A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

Investigation into the death of a man in April 2012 while in the custody of HMP Elmley

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 report of the investigation into the death of a man in April 2012, at HMP Elmley. He was 65 years old. The man died of a heart attack, with diabetes as a contributing factor. I offer my condolences to his family and friends.

An investigator carried out the investigation and a clinical reviewer conducted a review of the man's clinical care in custody. Elmley cooperated fully with the investigation. I apologise that the report has been delayed.

When the man went into prison in May 2011, he had a number of physical health problems including diabetes, heart disease, arthritis, high blood pressure and cholesterol. He was very overweight and this, combined with poor mobility, meant he led a sedentary life. The man collapsed while talking to his cell mate on Sunday 22 April. Officers and nurses went to his cell and quickly started cardiopulmonary resuscitation. They used a defibrillator, which gave several shocks, but he did not recover.

The clinical reviewer considered that, overall, the man's care was comparable to that which he could have expected in the community. However, we have identified the need for some improvements in the management of prisoners with complex medical conditions. Prison staff carried out the resuscitation attempts professionally, but there was an unnecessary delay in allowing ambulance staff into the prison. We cannot know whether this would have affected the outcome in the man's situation but it is vital to get trained paramedics to a patient quickly in a life-threatening situation.

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Prisons and Probation Ombudsman **March 2014**

CONTENTS

Summary	5
The investigation process	6
HMP Elmley	7
Key events	8
Issues	13
Recommendations	17

SUMMARY

1. On 6 May 2011, the man received a 17 year prison sentence and was taken to HMP Elmley. He had a lot of physical health problems including diabetes, cardiovascular disease, as well as mobility and hearing difficulties. His blood pressure was high and he was prescribed a range of drugs to help treat and control his medical conditions. The man was very overweight, at 22st 7lbs he was ten stones over his ideal bodyweight.

2. At the end of August, the man had a blood test (Hb1Ac) to determine how well his diabetes was controlled. The results showed that his average plasma glucose was well above the level generally accepted as an indicator of good control. The prison GP asked for the man to see the diabetes nurse as soon as possible but there is no evidence that this happened. His next general diabetic check was at the end of October. An Hb1Ac test was repeated on 7 December and still showed very high levels.

3. In December 2011, the man reported a recurrent chest infection. He was prescribed antibiotics, but his symptoms continued and, on 13 January, the GP ordered a chest X-ray. Four appointments during January and February were made but on each occasion the man did not turn up. Staff did not find out why. When the man's SystmOne record was checked, we found he had missed a total of 18 medical appointments. Healthcare staff at Elmley told us that a number of prisoners had complained that they had not been informed of appointments by wing staff and the prison has since introduced new monitoring arrangements. We make a recommendation about recording missed appointments.

4. On Sunday 22 April 2012 at 3.45pm, the man collapsed in his cell. His cell mate called for staff and two officers responded. One of the officers checked to see if the man was breathing and if he had a pulse, while the other officer radioed for healthcare staff to attend. The officers started chest compressions which were continued by the nurses. An ambulance was not called until one of the nurses arrived at the cell after a further few minutes. There was then an unacceptable delay in allowing the paramedics into the prison as gate staff carried out searches and asked for some equipment to be removed. We make recommendations about the need for emergency ambulances to be called without waiting for healthcare staff to attend and for ambulance staff to be given immediate access to prisoners in potentially life-threatening situations.

THE INVESTIGATION PROCESS

5. The Ombudsman's office was notified of the man's death on 22 April 2012. The investigator issued notices informing staff and prisoners of the investigation and asking them to contact her with any relevant information. No one responded.

6. The investigator visited Elmley and met members of the prison management team and staff involved in the man's care. She also obtained copies of the man's medical and prison records. Eastern and Coastal Kent Primary Care Trust (PCT) appointed the clinical reviewer to review the clinical care the man received. The clinical review is annexed to this report.

7. The investigator returned to Elmley with the clinical reviewer on 24 and 27 July, to interview staff and the man's cell mate, The man's cell mate.

8. Her Majesty's Coroner for mid-Kent was informed of the investigation and she provided a copy of the post-mortem report. A copy of this report has been sent to the Coroner.

9. One of the Ombudsman's family liaison officers, contacted the man's family to explain the purpose of the investigation. They did not identify any specific issues for the investigation.

10. We are sorry for the delay in issuing this report which was due to a backlog of cases which we are striving to clear, compounded by staffing changes during the course of the investigation.

HMP ELMLEY

11. HMP Elmley is part of the Sheppey group of prisons, which includes HMP Standford Hill and HMP Swaleside. Elmley serves courts in Kent and holds both remanded and sentenced adult men, as well as unsentenced male young adults between 18-21 years. It can hold more than 1,200 prisoners in five houseblocks, with a mixture of single, double and triple cells.

12. Eastern and Coastal Kent PCT commission healthcare services at Elmley at the time of the man's death. The healthcare centre includes a 29-bed inpatient unit. Two of the houseblocks have treatment rooms where consultations can take place.

