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 woman on 25 August 2014 at HMP Frankland

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 woman, who died of heart and liver disease on 25 August 2014 at HMP Frankland. She was 66 years old. I offer my condolences to her family and friends.

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

The woman had been in prison since 23 October 1984 and was serving a life sentence. She had been at Frankland since 2003 and was a transgender prisoner. She had longstanding hepatitis C which caused liver damage. In 2009, she had suffered a severe internal bleed while in hospital and was diagnosed with enlarged veins in her throat, diabetes and liver problems. Her liver disease became more serious over time.

In 2014, the woman was very ill and spent more time in hospital. Doctors were considering the possibility of a liver transplant and in July indicated that, without one, she would have only six to twelve months to live. On the morning of 25 August, the woman complained to other prisoners that she felt unwell. After lunch, another prisoner found her unresponsive in her bed and alerted officers who radioed an emergency medical code. Healthcare staff attended quickly, but the control room did not call an ambulance immediately. However, when nurses examined her, it was evident that she had died.

I am satisfied that the woman received a generally satisfactory standard of care at Frankland, but I am concerned that she did not always get the special diet she needed. The investigation also found that staff did not follow the required emergency response procedures and call an ambulance as soon as the emergency code was broadcast. Although it would not have affected the outcome for her, in other cases, such a delay could be crucial. I am also concerned that she was restrained during hospital stays without fully considered risk assessments to justify the use of restraints.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **March 2015**

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SUMMARY

1. The woman had been in prison since October 1984 and transferred to HMP Frankland in July 2003. She was a transgender prisoner. Doctors had diagnosed her with hepatitis C before she had arrived in prison and she became progressively more unwell. In December 2009, she was admitted to hospital and was diagnosed with poor liver function and diabetes. She had a severe internal bleed in hospital caused by varices (enlarged veins in the throat common to people with poor liver function and potentially fatal if they bleed). After this, doctors recommended a high protein, low salt, soft diet. The prison did not always provide this diet.

2. The woman continued to receive medical care in prison and from hospital doctors. On 24 April 2014, she went to hospital as an emergency because she vomited blood. On 28 April, she discharged herself but went back to hospital again on 7 May because she was still unwell. The hospital diagnosed a build up of fluid related to poor liver function. While there she had another variceal bleed. She recovered and returned to prison on 22 May.

3. On 1 July, the woman missed a hospital appointment because the prison's risk assessment did not note that she was using a wheelchair and the escorting officers refused to take her. On 4 July, she went back to hospital for treatment and to consider the possibility of a liver transplant. She came back to prison on 10 July and was told that without a transplant she had six to twelve months to live. No decision was made about a transplant.

4. On the morning of 25 August, the woman told other prisoners that she was feeling unwell but did not report this to staff. Before prisoners were locked up at lunchtime, she asked another prisoner to wake her up at 2.00pm. An officer unlocked her cell at about 1.40pm, but did not check for a response as she usually slept at lunchtime. At 2.00pm, a prisoner went to wake the woman. He was unable to get a response and went to get help. An officer went to the cell to check on her, but also could not get a response. He went asked another officer to radio an emergency code. The control room did not call an ambulance until ten minutes later. The officers went back to the cell but did not give any basic life support. Nurses arrived and examined the woman. They did not attempt resuscitation as it was apparent that she had died. Paramedics attended and, at 2.37pm, confirmed her death.

5. The clinical reviewer found that the woman received care generally equivalent to that she could have expected to receive in the community. Although this did not affect the outcome for her, the clinical reviewer was concerned about the lack of provision of a special diet and identified other issues such as poor record keeping, which the Head of Healthcare will need to address. We are concerned that she missed a hospital appointment because staff refused to take her; an ambulance was not called immediately when the emergency code was called and restraints were used, without proper justification, when the woman was in hospital. We make five recommendations.

THE INVESTIGATION PROCESS

6. The investigator issued notices to staff and prisoners at HMP Frankland informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.

7. The investigator obtained copies of the woman's prison medical records and relevant extracts from her prison records. She interviewed four members of staff and three prisoners at Frankland on 24 September 2014 and two more members of staff by telephone on 1 October. The investogator informed the Governor of the preliminary findings of the investigation.

