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 on 11 December 2013 while in the custody of HMP Isle of Wight

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 pneumonia on 11 December 2013, while in the custody of HMP Isle of Wight. He was 72 years old. I offer my condolences to the man's family and friends.

A clinical review was commissioned to investigate the man's clinical care. The prison cooperated fully with the investigation.

The man was sentenced to 12 years in prison in March 2012 and transferred to HMP Isle of Wight in July 2013. He had a number of chronic conditions which were well managed throughout his time in prison.

In November 2013, the man fell in his cell and injured his head. He was taken to hospital for treatment and while there was diagnosed with pneumonia. He returned to prison, but his health continued to deteriorate. On 10 December, he was admitted to hospital with severe pneumonia and died the following day.

The investigation found that in general the man received a good standard of care in prison. However, I consider that he should have been assessed for admission to the prison's inpatient unit after he was discharged from hospital and I am very concerned that nurses initially refused to attend the wing when he was found in a serious condition on 10 December. This is also the 15th report since 2012 into a death at HMP Isle of Wight in which I have raised issues about the inappropriate use of restraints on terminally ill prisoners. I am now formally drawing the matter to the attention of the Deputy Director of Custody

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **July 2014**

CONTENTS

SUMMARY

1. On 23 March 2012, the man was sentenced to 12 years in prison. He was sent initially to HMP Belmarsh where healthcare staff noted he had multiple health problems. He used a walking stick and wheelchair, had high blood pressure, asthma, bronchitis, arthritis and osteoporosis. A few years earlier, he had had some vertebrae (discs of the spine) removed and he suffered chronic back pain.

2. On 22 July 2013, the man transferred to HMP Isle of Wight. On 6 August, a nurse noted that the man, who was in a wheelchair, was unable to get to the healthcare unit because of the steps. Unless a nurse was available to help him, he had to wait outside for a nurse to come and give him his medication.

3. Over the next three months, healthcare staff saw the man regularly to review and manage his chronic conditions.

4. During the morning roll check on 7 November, an officer found the man collapsed on his cell floor with a head wound. He was taken to hospital for treatment and, while there, was diagnosed with pneumonia. He remained in hospital until 14 November. He returned to prison and to his cell on the main wing where healthcare staff saw him daily.

5. During the night of 23-24 November, the man fell four times. Other prisoners and officers on his wing were concerned that he needed more social care than they could give him. He deteriorated during 24 November and was taken to hospital where he was treated for his pneumonia. He was discharged on 5 December and returned to the same cell on the wing.

6. Healthcare staff visited him in his cell each day. At 8.30am on 10 December, officers found the man very unwell in his cell. They called a nurse who asked the officers to bring him to the healthcare unit. Officers explained that he was not well enough, but the nurse would not attend. Wing staff tended to him and, after two further calls, a nurse came and examined the man. The nurse asked for a doctor to attend. A doctor examined the man a few minutes later and arranged for him to be taken to hospital.

7. The man was admitted to hospital and diagnosed with severe pneumonia. He continued to deteriorate and died at 7.10am on 11 December.

8. The clinical reviewer considered that the man was mostly well cared for in prison and received care equivalent to that he could have expected in the community. However, we agree with his concerns that the wing was not the most appropriate location for him after he was discharged from hospital in November and that the healthcare unit is not accessible for wheelchair users. Nurses' initial reluctance to attend to see the man when he was ill on 10 December was unacceptable. We are not satisfied that the use of restraints for hospital appointments was always justified by fully considered risk assessments. We make four recommendations.

THE INVESTIGATION PROCESS

9. The investigator issued notices to staff and prisoners at HMP Isle of Wight informing them of the investigation and inviting anyone who had relevant information to contact her. No one responded.

10. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison record. She interviewed five members of staff and three prisoners at HMP Isle of Wight on 20 February. The investigator gave initial feedback on the investigation and followed this up in writing to the Governor.

11. NHS England commissioned a doctor to review the man's clinical care at the prison.

12. We informed HM Coroner for the Isle of Wight of the investigation, who provided the results of the post-mortem examination. We have sent the Coroner a copy of this investigation report.