13. Full time prison carers are employed to support prisoners who are not fully able to care for themselves because of age or disability. Emergency resuscitation equipment, including automated external defibrillators, are available in the healthcare centre, as well as on houseblocks one and three.

HM Inspectorate of Prisons

14. The Inspectorate of Prisons last conducted an announced inspection of HMP Elmley in March 2012. Overall, their findings were positive and they assessed the prison as a reasonably safe place.

15. The Inspectorate found that health care provision was good, but there was too much reliance on agency staff to address staff shortages. Prisoner perception of healthcare was poor. Access to services, apart from dental and physiotherapy, was good.

Independent Monitoring Board (IMB)

16. Each prison in England and Wales has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. In their report for 2012, the IMB reported that healthcare was going through a difficult time because of a change in the health provider. The IMB noted that more GP sessions were needed to prevent prisoners waiting too long to see the doctor.

Previous deaths at Elmley

17. There have been four previous deaths from natural cause deaths at Elmley in the past two years. In one of these cases, we found that non attendance at medical appointments was also a problem and that the reasons for missed appointments were not recorded on the prisoners' medical records. We made a recommendation about the need to record the reasons why prisoners did not attend appointments and what treatment had been missed.

KEY EVENTS

18. The man was convicted of serious offences and sentenced to 17 years imprisonment on 6 May 2011, at Canterbury Crown Court. He was taken to HMP Elmley. In reception, a nurse noted that the man was 64 years old and it was his first time in prison. The nurse did not think the man had any mental health problems but made a note of several physical health problems, including diabetes, bad back, coronary heart disease, replaced knee and arthritis. The man was mobile with the use of crutches and wore two hearing aids. He told the nurse he had a heart murmur and suffered with kidney stones. The man was admitted to the prison's in-patient unit so that his physical health could be assessed.

19. The next morning, a doctor saw the man. His blood pressure was 160/75mmHg which was high. (A blood pressure record of greater than 140/90 is classed as high). The doctor noted that he had not had his medication that morning. The man's major health condition was noted as diabetes. The doctor sought information from the man's community GP and prescribed the following medications:

- omeprazole (for indigestion);
- rosuvastatin (to treat high cholesterol and prevent cardiovascular disease);
- tramadol (pain killer);
- amitriptyline (an antidepressant);
- amlodipine (to treat high blood pressure and angina);
- furosemide (for hypertension and oedema – abnormal accumulation of fluid);
- lantus, metformin and glimepiride (all used to treat diabetes); and
- irbesartan (for high blood pressure).

20. On 8 May, the clinical team manager wrote that the man had alcohol dependency syndrome and that he should be monitored closely by staff. A secondary health screen noted the man was overweight at 22st 7lbs. His ideal body weight was 12st. The man left the in-patient unit on 16 May and went to live on houseblock one in the Vulnerable Prisoner Unit.

21. At an annual diabetes check with a nurse on 19 August, the man's weight was 22st 4lbs. His blood pressure was 140/80 mmHg. His HbA1c was noted to have been 8% in May. (HbA1c identifies average plasma glucose concentration which is tested to measure how well diabetes is under control. For non-diabetics the usual reading is 4-5.9%. For people with diabetes an HbA1c of under 6.5% / 48mmol/mol is considered good control). The man's next HbA1c result at the end of August had gone up to 9.2%. This represents poor glycaemic control. The doctor wrote that the man should see the diabetes nurse as soon as possible. There is no entry in his medical record to show that an appointment was made for the man to see the diabetes nurse. His next diabetic management check up was not until 31 October.

22. A podiatrist saw the man on 6 September. After complaining of very hot feet on 25 September, the nurse referred the man 'urgently' to the podiatrist again.

However, there was no subsequent podiatric appointment until December. The man did not attend this appointment.

23. A nurse reviewed the management of the man's diabetes on 31 October. His weight had increased to 22st 7lbs the nurse discussed diet and exercise with him. The man said he could not walk very much because of his painful degenerating knees (for which he took tramadol). The nurse noted his high HbA1c result and advised the man to walk as much as he could.

24. At a clinic for hypertension and weight management held on 21 November, an officer noted that the man could not attend the gym because of his medical problems and that he had a family history of high blood pressure. His blood pressure reading was 168/48 mmHg.

25. The doctor recorded that the man's HbA1c result was 83mmol/mol (over 9%) on 7 December. This indicated his diabetes continued to be poorly controlled.

26. On 15 December, the man told a doctor that he had a history of recurrent chest infections, lasting from four weeks to four months and if antibiotics and steroids did not work, he was admitted into hospital. He complained of a cough for the past five days and increased shortness of breath. The doctor prescribed an antibiotic and decided to review the situation in February. He thought the man might have chronic obstructive pulmonary disease (COPD) – a disease where the airways of the lung narrow over time causing shortness of breath. The doctor told the man to make another appointment if his symptoms got worse. The next day, the man saw a doctor and told her his chest was getting worse. She took observations and noted no shortness of breath or cyanosis (blue discolouration of the skin). The man said he could not sleep well and asked for sleeping tablets. She prescribed him Kalms (a natural remedy to aid sleep) for three nights.