8. NHS England commissioned a nurse to review the woman's clinical care at the prison.

9. We informed HM Coroner for Durham and Darlington of the investigation, who provided the post-mortem report. We have sent the Coroner a copy of this investigation report.

10. One of the Ombudsman's family liaison officers contacted the woman's partner, her nominated next of kin, to explain the investigation. He had some concerns about changes to her medication and the side effects caused by her medication. The clinical reviewer has addressed these in her review which is annexed to this report.

11. The woman's family received a copy of the draft report. They did not make any comments. 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 FRANKLAND

12. HMP Frankland is one of eight high security prisons in England and Wales. It holds more than 800 prisoners. There is 24 hour inpatient care. NHS County Durham commissions Care UK to provide healthcare services.

HM Inspectorate of Prisons

13. The most recent inspection of Frankland was in December 2012. The Inspectorate found that staff and prisoner relationships were good. Healthcare facilities were good and chronic disease and life-long conditions were well managed. Each wing had a healthcare treatment room and emergency resuscitation equipment. Inspectors noted that there were six transgender prisoners and a support worker had visited prisoners and delivered awareness training to 230 staff.

Independent Monitoring Board

14. 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 report for the year to November 2013, the IMB noted that there was a transgender policy to support transgender prisoners. Since April 2013, a custodial manager had liaised between the prison and the healthcare department, which had lead to greater consistency of treatment. The IMB considered that healthcare services were good.

Previous deaths at HMP Frankland

15. The woman was the fourth prisoner to die of natural causes at Frankland since January 2013. We have previously made recommendations about the need for an appropriate diet to be provided without delay for prisoners with special health needs; the need for fully justified risk assessments for prisoners in hospital and the need to avoid cancelling hospital appointments.

KEY EVENTS

16. The woman was a transgender prisoner in a civil partnership with another prisoner in HMP Frankland. She had been in prison since October 1984, when she was sentenced to life imprisonment for attempted murder with a minimum term to serve of eight years before she could be considered for release.

17. Before she was sentenced to prison, a doctor in the community had diagnosed the woman with hepatitis C. She had had the disease for at least 35 years and continued to receive treatment for this in prison. She became more unwell over time and, in December 2009, spent some time in hospital. In hospital, she had a severe bleed and was diagnosed with a poorly functioning liver, varices (enlarged veins in her oesophagus, often as a result of liver disease, which can cause a potentially fatal bleed), and diabetes. Hospital doctors banded the varices (placing an elastic ring around the enlarged vein) and she continued to receive treatment in prison for her health problems. Records show she needed a high protein, low salt and soft diet, because of her conditions. However, she did not routinely receive this diet until towards the end of her life.

18. Healthcare staff saw the woman frequently for her medical treatment. In July 2011, she retired from her prison job because of her poor health. In December, records show the woman told wing staff that she had good and bad days because of her stomach and that this would be a lifelong problem.

19. In 2012, doctors treated the woman for a circulation problem in her leg. Prison doctors saw her frequently throughout 2012 and 2013, and a hospital consultant saw her about her poorly functioning liver. In November 2013, investigations began to diagnose a lesion on her lip. It was diagnosed as non-cancerous and removed on 7 March 2014.

20. On 24 April 2014, the woman was taken to hospital after she vomited blood and her clinical observations indicated some concerns. Hospital staff reported that her condition was stable and she returned to the prison on 28 April after discharging herself. Hospital doctors had prescribed antibiotics and an intravenous proton pump inhibitor to reduce stomach acid. The discharge letter from the hospital gave two diagnoses of haematemesis (vomiting blood) and an upper intestinal bleed.

21. At 4.30pm on 6 May, the woman complained of severe abdominal pain when she ate, and told a nurse that because of this she had stopped eating. The nurse noted the woman's abdomen was distended and she had fluid retention (oedema) in her lower legs. The nurse arranged an urgent appointment with the doctor.

22. A prison GP examined the woman the next day, 7 May. Her temperature was 36.7 (slightly low), blood pressure 127/85 (slightly high) and pulse 86 (within normal range). The GP noted she had early jaundice, as well as the fluid retention in her legs and a distended abdomen. He considered that she might have ascites (a build up of fluid), related to a liver disorder and sent her back to hospital. In hospital, she was 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).

