



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in April 2014 at
HMP Doncaster**

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 the man, who died in April 2014 at HMP Doncaster. He was 62 years old. The man died of bronchopneumonia and pleurisy. I offer my condolences to the man's family and friends.

The investigation was carried out by an investigator. A clinical reviewer reviewed the clinical care the man received at HMP Doncaster. The prison cooperated fully with the investigation.

The man was sentenced to ten years and six months in prison in April 2013 and sent to HMP Doncaster. He had complex medical needs, particularly as he had been treated for throat cancer in 2008. As a result, he was fitted with a breathing tube (tracheostomy), which he managed himself.

Healthcare staff saw the man frequently. While aspects of his clinical care were satisfactory, the clinical reviewer has identified a number of areas for improvement. The man did not always receive his medication as prescribed and he was not assessed or his care plans updated after he returned from hospital in December 2013 and April 2014. There was also a lack of information in his medical record which resulted in a delay in obtaining important parts to help him manage his tracheostomy.

I am also concerned that the prison was unable to provide my investigator with all relevant risk assessments regarding the use of restraints on the man. However, it is clear that he was restrained inappropriately for his last hospital admission when he was very sick and had very limited mobility. I have, therefore, repeated a previous recommendation about the inappropriate use of restraints on seriously ill prisoners at Doncaster.

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

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SUMMARY

1. The man was sentenced to ten years and six months in prison for sexual offences on 15 April 2013 and sent to HMP Doncaster. During his initial health screen, the man said he had some mental health problems and was generally unwell; he had not misused alcohol or drugs. He said that he had been treated for throat cancer in 2008 and it was noted that he had a tracheostomy tube (for breathing) which he looked after himself.
2. From April until November 2013, healthcare staff saw the man on several occasions for various medical conditions, including his mental health. He had a care plan which was regularly updated by healthcare staff. He self managed his tracheostomy and had a nebuliser to ease his breathing. On occasions, he complained that his pain management was not effective. Records show that he did not always receive his medication on time or as prescribed.
3. On 24 December 2013, the man attended hospital for day surgery, but was admitted to hospital following concerns that he might have a perforated lung. The following morning, a scan found that he had fluid near his lungs, but the man discharged himself against medical advice.
4. On 26 December, a nurse saw the man, but there is no evidence that she completed any form of an assessment or that a new care plan was started.
5. In March 2014, his hospital consultant told the man that the fluid seen next to his lung (pleural effusion) needed investigation to see if this was connected to his previous cancer.
6. The man was admitted to hospital on 2 April for diagnostic tests. He had a chest drain and X-rays were completed. He returned to prison the following day. There is no record that healthcare staff saw or assessed him until that night when a nurse gave him his medication. The nurse told us that the man appeared alright at that time.
7. At 9.10am on 5 April, an officer found the man unresponsive in bed, she called an emergency code and attempted resuscitation. Healthcare staff and officers attended and continued attempts to resuscitate the man. Paramedics attended and pronounced him dead at 9.30am.
8. We agree with the clinical reviewer that, while aspects of the man's healthcare at Doncaster were satisfactory, there were also areas requiring significant improvement, specifically in the prescribing and administering of medications, the updating of care plans and management of prisoners with particular clinical needs, and record keeping. We are also not satisfied that the use of restraints when the man went to hospital was always justified. We make six recommendations.

THE INVESTIGATION PROCESS

9. The investigator issued notices to staff and prisoners at HMP Doncaster informing them of the investigation and inviting anyone with 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. On 20 May, she interviewed seven members of staff at Doncaster. The investigator gave the duty operational manager initial feedback on the preliminary findings of the investigation.
11. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.
12. We informed HM Coroner for South Yorkshire of the investigation, who provided the cause of death. We have sent the Coroner a copy of this investigation report.
13. One of the Ombudsman's family liaison officers contacted the man's family, to explain the investigation and offered to meet with the family to discuss any concerns they may have had. The family liaison officer and the investigator met the man's family on 23 June 2014. The man's family said they were unhappy with the medical care he received and they raised a number of concerns:
 - They were concerned that he was not provided with the correct equipment and medication for his tracheostomy which led to infection and restretching of the hole in his throat.
 - The man's family were concerned that the prison did not take account of his poor hearing and at times he did not fully understand what was being said. They were concerned this affected his consultations with the doctor and receiving medication. The man's family were also concerned he was not appropriately informed or prepared for tests on his hearing aids.
 - The man's family asked what medical care he received, whether this was appropriate and whether he missed any of his prescribed medication.
 - They also asked what time was he last checked on 4/5 April.
14. The man's family received a copy of the draft report. They raised a number of issues and questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