13. One of the Ombudsman's family liaison officers contacted the man's wife to explain the investigation. His family asked whether he should have been located in the prison's healthcare unit when he returned from hospital in November. His family also raised a number of other matters, not directly related to his death, which we have covered in separate correspondence.

14. The man's family received a copy of the draft report. They pointed out some omissions. They remained concerned about the rapid deterioration in his health and disagree with the conclusion of the independent clinical reviewer that his care was equivalent to that he could have expected in the community. We have made some amendments to clarify some of the issues they raised. The man's family also raised a number of questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence. The prison has also submitted an action plan detailing what they have done to address the issues we raised and this is included at the end of the report.

HMP ISLE OF WIGHT

15. HMP Isle of Wight is an amalgamation of two prisons, Parkhurst and Albany. The prison holds mostly sex offenders. The man lived on the Parkhurst site.

16. Care UK provides healthcare services at the prison. There is an inpatient healthcare unit (IHU) with 18 beds on the Albany site, catering for prisoners with a wide range of mental health, general medical, rehabilitative and health-related respite needs.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Isle of Wight was in May 2012. The Inspectorate noted that there had been some sustained improvements at the Parkhurst site. Provision for older prisoners and those with disabilities was generally found to be good and prisoners with chronic conditions were regularly reviewed. Prisoners with urgent issues at the Parkhurst site usually saw a GP within a day and ten days for routine appointments.

Independent Monitoring Board

18. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recently published annual report for 2012, the IMB commented that waiting times for GP appointment varied and prisoners at the Parkhurst site had to wait longer. The Board noted the inpatient healthcare unit provided a very high standard of care.

Previous deaths at the Isle of Wight

19. The man was the eighth prisoner to die from natural causes at HMP Isle of Wight since January 2013. In 14 previous reports from January 2012 we have identified that restraints were used inappropriately on terminally ill prisoners taken to hospital.

KEY EVENTS

20. The man was sentenced to 12 years in prison for sexual offences on 23 March 2012 and was initially sent to HMP Belmarsh.

21. Healthcare staff noted that the man was a heavy smoker of cigarettes and had a number of chronic conditions. These included high blood pressure, asthma, bronchitis, rheumatoid arthritis, osteoporosis and chronic back pain after previous surgery. He used a walking stick and a wheelchair. He was prescribed a number of medications to manage his conditions. When he first arrived at Belmarsh he was admitted to the prison's healthcare unit.

22. The man moved to a houseblock on 12 June. Over the next year, he continued to suffer from a number of chronic symptoms including back, shoulder and chest pain and was treated with various pain relief medications. He declined smoking cessation advice and continued to smoke. His family did raise concerns with the prison about his deteriorating health in December 2012.

23. On 22 July 2013, the man transferred to HMP Isle of Wight and was admitted to the inpatient healthcare unit at the Albany site. At an initial health screen, a nurse noted his chronic conditions, that he was allergic to penicillin and used a wheelchair. A prison doctor saw him the next day and recorded his medical conditions and medication. He noted that the man possibly had chronic obstructive pulmonary disease (COPD - a term used to describe a number of lung diseases) and needed a spirometry test (a measure of lung function). The man was placed on a waiting list for the test but there is no record that it was carried out.

24. A nurse helped the man shower on 24 July and noticed he pushed his wheelchair in front of him to help him mobilise. A doctor suggested an occupational therapy assessment to help him mobilise more comfortably. There is no record that this was done.

25. On 26 July, the man was moved to a cell in the main prison on the Albany site, but on 31 July he moved to a ground floor single cell on a wing at the Parkhurst site.

26. On 6 August, a nurse noted the man had trouble getting to a GP appointment because of steps to the healthcare unit at the Parkhurst site. In order to collect his medication, his 'pad pals' (prisoners who help less able prisoners to cope with day to day living) wheeled the man to the healthcare unit to wait outside for a nurse to administer it. There was no shelter.