23. Hospital doctors treated her ascites with medication to help reduce water retention. The prison phoned daily for updates and, on 15 May, the woman became very ill. She had a severe bleed and had a blood transfusion. On 16 May, nurses asked for her next of kin to be contacted because it was possible she could die. Staff told her partner (another prisoner at Frankland) later that day. Escort officers removed the escort chain from the woman at 1.20am when she had an emergency operation and reapplied the chain at 1.50am, once she was in the recovery unit. At 3.00pm, a prison manager reviewed the risk assessment and decided that, as a result of her health, restraints should be removed while she was in her room, but could be applied if she moved around the hospital.

24. The Head of Healthcare and a nurse from the prison, visited the woman in hospital on 16 May. Hospital staff told them she could have another bleed at any time, which could be fatal. Hospital staff informed her about her condition. The Head of Healthcare and nurse discussed the woman's ongoing care with healthcare and prison staff for when she returned to prison. Staff informed her partner and noted they would keep him informed about the woman's clinical management.

25. While in hospital, the woman responded to treatment and officers reapplied the escort chain on 18 May. She had a heart scan in hospital on 21 May, which showed no concerns. She returned to the prison the next day. At her request, she went back to her cell on her wing, rather than to the prison's healthcare centre.

26. On 23 May, a doctor reviewed the woman's medication. On 27 May, a nurse examined her on the wing and noted her ascites was increasing and that she was not sleeping. She admitted her to the healthcare centre. Nurses advised the woman to eat soft foods to avoid aggravating the enlarged veins in her throat. On 4 June, she discharged herself from the healthcare centre because of what she described as an incident with an officer. We do not know what this incident was and the woman chose not to disclose the details to anyone.

27. On 26 June, the woman complained to a nurse of abdominal pains and asked for a doctor's appointment. The next day a prison GP noted that her abdomen was painful and swollen and tried to contact the hospital consultant, without success. On 1 July, the woman missed a hospital appointment. The healthcare records indicate that this was because she was using a wheelchair and the escorting officers would not take her as this had not been noted on the risk assessment. They said that the restraints procedures would need to be changed as a result and a taxi with wheelchair access could not be hired at short notice. (It is not clear what the appointment was for or when she had begun to use a wheelchair for longer distances.)

28. On 3 July, a hospital consultant contacted a prison GP and said they would explore palliative care options and that the woman should be admitted to hospital the next day. On 4 July, she was taken to hospital. While receiving

treatment through a drip, the use of an escort chain was authorised. At other times, she was restrained by handcuffs, but it is not clear from the records exactly when different levels of restraints were used.

29. In hospital, a consultant examined the woman and she had the ascites drained. On 10 July, she returned to the prison and refused to stay in the healthcare centre, against medical advice. She needed a low salt, high protein, soft diet. On 17 July, a nurse noted that the soft diet the woman was receiving was unsuitable as it was packet soups and noodles which were high in salt. The nurse spoke to catering staff about this, who said they would contact her about pureeing food instead. There is no evidence this happened.

30. On 18 July, a Macmillan palliative care nurse, spoke to the woman about her condition. The woman said that she was aware she had 6-12 months to live and wanted to explore the option of a liver transplant. Her main concern was her diet. She told the nurse that she would not go to the prison's healthcare centre because of a previous bad experience with an officer there. The nurse noted this could impact on the woman's care, but the woman would not allow her to discuss it with the Head of Healthcare. Although she had a terminal condition, she was not treated as a palliative patient because the option of active treatment (a liver transplant) was still being considered.

31. On 20 July, the woman told her key worker (a nurse) that she would consider going back to the healthcare centre if she could have her door open at certain times. The nurse said she would discuss this in a multidisciplinary team meeting and inform her about the outcome. The meeting did not take place before the woman died.

32. Healthcare staff continued to monitor the woman. On 1 August, a nurse spoke to prison catering staff and explained again that the woman needed a high protein, low salt, soft diet. It was agreed that wing staff could order food the day before to facilitate this. The nurse also noted that she would investigate buying a slow cooker so the woman could prepare soft foods herself. On 15 August, the woman complained to a nurse that she was still not receiving soft foods. The nurse spoke to catering staff again and they agreed they would provide cream, cottage cheese, yoghurt and egg daily. Records show the woman received a soft food diet from this date and received a slow cooker a few days before she died.

