead.

48. All of the man's outpatient appointments were kept and, as noted previously, he received good support from staff of various disciplines. His pain was well controlled and we agree with the clinical reviewer's opinion that he received appropriate pain relief. Care plans were implemented and an end of life pathway initiated when he neared the end of his life. The clinical reviewer comments that it was used appropriately and was beneficial to him.

The man's location

49. The man lived on I wing at Wymott, which is a special unit for older prisoners or those less mobile. On this unit, although the landing is locked, prisoners are not locked in their cells. Two full time carers work on the wing to help with personal and social care and, as noted, his friends said that the carers did all they could to help him.

50. In the week before he moved to Preston, the man began to experience some difficulties. He suffered some falls and was incontinent during the night. His friends told us that a night patrol officer was very supportive and helped him at the time.

51. We were told that the man was reluctant to move to Preston as he wanted to stay at Wymott with his friends. However, a move was arranged when he had deteriorated to the extent that he required nursing care overnight and he moved on 29 August. A further move to a hospice near to where his wife lived was arranged, but he died before that date. (This is discussed further in the section on compassionate release.)

52. We are satisfied that the man's wish to remain on I wing as long as possible was respected, and that he received very good care and support while living on I wing at Wymott. The move to Preston was appropriate at the time.

Liaison with the man's family

53. Prison Service guidance states that prisons must engage with the families of seriously or terminally ill prisoners and encourage a terminally ill prisoner to do likewise. The man was initially reluctant to tell his family of his diagnosis as he was concerned about his wife's health and how she would take the news. A nurse encouraged him to speak to his family, but he chose not to do so.

54. By 27 August, when his health had deteriorated significantly, the man agreed that his daughter should be contacted. The safer custody manager telephoned her later that day and arranged for her to visit the prison on 28 August. At the start of her visit, the manager and a nurse met the man's daughter and explained her father's diagnosis and the recent deterioration in his health.

55. The man's daughter told his wife about the diagnosis and she visited him on 29 August after he had moved to Preston. Several members of the family visited him over the course of the week.

56. When the man died his daughter was telephoned with the news as had been agreed with her in advance. A family liaison officer was appointed the next day and spoke to the family about funeral arrangements and returning his property. The funeral was held on 20 September. Wymott contributed to the costs in line with national guidance.

57. We are satisfied that, once the man agreed that his family should be informed of his illness, the family contact was handled sensitively and appropriately.

Compassionate release and Release on Temporary Licence

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

59. Release on temporary licence (ROTL) can be granted for precisely defined and specific activities which cannot be provided in the prison. A risk assessment is completed to ensure that the prisoner's temporary release does not present unacceptable risks. The governor of the prison is able to grant the temporary licence and will decide whether the prisoner is to be accompanied by staff.

60. The man was due to be released from prison on 5 October 2013. It was initially planned that he would move to an approved premises (formerly known as probation and bail hostels) but, as he became more unwell, this became unrealistic. The consultant's view on 19 August, when asked for advice on his needs upon his impending release, was that his long term prognosis was poor and he would require "supportive care" on release. The plan then was that he would be released to his family home on 5 October (although, at the time, he had yet to tell his family of his diagnosis).

61. After the deterioration in his health in late August, the prison began to prepare an application for early release on compassionate grounds. A doctor completed the medical assessment on 1 September and noted that the man was bed-bound, receiving palliative care and had a poor prognosis. The consultant was contacted for an up to date view of his diagnosis and prognosis, although it does not appear that this was received before his death.

62. A prison probation officer (offender manager) completed an assessment on 2 September and concluded that, although the man remained a risk to children, his medical condition allowed him to be released as long as appropriate public protection measures were in place. The Governor completed her assessment on 4 September and supported his release.

63. At the same time, funding was agreed with local commissioners for a place at a hospice near to the man's wife's home. He was due to move and the

Governor had approved escorted release on temporary licence for the placement, but he died before the move could take place or his application for full compassionate release was submitted.

64. The man was due for release on 5 October. All the reports for his application for compassionate release were positive and our view is that he was a strong candidate for release (although further supporting evidence from the consultant was also required). Sadly, he died before his application was submitted. We acknowledge that timing of such an application is difficult. The consultant's view expressed on 19 August (indicating that he was expected to live beyond his release date) was unlikely to have been sufficient to meet the criteria for early release. We also accept that he deteriorated quickly in late August and there was little time to prepare the application once it became clear he might die before his release date.