27. Over the next three months, healthcare staff saw the man regularly to treat and monitor his chronic conditions. Sometimes nurses saw him on the wing and other times he went to the healthcare unit for appointments. When healthcare staff had time, they helped him down the steps into the unit, otherwise he waited outside for nurses to bring him his medication.

28. At 7.30am on 7 November, an officer found the man on the floor of his cell bleeding from a wound in his head. He alerted a colleague who radioed a Code Red (indicating a life-threatening emergency due to loss of blood) and the control room called an ambulance. A nurse attended with an emergency bag. The man appeared to be having a seizure. The nurse was unable to take observations. Paramedics arrived quickly and the man was taken to St Mary's Hospital. Restraints were not used.

29. Hospital doctors diagnosed a subdural bleed (a bleed around the brain) and pneumonia and placed them man in an induced coma.

30. A prison family liaison officer contacted the man's wife on 8 November, to let her know he was in hospital. She offered support and information about visiting him. The family liaison officer remained in contact with the man's family from this point on.

31. Healthcare staff telephoned the hospital daily for updates on the man's condition, which improved over the following days. On 11 November, he was conscious again and considered more able. He was then restrained by 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).

32. The man was discharged back to prison on 14 November and returned to his cell on the wing. He was prescribed medication for pneumonia and healthcare staff monitored him daily on the wing.

33. On the morning of Friday 22 November, a doctor examined the man after he had complained of chest pains. A nurse checked his pulse rate which was high at 107. His blood pressure was normal. The doctor suggested transferring the man to the inpatient unit for observation, but this did not take place immediately. He went back to his wing and, in the afternoon, wing staff asked a nurse to attend because the man seemed to have deteriorated. A nurse took his blood pressure (116/77), temperature (36.3) and pulse (93) all of which were within normal range. She was unable to take his oxygen levels as he became agitated. A doctor reviewed his observation results and noted they were normal. He said that the man could remain on the wing for the weekend and continue treatment with antibiotics.

34. The same day the man's wife and mother-in-law arrived for a visit, but this could not go ahead as the man was too unwell to attend the visits hall. A prison manager offered them overnight accommodation and said they could visit when the man was moved to the inpatient unit the next day, where it was planned he would move. However, his family were unable to stay or return to visit the next day.

35. A nurse gave the man his medication on 23 November. He said he had no memory of the day before, so she made an appointment for the GP to examine him two days later. (This did not go ahead because the man had been taken to hospital by then.) He did not move to the inpatient unit as had been planned the day before.

36. At 3.10am on 24 November, an operational support grade recorded that he had found the man on the floor of his cell struggling to get up. Other officers helped him get him back to bed.

37. The operational support grade found the man on the floor again at 4.10am and staff again helped him back to bed. That morning, a senior officer told the duty governor that he considered that the man needed social care which they could not provide effectively on the wing.

38. Later that day, a nurse recorded that the man had problems feeding himself, drinking and taking tablets, and that the wing staff were concerned that he had fallen out of bed four times that day. At around 4.00pm, a nurse saw the man and noted he was frail, could not mobilise easily or feed himself. He took observations and noted his oxygen levels were low. The man was taken to St Mary's Hospital, Newport by ambulance. He was restrained by an escort chain.

39. On 26 November, a clinical team manager from the prison contacted the hospital for an update. Nurses told her the man was not eating or drinking properly and was being treated with antibiotics for pneumonia. He had also become aggressive and non-compliant with some of his treatment. The manager told hospital staff that the man had only become aggressive since he had returned from hospital the weekend before, after his head injury. It is not clear whether the hospital followed this up.

40. A prison clinical team manager contacted the hospital on 27 November, and was told that the man was having treatment for suspected tuberculosis. The hospital isolated him. Escort officers then removed the restraints and stayed outside his room.

41. On 3 December, the hospital confirmed that the man did not have tuberculosis. Escort staff noted he was improved, but there was "a deterioration in manners" and reapplied the escort chain. Escort staff recorded that, although his health had improved, the man became confused and often did not know why he was in hospital, or that he was a serving prisoner. They said his behaviour was poor, bizarre and obstructive. The hospital physiotherapist assessed the man and recorded that he could not stand or walk.