33. On 25 August, staff saw the woman walking around the wing in the morning. She spoke to other prisoners and complained of having stomach pains and feeling unwell, but does not appear to have mentioned this to any of the staff. She usually slept at lunchtime. At about 11.40am, just before prisoners were locked in their cells over the lunch period, she asked another prisoner to wake her up at 2.00pm.

34. Around 1.40pm, an officer unlocked the woman's cell, but did not go in and left the door slightly ajar. The officer told the investigator that, because of the woman's medications, it was not unusual for her to be asleep at lunchtime so she did not disturb her. (We would usually expect officers to check prisoners' welfare when they unlock them but accept that in these circumstances it was reasonable for the officer not to disturb the woman.) At about 1.55pm, a prisoner went into the woman's cell to wake her up. He saw that she was

lying on her left side, and her eyes and mouth were open. He called her name a few times, then shook her right shoulder, but could get no response. The prisoner went to get an officer.

35. An officer went to the cell to check the woman. He said the cell was dark, the curtains were drawn and she was under the covers. He could not get a response and checked her neck for a pulse, but could not find one and her skin felt cool. He asked another officer to radio a code black (an emergency code indicating circumstances such as loss of consciousness or difficulty breathing) and went back to the cell. The officer radioed a code black (recorded in the control log at 1.59pm and shown on CCTV) and went into the woman's cell. A senior officer followed shortly after. This was about half a minute after the first officer, first left the cell. The staff were unable to find any signs of life, but did not attempt to resuscitate the woman.

36. A nurse arrived about two minutes after the emergency code was called. She could find no signs of life and noted there was evidence of blood pooling on the side the woman was lying on, indicating she had died. Three more nurses arrived about five minutes later to offer assistance, but also did not attempt resuscitation because they considered the woman was clearly dead. At 2.09pm, the control room called an ambulance, which arrived at 2.14pm. Paramedics confirmed death at 2.37pm.

37. At 2.19pm, a senior officer told the woman's partner, who was a prisoner on another wing, that she had died. Although her death had not formally been confirmed at that time, the nurses had no doubt that she had died and staff were concerned that her partner might find out from other prisoners if they waited any longer to inform him. The prison appointed a family liaison officer, who offered help and advice to the woman's partner. The prison organised and paid for her funeral, in line with national guidelines.

38. A senior manager debriefed staff involved in the emergency response and offered appropriate support. A Governor's notice informed staff and prisoners of the woman's death and offered support. Officers reviewed prisoners identified as at risk of suicide and self-harm, in case they had been adversely affected by the news of the woman's death.

39. A post-mortem found that the woman died from ischaemic heart disease (disease of the blood vessels supplying the heart) due to coronary atheroma (fatty deposit within the arteries) with the contributing conditions of diabetes mellitus and cirrhosis of the liver.

ISSUES

Clinical Care

40. The clinical reviewer found that most aspects of the woman's clinical care were equivalent to that she could have expected to receive in the community. However, she was concerned that the woman did not consistently receive a special diet and identified some other areas for improvement in standards of healthcare services, such as record keeping and delays in referring her for a lesion on her lip that was first noticed in 2010. We do not repeat all the clinical reviewer's recommendations in this report, but the Head of Healthcare will need to address them.

Missed hospital appointment

41. On 1 July 2014, the woman was not able to attend a hospital appointment. We were told that this was because the risk assessment did not record that she would be using a wheelchair. Records show that officers said that a wheelchair taxi was not available at short notice and the restraints procedures needed changing to reflect that she was in a wheelchair, so they would not take her. We were told in interview that officers might have been concerned about getting the woman out of the taxi and into the wheelchair. It is not clear why managers could not amend the risk assessment at short notice and arrange suitable transport. Records show that the woman was able to stand and walk short distances unaided, so it is likely she could have got herself from the wheelchair and into the taxi that was already booked. Prisoners should not miss scheduled hospital appointments without good reason and we are not satisfied that sufficient was done before this appointment was cancelled. We make the following recommendation:

    The Governor should ensure that there are appropriate arrangements to take prisoners to hospital appointments and that prisoners do not miss appointments unless there are properly justified, exceptional and fully recorded reasons.