HMP & YOI DONCASTER

15. HMP &YOI Doncaster is a Category B local prison which can hold up to 1,145 adult and young men. The prison is managed under contract by Serco Home Affairs. NHS Nottinghamshire Trust provides healthcare. The prison contains its own in-patient facility and has both mental health and substance misuse teams.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Doncaster was in March 2014. The Inspectorate noted that some aspects of health care were good, but the overall service was marred by gaps and delays in the administration of medicines, flawed applications and complaints procedures and rude and unprofessional behaviour by a few of the nursing staff. Clinical governance arrangements were generally good. Waiting times for clinics were short and attendance rates were good.

Independent Monitoring Board

17. 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 September 2013, the Board noted that Nottinghamshire NHS Trust had vastly improved its procedures and this was reflected across the prison. The IMB was satisfied that prisoners received appropriate healthcare.

Previous deaths at HMP Doncaster

18. The man was the third prisoner to die at Doncaster from natural causes since the start of 2012. We have raised the issue of the unjustified use of restraints before.

KEY EVENTS

19. On 15 April 2013, the man was sentenced to ten years and six months in prison for sexual offences and sent to HMP Doncaster.
20. During his initial health screen, the man said he was a light cigarette smoker, had never misused alcohol or drugs and was generally unwell. The nurse noted he was diagnosed and treated for throat cancer in 2008 and he had a tracheostomy tube which he managed himself. The man said he had outstanding hospital appointments and needed a lot of medication to manage his condition.
21. On 17 April 2013, a nurse saw the man who said that his pain relief medication had been reduced since arriving in prison. He said he was feeling depressed and the nurse referred him to the mental health team. Later the same day, a mental health nurse saw the man who said that he was feeling depressed. He also explained that he cleaned his tracheostomy himself and needed an adhesive remover and rubber bungs to maintain the airway, which were provided.
22. Records show that the man had a history of depression and had attempted to take his own life in 2012. During his time at Doncaster he was seen regularly by the mental health team and was monitored using the prison's suicide and self-harm monitoring process (known as ACCT) on a number of occasions.
23. On 18 April, a prison GP reviewed and increased the man's pain relief.
24. The man needed to receive medication three times a day at regular intervals and healthcare staff saw him frequently to administer this. In May, a pharmacy technician, noted that there was a supplier problem with obtaining some pain relief patches and it took several days to get these.
25. On 17 June, records show the man attended a local clinic for a hearing test. nurse saw him and she said he was disgruntled about not being told where he was going. She explained that this was normal practice and was for security reasons.
26. The nurse met the man on Friday 26 July to administer his afternoon medication and he complained that he was in pain because he did not receive his medication at regular intervals and had not received it for five days. The nurse agreed with the man that nurses should be more careful about him receiving his medication on time to ensure it was effective. She told her manager who reminded staff of the importance of issuing his medication on time. She noted the man's prescription had expired and left a note for the doctor to write up a prescription on the Saturday, but this did not happen until the Monday (29 July). There was a further delay as the prescription was not sent to the pharmacy until the following day.
27. The nurse noted during August that, although the man's was receiving his medication, the times had slipped. On six occasions in October, the nurse

noted that she was unable to administer his medication because the man was sleeping and would not wake up.