42. On 5 December, the man was discharged back to the prison, and returned to his cell on the wing despite his lack of mobility. Healthcare staff monitored him daily.

43. On 8 December, a nurse recorded that the man said he did not feel well and asked for his inhaler as he found it difficult to breathe. The nurse noted that he had not had an inhaler prescribed since July 2012, and arrangements were made for him to see a doctor the next morning. There is no record that this happened.

44. There is nothing further in the man's record until 10 December. At about 8.30am, two officers went to see him in his cell as night staff had been concerned about him. They found him extremely unwell, doubly incontinent, and unable to stand. The senior officer phoned the healthcare unit and explained the situation. He spoke to a female nurse who asked them to bring the man to the healthcare unit. The senior officer explained that the man was distressed, wearing soiled clothes, unable to stand and was unwell. He told the investigator that the nurse asked him to get the man to clean himself and then bring him over to the healthcare unit. She declined to visit him on the wing. The investigator was later told that the name of the only female nurse on duty that morning out of three members of healthcare staff. That nurse told the investigator that she had no recollection of being called.

45. The man became more distressed and the other officer telephoned the healthcare unit again to see if someone would come to the wing to examine the man. He said that the nurse he spoke to (he could not recall who it was or whether the nurse was male or female) said that they were busy. The officers washed the man and put him in clean clothes, but considered he was not well enough to go to the healthcare unit and needed to be seen on the wing. The officers made him comfortable in his bed.

46. The senior officer was uncertain of the times, but said it took between 60-90 minutes to reach this stage since they first telephoned for a nurse. He called the healthcare unit again and spoke to a male nurse, who then came to the wing at around 9.45-10.00am. The nurse noted the man's legs were swollen up to his knees, he was coughing, said he had not eaten for two days and was confused. He asked for a doctor to see the man and a doctor arrived a few minutes later. He examined the man and requested an ambulance at 10.24am.

47. The man was taken to hospital restrained by an escort chain. He was admitted to hospital at 11.15am and at 3.30pm the restraints were removed. The man continued to deteriorate and died at 7.10am on 11 December.

Support for staff and prisoners

48. A Governor's notice informed staff and prisoners of the man's death. A memorial service for him was held at the prison.

Family liaison

49. A prison family liaison officer visited the man's wife at her home at 12.45pm and informed her of his death and offered support. The prison contributed towards the funeral costs, in line with national guidelines.

Post-mortem report

50. The post-mortem examination concluded that the man died of fulminant pneumonia (sudden and severe pneumonia) and damaged lungs. The post-mortem report states that he had developed pneumonia and been treated with

antibiotics during his recent admission to hospital, but was very ill when readmitted. The hospital gave him supportive treatment, as he was expected to die as a result of his chest condition. The report also states that the man's respiratory disease exacerbated the return of his symptoms.

ISSUES

Clinical care

51. The clinical reviewer noted that the man was in poor health at the time he arrived in custody in 2012. Many of his symptoms throughout his time in prison related to his chronic medical conditions. In general, he was assessed and treated appropriately.

52. While the clinical reviewer found that the overall standard of clinical care given to the man in prison was at least as good has he could have expected in the community, he was concerned about the man's location in the prison after his fall, access to the healthcare unit and the nurses' response to being asked to examine him on 10 December. We agree with each of the clinical reviewer's concerns.

Location

53. The man was located in a single ground floor cell in the main prison. He had wall bars in his cell to aid his mobility and was assisted in his day to day living by 'pad pals'. However, the showers on the wing are not accessible by wheelchairs and he needed upper body strength to transfer to the shower seat. He had needed assistance with showering for some time. His 'pad pals' told us that, after his return from hospital in November, the man was not able to move as much and could not do the same things he had been able to do before. They thought he needed 24 hour care and told officers on the wing. Wing staff reported the same issues and were concerned that his accommodation and environment were not appropriate for his needs.

54. On 22 November, it was originally planned that he would move to the inpatient unit when he was so unwell he was unable to attend the visits hall to see his family. A doctor subsequently decided that, because he was not any worse than some other prisoners on the wing, and his observations taken later the day were normal, the man should remain on the wing.