Restraints, security and escorts

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

66. The man had several hospital outpatient appointments after his referral and diagnosis. A risk assessment was completed before each, in which he was always marked as a high risk to children (on a scale of low, medium, high) due to the nature of his offence, with all other risks, including the risk of escape and to the general public, assessed as low.

67. The man's biopsy on 6 June was taken by means of a bronchoscope. This is an intrusive procedure involving the insertion of a long thin fibre optic tube into the lungs via the mouth or throat. The medical section of the risk assessment for this appointment highlighted that he "may need a wheelchair". The risk assessment was authorised by the Head of Security, who concluded that two officers should make up the escort with a single pair of handcuffs being used to attach the man's wrist to that of one of the officers. The handcuffs were not removed for the bronchoscopy.

68. Ten radiotherapy appointments were scheduled on consecutive weekdays from 15 July, with a separate risk assessment completed before each. The

purpose of the appointment was sometimes highlighted in the medical section of the risk assessment, but not always. It was sometimes noted that the man required a wheelchair and sometimes that he just used walking sticks. Two officers always made up the escort and an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer) was usually authorised, although sometimes a single pair of handcuffs was used. During the last three appointments, the escort chain was removed for the duration of treatment (although it was not specified on the risk assessment that this should happen) and then re-applied.

69. The man was 67 years old, had poor mobility which meant he sometimes used a wheelchair, and had been diagnosed with a terminal illness. While his offences were of a serious nature, the circumstances would not suggest that he was a current risk to the general public and he was a very low risk of escape. We consider that an escort of two officers without the use of restraints should have been sufficient. It is particularly troubling that the man was handcuffed during radiotherapy, contrary to the explicit guidance of the High Court judgement. We make the following recommendation:

The Governor of Wymott 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 at the time.

RECOMMENDATIONS

1. The Head of Healthcare at Wymott should ensure that radiology reports are assessed and followed up appropriately in line with recommended action.

2. The Head of Healthcare at Wymott should ensure that the results of regular weight measurements taken on the older prisoners' unit are included in medical records and that prisoners with significant weight loss are referred to a doctor for review.

3. The Governor of Wymott 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 at the time.

ACTION PLAN: The Man – HMP Preston

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Head of Healthcare at Wymott should ensure that radiology reports are assessed and followed up appropriately in line with recommended action.	Accepted	A revised pathway has been developed to ensure that all correspondence is actioned in a timely manner. All radiology reports are currently received by post/fax as letters. This is different from the way pathology reports are received; these are entered directly onto SystmOne by the pathology department at the NHS hospital. The pathology report software includes an action plan incorporating a system of alerts and flags. The practice manager will approach TPP (the company that produces SystmOne clinical software) to see if the software can be developed so that radiology reports can be reported directly onto SystmOne in the same way as the pathology reports. If this is not possible a local procedure will be developed for healthcare staff/GPs to follow, which will include other SystmOne electronic applications such as auto-consultation. All staff have been made aware via the team/governance meeting that any requests for appointments should be clearly recorded in the record and the appointment ledger to reflect the reason for the appointment.	Completed and ongoing. Head of Healthcare 30 June 2014 Head of Healthcare Completed and ongoing Head of Healthcare	

			If the radiology report identifies abnormalities or if any actions are identified the GP will complete the auto-consultation template (or TPP developed template) and ensure that appropriate staff are made aware of any follow-up actions.		
2.	The Head of Healthcare at Wymott should ensure that the results of regular weight measurements taken on the older prisoners' unit are included in medical records and that prisoners with significant weight loss are referred to a doctor for review.	Accepted	The older persons lead will now ensure that all measurements taken by the social carers are read coded and entered into the clinical records. If concerns are raised the older persons lead will refer the prisoner, where appropriate, for an examination. In the case of significant weight loss the prisoner will be referred to the GP or nurse practitioner. Information, including concerns regarding deterioration in health or well-being will be shared via the social carers on a regular basis. The monthly carers' meetings and the daily nurse presence on the wings will also capture any immediate or ongoing concerns/issues about an individual.	Completed and ongoing Head of Healthcare	
3.	The Governor of Wymott 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 at the time	Accepted	A memo has been issued to all governors and custodial managers reminding them that the use of restraints must be proportionate to the risk presented by the prisoner at the time and take into account individual circumstances Governors and custodial managers undertaking bed watch checks will also check the level of restraints.	Completed and ongoing Governor	