28. For six days from 11 October, the man was missing a stoma button (a valve to ease breathing for his tracheostomy tube). The name of the replacement part was not noted in the man's record and he was unable to remember it, so healthcare staff spent several days making enquiries before ordering the new part. The man said that he was struggling to breathe but a nurse noted that there was no evidence of respiratory distress or breathing difficulties.
29. On 17 October, a prison GP tried to fit the replacement stoma button, however he said that it did not fit correctly. He spoke to hospital staff who said the hole in the man's throat would need repuncturing at hospital. The following day the man went to hospital and the procedure was completed. On return to the prison, the escorting officers told a nurse that the hospital were still not happy with the fit and the man might have to return to hospital.
30. On 24 December 2013, the man was admitted to Royal Hallamshire Hospital, Sheffield, for a procedure related to his tracheostomy. He underwent a scan that showed he had fluid on his lungs and he was told he needed antibiotics. However, on Christmas day, he was escorted back to prison after discharging himself against medical advice. A doctor completed the hospital discharge summary. She said he had a pleural effusion and pneumonia which required further investigation and treatment with antibiotics. The doctor said that she had warned the man that if he refused to stay in hospital he risked respiratory failure that could lead to death, but he said he wanted to take the risk and was discharged without any medication. There is no record of why he chose to discharge himself. The following morning, a nurse saw the man and removed a flexible tube that had been left in his arm by the hospital. However, there is no evidence that she assessed the man any further or reviewed his care plan. There is also no evidence that healthcare staff monitored the man for any breathing difficulties.
31. On 3 January 2014, a locum GP referred the man to the hospital for an appointment with the hospital respiratory physician for further investigation as advised in the doctor's letter. A consultant physician in respiratory medication at Doncaster Royal Infirmary, a doctor wrote to the prison on 14 February to say that the man's X-ray had raised suspicions of lung cancer and a chest clinic appointment would be made for him. However, there is no information in his medical record of when he went for this X-ray.
32. A hospital respiratory physician saw the man on 19 March at the Royal Hallamshire hospital. He told him that the fluid on his lungs could be linked to his previous cancer and further investigations were needed.
33. The man was admitted to hospital on 2 April, and underwent a procedure to check and drain the fluid from his lungs. He was restrained using double handcuffs for the trip to the hospital and an escort chain at the hospital (double cuffs are when the prisoner's hands are cuffed in front of him and one wrist is attached to a prison officer by an additional set of cuffs. An escort

chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer).

34. The hospital discharged the man back to prison with antibiotic medication on 3 April. There is no record of anyone from healthcare seeing him until 10.51pm when a nurse administered his medication. During his interview with the investigator he said that he had no concerns about the man at that time.
35. At about 8.40pm on 4 April, a nurse saw the man to give him his night medication. The officer accompanied him and said the man told the nurse he was sore and stiff but okay. At about 10.40pm, the nurse gave the man his medication through the cell hatch (the prison was in night state, which means that cell doors should not be opened unless there is an emergency). He told us that he had no concerns about the man that night.

Events on 5 April

36. At approximately 7.00am, an officer unlocked the man's cell and told us that she saw him on his bed dressed and apparently asleep. She said from her knowledge of the man, he often woke at around 6.00am, dressed himself and would then return to sit upright on his bed. She said very often he would doze off in this position, so she was not concerned.
37. The officer returned to the man's cell at about 9.10am to get him up for his medication. She told us she knocked on the cell door but there was no response, she went over to shake him and then realised his hand was discoloured and cold. The officer called a code blue (an emergency code meaning a prisoner is unresponsive or not breathing) and started chest compressions. She tried to clear the man's tracheostomy to begin mouth to throat resuscitation but was unable to adjust him on the bed so she continued with the chest compressions until healthcare staff arrived. She said that she did not know about resuscitation for someone with a tracheostomy or that there was a suction kit kept in an emergency bag in healthcare to be used.
38. Two nurses arrived at the man's cell just after 9.10am. A nurse had the emergency medical response kit with her which contained a suction machine for clearing the man's tracheostomy tube. Both nurses could find no signs of life and assessed that resuscitation was not appropriate. Paramedics arrived at 9.19am and the nurses gave a history of the man's condition. Paramedics pronounced the man dead at 9.30am.

Liaison with the man's family

39. At 11.15am, a prison family liaison officer visited one of the man's daughters to break the news of his death and offer support. His family visited the prison on 14 April.
40. The man's funeral was held on 2 May, the prison offered a financial contribution in line with national guidelines.