55. The clinical reviewer notes that when the man returned from hospital on 14 November, his physical state and capabilities should have been better assessed. He had suffered a significant head injury and was still being actively treated for pneumonia. The clinical reviewer states that the man's physical condition should have warranted admission to the prison inpatient unit on this and subsequent returns from the hospital. Although this might not have changed the outcome, he would have had closer medical supervision and suffered less distress as a result. It would also have enabled him to see his family when they visited. We agree that there was insufficient assessment of his needs and the records of his condition at the time indicate that his wing was no longer an appropriate location. We make the following recommendation:

The Head of Healthcare should ensure that there is an effective documented assessment of prisoners returning from hospital, so that they are located appropriately dependent on their abilities and needs.

Access to the healthcare unit

56. Because the man used a wheelchair, he could not access the healthcare unit (which has steps) to collect his medication. Staff told the investigator that when they had the time they would help him down the steps into the unit. Otherwise, he had to wait outside for nurses to come out and dispense his medication to him. The clinical reviewer noted that having to wait outside with no cover cannot have been easy for someone with the man's medical conditions. He also stated that nurses having to leave the healthcare unit to take medication to a prisoner outside can contribute to inaccuracies in record keeping and is undesirable. We are concerned and surprised that, of all areas of the prison, there was no disabled access to the healthcare unit to allow the man and other wheelchair users to collect their medication, or alternative arrangements to dispense their medication to them so they do not have to wait outside. We make the following recommendation:

The Governor and Head of Healthcare should ensure that prisoners who are wheelchair users are able to access the healthcare unit to collect medication or introduce alternative appropriate and safe arrangements.

Healthcare response on 10 December

57. At 8.30am on 10 December, officers found the man in his cell, very unwell, doubly incontinent and unable to stand. They asked a nurse to attend twice but each time the nurse declined and asked the officers to bring him to the healthcare unit. We do not know whether the officers spoke to the same nurse each time but on the first occasion it appears to have been a nurse, who said she was unable to recall this and therefore unable to explain why she did not attend. Eventually at around 9.45-10.00am, another nurse went to the man's cell and called a doctor, who in turn requested an ambulance. The nurse said he was unaware of the earlier calls to the healthcare unit. The man was seriously ill and died just one day later.

58. We are concerned that nurses refused to attend, even after officers explained the man appeared very ill. The clinical reviewer considered that, while more prompt medical attention would not necessarily have affected the outcome, it would have limited his distress. We make the following recommendation:

The Head of Healthcare should ensure that all nurses respond appropriately and promptly to urgent requests for help from wing staff.

Restraints, security and escorts

59. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as 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 about 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.

60. When the man was taken to hospital on 7 November as an emergency, he was unrestrained and accompanied by two officers. His risk was reassessed again in hospital on 11 November and, although assessed as low risk of escape, he was restrained with an escort chain. The escort record shows that hospital nurses said that his head injury could have caused deterioration in his behaviour, but there is no other medical input into the risk assessment to show how or whether this increased his risk of escape.

61. On 24 November, the man was in a frail condition and his oxygen levels were low. He was taken to hospital and assessed as low risk of escape. There was only limited medical input which said that he was frail and agitated. He was restrained using an escort chain, which was removed in hospital. The escort chain was reapplied on 3 December when the man's condition was considered to have improved. This was despite the fact that a physiotherapist assessed him the same day and noted that he could not stand or walk.

62. On 10 December, the man was very ill and confused and was taken to hospital. He was again assessed as low risk of escape, but there is no record of medical input about his medical condition and how this affected his risk. He was accompanied by two officers and restrained by an escort chain.

63. The reasons given in the escort record for reapplying restraints often concerned the man's behaviour and improved mobility. However, he was in a wheelchair and needed help to go to the toilet. On 3 December, he could not stand or walk. An objective assessment of his risk should have concluded that the possibility of him escaping from two escort officers was unlikely in the extreme. All the risk assessments described the man as a low risk of escape.