The woman's diet

42. In 2010, doctors advised that the woman needed a low salt, high protein, soft diet. The low salt and high protein diet was to aid her liver problems as well as her diabetes. The soft diet was to avoid aggravating her varices to prevent a fatal bleed. There is no evidence that the woman received the medically recommended diet routinely until shortly before her death. Although the lack of an appropriate diet did not affect the outcome for the woman, in other situations it could have serious consequences. We had similar concerns during an investigation into a death at the prison in 2013 and made a recommendation about the need to provide an appropriate diet. Frankland accepted this recommendation and said that had put measures in place for better communication between healthcare staff and the catering manager. We repeat the recommendation:

    The Governor and Head of Healthcare should ensure that prisoners with serious illnesses receive an appropriate diet to meet their needs without delay.

Emergency response

43. When the first officer established that the woman was unresponsive, he locked the cell and met another officer to radio a code black. The investigator was told there is one radio for each landing, which the officer in charge for the day holds. The first officer said he did not want to call down the landing for an emergency code to be radioed which is why he left the cell. The officer could have asked the prisoner to get help, or shouted down the corridor for assistance. Although it would not have made a difference for the woman, in other circumstances it could.

44. The second officer called a code black at 1.59pm, but the control room staff did not call an ambulance until 2.09pm. (Although Prison Service Instruction 3/2013 requires prisons to have a two level code system, usually red and blue, that differentiates between a blood injury and all other injuries, Frankland uses three codes: yellow for burns and fractures, red for blood injuries and black for unconscious or breathing difficulties). Frankland's local protocol states the control room should call an ambulance automatically as soon as any emergency code is radioed, but this was not done.

45. Although it would not have changed the outcome for the woman, calling an ambulance immediately could make a significant difference in other circumstances. We make the following recommendation:

    The Governor should ensure that the control room calls an ambulance as soon as an emergency medical code is broadcast.

46. Although a nurse arrived within two minutes of the emergency code being called, we are concerned that none of the prison staff who were on the scene first, began basic life support. Unless there are clear signs of death, it is vital that if a person is unconscious, cardiopulmonary resuscitation is started as soon as possible to improve the chances of survival. The officers did not assess that the woman had died, yet none of them attempted resuscitation. In the event, once nurses examined her, it was apparent that she was dead and to attempt resuscitation would be futile. However, the officers were unaware of this and they were not confident to attempt resuscitation, although one had up to date first aid training. While this did not affect the outcome for the woman, staff training is important and the lack of confidence in basic life support could have serious consequences in other circumstances. We therefore make the following recommendation:

    The Governor should ensure that staff receive sufficient guidance and training to understand the benefits of immediate cardiopulmonary resuscitation (CPR) for a prisoner who is not breathing and that CPR should be started, unless there is clear evidence that it would be futile in the circumstances.

Restraints

47. 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 the 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 and kept under review as circumstances change.

48. On 15 May 2014, the woman was in hospital she vomited and passed a lot of blood. She had an operation in the early hours of 16 May and nurses were concerned that she might die. Although the escort staff sought permission to remove her restraints, the escort chain was removed only while she was unconscious in the operating theatre (for 30 minutes). The level of restraint was not fully reviewed and the restraints removed until 3.00pm on 16 May, rather than when her circumstances changed and her symptoms first became life- threatening.

49. On 4 July, the woman went back to hospital and was restrained by a single handcuff. Staff were advised that if she stayed overnight, an escort chain should be used instead. It is apparent from the escort records that at the time, an escort chain was used only when the woman received intravenous treatment and handcuffs were used at all other times. (It is not apparent from the records whether single or double handcuffs were used.) It is not clear at what times she had intravenous treatment and from the records it appears that staff did not use an escort chain until 8 July.

50. We are concerned that the level of restraints used when the woman was in hospital did not fully take into account her level of risk and the records do not always specify clearly what type of restraints were used at what time. She was seriously ill with no history of escape and needed a wheelchair to move longer distances. Although healthcare staff noted her use of a wheelchair on the 4 July risk assessment, they but did not make clear whether or how her condition impacted on her risk of escape, as required by the 2007 High Court judgement.

51. Ultimately, it is the Governor's responsibility to ensure that the process is managed properly, but the Head of Healthcare also needs to ensure that healthcare staff understand their responsibilities and have appropriate and considered input into the risk assessment process. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

RECOMMENDATIONS

1. The Governor should ensure that there are appropriate arrangements to take prisoners to hospital appointments and that prisoners do not miss appointments unless there are properly justified, exceptional and fully recorded reasons.