Support for staff and prisoners

41. Staff and prisoners were informed of the man's death by a Director's notice which offered support to anyone affected. The interim deputy director, held a debrief for all staff involved in the incident. Officers and healthcare staff told the investigator that they had felt well supported. Prisoners at risk of suicide or self-harm were reviewed and checked in case they had been affected by the man's death.

Post-mortem

42. A post mortem report concluded the man died of bronchopneumonia and left sided pleurisy.

ISSUES

Clinical Care

43. The clinical reviewer concludes that, from April 2013 until his hospital admission in December 2013, the man's physical health appeared to be stable and that many aspects of his healthcare were satisfactory. For example, he was supported by healthcare staff to be self caring and independent and he received good support from mental health services. The man also attended his hospital appointments and was referred in a timely manner to the appropriate specialist consultant teams when his physical health deteriorated. However, we agree with the clinical reviewer that there were also areas for significant improvement, specifically there were inadequacies in the management of the man's prescribed medication; nursing plans were not always appropriately updated; and record keeping was deficient.

Prescribed medication

44. The clinical reviewer notes that, on occasions, the man did not receive his medication at the prescribed times and that it is important that medication is taken regularly to ensure appropriate dosage. In July 2013, the man complained that he had not had medication for five days. Only then was it noted that his prescription had expired and he could not have his medication until a new prescription was written up. His medication was further delayed because it was the weekend and, despite a note for a GP to write a prescription on Saturday morning, it was not completed until the Monday. On another occasion, it took several days to gain a supply of the analgesic medication needed by the man. This is not acceptable.
45. There needs to be a robust system in place to ensure that prisoners receive their medication in a timely manner and in accordance with their prescription. We note that this was also a matter raised by HMI Prisons in their recent report and about which they made a recommendation. We make the following recommendation:

The Head of Healthcare should ensure that there are no delays in prescribing medication and prisoners receive their medication in a timely manner and as prescribed.

Healthcare plans

46. On 24 December 2013, the man was admitted to hospital for a day procedure, but was kept in due to concerns that he may have a perforated lung which needed investigation and treatment with antibiotics. However, the man discharged himself against medical advice and did not receive the antibiotics. The discharge letter said he should be monitored for shortness of breath. A nurse saw him the following morning, but there is no evidence that she assessed him any further or reviewed and updated his care plan. There is no evidence that healthcare staff monitored the man for shortness of breath. On

3 April, after the man returned from hospital once again there is no evidence of any healthcare assessment or review. We make the following recommendation:

The Head of Healthcare should ensure that prisoners returning from hospital are assessed and healthcare plans appropriately reviewed and updated.

Record keeping

47. The man had complex medical needs and the clinical reviewer is satisfied that until December 2013, there were some good entries in his SystmOne record (computerised medical record), which showed an initial assessment and a care plan, which was implemented. After December 2013, entries are sparse with little detail.
48. The clinical reviewer also found that there was no information in the record of the type of tracheostomy, size and details of any replacements parts. Considering this was an important piece of equipment for the man, it should have been noted. Unfortunately, when the man lost the stoma it took eight days for a replacement because this information had not been recorded. We make the following recommendation:

The Head of Healthcare should ensure that all healthcare staff fully adhere to the requirements for accurate and contemporaneous record keeping in accordance with the required standards of the General Medical Council and Nursing and Midwifery Council. Also, that all information regarding the management of a prisoner's specific medical condition is recorded in the SystmOne record.

Emergency response

49. When the man was found unresponsive on 5 April, the officer had basic first aid training and did her best in attempting resuscitation with the man's tracheostomy tube. Healthcare staff had not given any information to wing staff about the man's tracheostomy or what to do if there was a medical emergency. Nursing staff were aware that the suction machine for clearing the tube was in a medical emergency bag in healthcare and this should have been accessible to wing staff who should have been trained to use it in the event of an emergency. We make the following recommendation:

The Head of Healthcare should ensure that there is a system in place for officers to be informed of any special health care needs or risks for prisoners and appropriate emergency equipment and training is made available.

Restraints, security and escort assessment

50. 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.