64. We are not satisfied that the decisions to use restraints were justified by fully considered risk assessments that took into account the man's medical condition at the time and how this impacted on his risk of escape, as required by the 2007 High Court judgement. We are concerned that this is a matter we have raised with HMP Isle of Wight a large number of times before. Recommendations have been made and accepted, yet there had been little

change in practice. We therefore make the following recommendation to the Deputy Director of Custody for the Isle of Wight.:

The Deputy Director of Custody for South Central should ensure that there are appropriate arrangements and guidance at HMP Isle of Wight which ensure that all managers and staff responsible for undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the medical condition of the prisoner and are based on the actual risk the prisoner presents at the time.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that there is an effective documented assessment of prisoners returning from hospital, so that they are located appropriately dependent on their abilities and needs.

2. The Governor and Head of Healthcare should ensure that prisoners who are wheelchair users are able to access the healthcare unit to collect medication or introduce alternative appropriate and safe arrangements.

3. The Head of Healthcare should ensure that all nurses respond appropriately and promptly to urgent requests for help from wing staff.

4. The Deputy Director of Custody for South Central should ensure that there are appropriate arrangements and guidance at HMP Isle of Wight which ensure that all managers and staff responsible for undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the medical condition of the prisoner and are based on the actual risk the prisoner presents at the time.

ACTION PLAN: The man – HMP Isle of Wight

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 should ensure that there is an effective documented assessment of prisoners returning from hospital, so that they are located appropriately dependent on their abilities and needs	Accepted	All prisoners are assessed by prison healthcare staff prior to their return from Hospital. The Head of Healthcare will ensure that the documented assessment considers the appropriate location for the prisoner on return to prison.	Head of Healthcare June 2014	
2	The Governor and Head of Healthcare should ensure that prisoners who are wheelchair users are able to access the healthcare unit to collect medication or introduce alternative appropriate and safe arrangements.	Accepted	Plans were in place for disabled access to the Primary Healthcare facility at the Parkhurst site prior to the death of the man and the access will be complete in the next 6 – 10 months. Alternative appropriate and safe arrangements for the distribution of medication will be considered and introduced.	Head of Estates March 2015 Head of Healthcare June 2014	
3	The Head of Healthcare should ensure that all nurses respond appropriately and promptly to urgent requests for help from wing staff.	Accepted	The Head of Healthcare accepts that nurses should respond appropriately and promptly to urgent requests for help. The prison and health care staff currently operate a 'code blue/code red' response system. The Head of healthcare will work closely with prison colleagues to improve the communication and appropriate response required for other urgent requests for assistance.	Head of Healthcare Completed and ongoing	
4	The Deputy Director of Custody for South Central should ensure that there are appropriate arrangements and guidance at HMP Isle of Wight which ensure that all managers	Accepted	The Head of Operations has briefed senior staff at operational briefings, and sent an email to all operational managers, to remind them of the need to consider the use of restraints on an individual basis and to take medical assessments of mobility into consideration when assessing each prisoner's	DDC Completed and ongoing	

	and staff responsible for undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the medical condition of the prisoner and are based on the actual risk the prisoner presents at the time.		risk of escape and/or risk of causing harm to others. The South Central DDC has discussed this issue with the Governor and is content that appropriate action has been taken to remind staff of their responsibilities in line with the attached senior leaders' bulletin from the Director of Public Sector Prisons and the Deputy Director of Contracted Prisons issued in January 2014. The DDC and Governor undertake to ensure that where restraints can be safely removed for prisoners with terminal or serious illnesses they will be and that no prisoner will wear restraints without a full and up to date justification. The decision making process with regards to the appropriateness of restraints has now significantly improved with different departments working closer together when decisions are made and questions in risk assessments now accurately record clinical information regarding a patient's mobility. Operational managers inform senior managers when a risk assessment has been completed. They then reassess this within 24 hours of any prisoner being admitted to hospital or immediately following any serious decline in their medical condition. Escorting staff also make dynamic assessments of a prisoner's mobility and behaviour during an escort and record this on Prison-NOMIS upon their return to the prison.		