2. The Governor and Head of Healthcare should ensure that prisoners with serious illnesses receive an appropriate diet to meet their needs without delay.

3. The Governor should ensure that the control room calls an ambulance as soon as an emergency medical code is broadcast.

4. The Governor should ensure that staff receive sufficient guidance and training to understand the benefits of immediate cardiopulmonary resuscitation (CPR) for a prisoner who is not breathing and that CPR should be started, unless there is clear evidence that it would be futile in the circumstances.

5. The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

ACTION PLAN: The woman – HMP Frankland

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible
1	The Governor should ensure that there are appropriate arrangements to take prisoners to hospital appointments and that prisoners do not miss appointments unless there are properly justified, exceptional and fully recorded reasons.	Accepted	This requirement will be explained fully to all new and existing staff to ensure that prisoners do not miss hospital appointments unless there is an exceptional reason, and that in the event that this happens, reasons for the decision are recorded. Any decisions to alter hospital appointments will only be made after full discussion between Security and Healthcare. Where the clinical indication and Security recommendations do not align, a decision will be made by the Governor in charge of the prison.	30 April 2015 The Governor Head of Security Head of Healthcare
2	The Governor and Head of Healthcare should ensure that prisoners with serious illnesses receive an appropriate diet to meet their needs without delay.	Accepted	The new Athena Menu Management system will enable the catering department to manage special diets more effectively as the new system has the facility to set up special diets restricting food groups or highlighting meals which are for instance, high in protein and low in fat. The Athena system will also keep a thorough record of the meals and the supplements provided to offenders. Dietary requirements will be passed to catering department via the F35 system and liaison continues for all those on the palliative care register.	31 March 2015 The Governor Head of Healthcare Head of Residence
3	The Governor should ensure that the control room calls an ambulance as soon as an emergency medical code is	Accepted	Medical Emergency response codes are in place and in line with PSI 03/2013. A notice to staff has been re-issued and published to inform all staff of this instruction and their	Completed The Governor, Head of Operations

	broadcast.		responsibilities during medical emergencies. Emergency Control Room staff have been briefed in relation to their actions/response if a medical emergency (code red or blue) is called and a copy of the instruction is placed on the Control room desk. A global email has also been sent to all Frankland staff outlining the protocol in a brief and easy format.	
4	The Governor should ensure that staff receive sufficient guidance and training to understand the benefits of immediate cardiopulmonary resuscitation (CPR) for a prisoner who is not breathing and that CPR should be started, unless there is clear evidence that it would be futile in the circumstances.	Accepted	In October 2014, the British Medical Association, RCN and Resuscitation Council issued new guidance on making decisions about attempting cardiopulmonary resuscitation (CPR). NOMS Equality, Rights and Decency Group is due to meet with NHS England colleagues in early 2015 to discuss the guidance, after which a note will be issued to prison staff. Following this, the Governor and Head of Healthcare will then draft clear guidelines for staff about the circumstances in which resuscitation is appropriate. This will be reiterated to staff via Notice to Staff and emphasised through Safer Custody Meetings.	30 April 2015 NOMS ERDG The Governor Head of Healthcare
5	The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on	Accepted	All risk assessments will be carried out in line with the Graham judgment. Risk assessments for prisoners taken to hospital are now based on a consideration of the individual's circumstances and the actual risk the prisoner presents at the time. There is an underpinning regard to not only the individual's risk of escape but also their	30 April 2015 The Governor Head of Security Head of Healthcare

	the actual risk the prisoner presents at the time.		risk to the public. Risk assessments for prisoners in hospital are dynamic and the use of restraints is reviewed, as necessary, to take into account any significant changes in circumstances. Specific ongoing consideration is given to medical opinion as to the use of restraints and the prisoner's condition and treatment, with reductions in the level of restraint as necessary. Such reviews form not only part of the daily management check, but are conducted on the basis of continuous assessment of risk by the escorting staff in attendance. Subsequent management checks will also review the condition of the prisoner to establish if there has been and deterioration and this will be reflected in the commentary on the document. This requirement will be explained fully to all new and existing staff to ensure that prisoners do not miss hospital appointments unless there is an exceptional reason, and that in the event that this happens, reasons for the decision are recorded.	