51. Full documentation was only available for the last hospital admission. Despite a request for copies of all escort risk assessments to be sent to the investigator, we were not provided with all the risk assessments/ bed watch logs prior to April 2014. It is a requirement of Prison Service instructions and essential to independent investigation that all relevant documents are made available to the Ombudsman, so that there is an accurate chronology of events and transparency and assurance regarding the treatment of prisoners.

The Director should ensure that escort risk assessments for all hospital visits are completed, retained and available to the investigation as outlined in PSI 58/2010.

52. In his categorisation assessment, the man was a category B prisoner and, on 1 April 2014, a risk assessment was completed to consider the man for category C status. The assessment noted he did not have any alcohol or drug dependency issues, was assessed as low risk to the public, known adult and staff. Medium risk to children and had disability needs.
53. Before this could be considered, the man was taken to hospital on 2 April. The escort risk assessment said he was a medium for risk in all areas (to the public due to the nature of his offence, escape potential, risk of hostage taking, outside assistance and history of violence). He was also assessed as medium risk for known instances of drug or alcohol abuse and with a previous escape/abscond history. However, the man did not have any history of previous escapes or absconds and there were no known instances of alcohol or drug abuse. The security section of the risk assessment said that there were unresolved domestic issues which indicated a desire to escape but we could find no evidence of this.
54. The medical part of the risk assessment noted that there were no medical objections to restraints being used, but did not say whether his condition impacted on his risk of escape as required by the 2007 High Court judgement. The healthcare assessment was completed by a healthcare administrator. She told us that she had been told by security that "no medical concerns are ever raised on the form". However, the security manager denied this. An

operational manager authorised the use of double cuffs en route to the hospital and an escort chain on arrival. He also said that handcuffs should only be removed when the man was under anaesthetic and a manager should be informed.

55. Double cuffing entails the prisoner having his hands cuffed in front of him and then having one wrist attached to a prison officer by an additional set of handcuffs. This is usually required for moving category A or category B prisoners in good health. We can find no evidence to support this decision on such a seriously ill prisoner and no evidence that there was any consideration of how his health condition impacted on this risk. The manager told us that the man was a category B, long term sex offender and that Prison Service instructions required that the restraints to be used were double cuffs. However, advice for prisons is outlined in 'Prisoner Escort and Bedwatch Function', an agreement between the National Offender Management Service (NOMS) and the NHS. The agreement notes that using restraints on terminally or seriously ill patients should be considered inhumane except when justified by security considerations. It goes on to say:

"Levels of restraints used on prisoners must at all times be proportionate to the perceived security risks and be balanced by consideration of care and decency for the prisoner."

56. At this time, the man was in very poor health and could not walk very far unaided. The Prison Service has a responsibility to protect the public, but security must be balanced with humanity and measures must be proportionate to a prisoner's individual circumstances. We are not satisfied that the risk assessments fully took into account the man's risk and condition at the time. There was insufficient healthcare input into the risk assessment on 2 April and we are concerned that this appears to have been completed by a healthcare administrator and not a clinician. It is not sufficient for healthcare staff simply to say that there are no medical objections to the use of restraints. There needs to be active consideration of how a prisoner's health and mobility impacts on his risk of escape as required by the 2007 High Court judgement. Ultimately, it is the Director's responsibility to ensure that the process is managed properly, but the Head of Healthcare needs to ensure that healthcare staff understand their responsibilities and have appropriate input into the risk assessment process. We make the following recommendation:

The Director and Head of Healthcare should ensure that 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.

Family concerns

57. The man's family were concerned that the prison did not take into account his poor hearing. They were concerned this affected his consultations with the

doctor and receiving his medication. They were also concerned that he was not appropriately informed or prepared for tests on his hearing aids.

58. We are satisfied that the prison were aware of the man's poor hearing and that he attended clinic appointments for his hearing aids. Records indicate that on one occasion he was irritated because he had not known about an appointment in advance, but a nurse explained that advance notice was not possible due to security arrangements.
59. Records show the man frequently discussed his concerns, particularly about his medication, with healthcare staff and there is no indication that he had any difficulty understanding or making himself understood.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that there are no delays in prescribing medication and prisoners receive their medication in a timely manner and as prescribed.
2. The Head of Healthcare should ensure that prisoners returning from hospital are assessed and appropriate updated healthcare plans put in place, including for recording observations.
3. The Head of Healthcare should ensure that all healthcare staff fully adhere to the requirements for accurate and contemporaneous record keeping in accordance with the required standards of the General Medical Council and Nursing and Midwifery Council. Also, that all information regarding the management of a prisoner's specific medical condition is recorded in the SystemOne record.
4. The Head of Healthcare should ensure that there is a system in place for officers to be informed of any special health care needs or risks for prisoners and appropriate emergency equipment and training is made available.
5. The Director should ensure that escort risk assessments for all hospital visits are completed, retained and available to the investigations as outlined in PSI 58/2010.
6. The Director and Head of Healthcare should ensure that 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

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible
1	The Head of Healthcare should ensure that there are no delays in prescribing medication and prisoners receive their medication in a timely manner and as prescribed.	Accepted	A system and process review of medicine management has been carried out. A new process has been developed and was implemented on 15/08/14. All medicines are now ordered and overseen at the point of reception by the Pharmacy technician.	Completed Head of Healthcare, Nottinghamshire NHS
2	The Head of Healthcare should ensure that prisoners returning from hospital are assessed and appropriate updated healthcare plans put in place, including for recording observations.	Accepted	A standard operating procedure has been developed to direct all Clinicians about the procedure that needs to be followed when patients return from Hospital. This process incorporates updating care plans, ensuring the discharge letter is received and scanned onto the patient's clinical record, and making a timely and appropriate record of the patient's clinical needs upon their return to the establishment.	Completed Head of Healthcare, Nottinghamshire NHS
3	The Head of Healthcare should ensure that all healthcare staff fully adhere to the requirements for accurate and contemporaneous record keeping in accordance with the required standards of the General Medical Council and Nursing and Midwifery Council. Also, that all information regarding the management of a prisoner's specific medical condition is	Accepted	All staff are trained in Information Governance, and annual updates of this are mandatory. Medical records are also audited annually by the Trust's Clinical Audit Team. Additional audits are completed by the Clinical Matron, with any omissions or failings being reported through the Trust's Incident Reporting system. Incidents are reviewed by the Head of Healthcare and any performance issues that are identified are managed through the Trust's performance management policy.	Completed Head of Healthcare, Nottinghamshire NHS

	recorded in the SystmOne record.			
4	The Head of Healthcare should ensure that there is a system in place for officers to be informed of any special health care needs or risks for prisoners and appropriate emergency equipment and training is made available.	Accepted	<p>Special healthcare needs or risks are shared with staff in accordance with Data Protection and the Information Governance Policy.</p> <p>Information pathways exist within ACCT support, Cell Sharing Risk Assessments, Prison NOMIS, Multi Agency Public Protection Arrangements, Multi Agency Risk Assessment Planning, Interdepartmental Risk Management Teams, and Security Information Sharing.</p> <p>Emergency equipment is maintained weekly and a log is completed for audit purposes. All NHS staff are fully trained in the use of automatic external defibrillators and life support principles.</p>	<p>Completed</p> <p>Head of Healthcare, Nottinghamshire NHS</p>
5	The Director should ensure that escort risk assessments for all hospital visits are completed, retained and available to the investigations as outlined in PSI 58/2010.	Accepted	Records of all escorts and bedwatch risk assessments and visits are retained and available for inspection.	<p>Completed</p> <p>Assistant Director Secure Operations, HMP Doncaster</p>
6	The Director and Head of Healthcare should ensure that 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.	Accepted	<p>A new standard operating procedure was implemented on 08/09/14. Clinical staff now attend Reception at the point of discharge for all patients. The risk assessment is only endorsed when signatures assure that the patient's clinical needs have been appropriately assessed and all risk indicators have been considered.</p> <p>Risk assessments for restraints are then undertaken and reviewed as and when medical staff advise that a prisoner's medical condition has changed.</p>	<p>Completed</p> <p>Head of Healthcare, Nottinghamshire NHS, Director</p>