27. The doctor saw the man on 27 and 30 December for a persistent cough and oedema (swelling due to the build up of fluid in tissues) in his legs. She noted that his chest was clear, there was no collapse or cyanosis and no shortness of breath. She prescribed antibiotics. The doctor considered his circulation was compromised and that he had mild pitting oedema in both ankles. When interviewed, the doctor said she decided to increase his furosemide and felt the swelling could have been due to several things, including heart failure. A nurse saw the man on 13 January 2012 because he was still complaining of a cough, despite the antibiotics. The nurse consulted the doctor, who ordered a chest X-ray as the cough had persisted for weeks.

28. The appointment for a chest X-ray was on 19 January, but the man did not attend. The reason for his non-attendance was not followed up and the appointment was re-booked for 26 January. The doctor saw the man again on 23 January because of his continuing cough. She noted that the chest X-ray had not been done and told him the new date. The man did not attend the healthcare centre for his chest X-ray on 26 January. Again, staff did not follow up the reason but another appointment was made for 2 February.

29. A doctor reviewed the findings of previous tests and diagnosed mild chronic obstructive pulmonary disorder (COPD) and prescribed inhalers on 2 February. Despite having an appointment in the X-ray clinic that day and having seen the doctor in the healthcare centre, the medical record indicates that the man did not attend for his X-ray. He did not attend the fourth X-ray appointment either on 9 February. No follow up was done and no subsequent appointments were made for a chest X-ray.

30. On 2 March, the nurse recorded that the man's diabetes was poorly controlled and that a referral would be made to the diabetic specialist nurse. The nuurse took medical observations of the man on 6 April and noted his weight to be 22st 4lbs and that his BMI had not fluctuated very much since August 2011. The diabetes nurse had asked for his BMI history in order to decide whether to continue prescribing (exenatide – an injection administered under the skin to help regulate glucose metabolism and insulin secretion).

31. Staff in the vulnerable prisoners' unit, where the man lived for most of his time at Elmley, said he was not wheelchair-bound, but was disabled as he needed a walking stick to move about. His cell was on the ground floor (called the one's landing) and had been adapted for wheelchair use. A nurse brought his medication to him in his cell so that he did not have to go upstairs to collect it. He also had a prisoner carer to help him with basic needs such as collecting meals and keeping his cell clean.

32. The man and his cell mate got on well together and had shared a cell for over a year. They spent time watching television, talking and reading. The man's cell mate said the man sometimes walked around the houseblock a little, using two crutches. The man's cell mate said that the man slept a lot including during the day.

33. Two officers were on duty during the day on Sunday 22 April. The man had stayed in bed for a while that morning, which the officers said was not unusual. Later, he had fallen while he was showering. The officers helped him get up and he then dressed himself.

34. One officer saw the man and his cell mate watching television between 2.00pm and 2.30pm, when he unlocked them for a period of social time (association) on the wing. The man's cell mate was sitting in a chair and the man was on his bed. The man's cell mate said he asked the man if he was okay, put his coffee down and then heard a snoring type noise from the man. He turned round and went over to the man. He heard a gurgling noise and then went out of the cell to call staff for help.

35. The man's cell mate thought the man had collapsed soon after returning from his shower. However, he must have been mistaken in his recollection because he described how the man had taken his shower in the morning, after he had showered himself, suggesting there must have been at least a few hours between the shower and when the man collapsed at 3.45pm.

36. At about 3.45pm, the officer was on the second floor landing when he said he heard someone on the first landing shout up to him saying something had happened to the man in his cell. The officer ran down to the cell. He saw the man lying on his back on the bed making raspy breathing sounds. The officer radioed for the healthcare first responder to attend. He indicated a code blue so that the healthcare staff would know that the prisoner was having problems breathing. The communications room recorded the time of this call as 3.48pm. The officer, who had been in the main office arrived at the cell just after the other officer.

37. One of the officers checked for breathing and a pulse. He said the man was extremely pale and slumped on the bed. He found a very faint pulse in his neck but the man was unresponsive and not breathing. He then began chest compressions while the other officer took the man's cell mate out of the cell. The officer said the man appeared to take one sharp intake of breath (this might have been a gurgle reflex, not a true breath). He then stopped doing compressions. The man did not take any more breaths so after checking for his pulse again, without success, the officer resumed chest compressions. Another officer then arrived at the cell, followed by two nurses. One nurse estimated that it took her a few minutes to get there. When she arrived, she asked for an ambulance to be called.

38. The duty governor, had also reached the cell around this time. He asked the officer to go to the office (about six metres away) and ring the communications room to ask them to call an ambulance. The communication room noted this time as 3.56pm although the ambulance report states the time as 3.59pm. The officer then returned to the cell. The nurse asked the staff to lift the man off the bed and onto the floor to provide a firmer surface and allow more room.

39. The nurse attached a defibrillator. After two minutes of chest compressions a shock was given in accordance with the machine's readings. The staff continued cardiopulmonary resuscitation, using an airway and ambu-bag to assist ventilation until the paramedics arrived. Cycles of 30 chest compressions were given followed by two breaths. The nurses were able to get readings for the man's oxygen saturation level and pulse between 4.00pm and 4.09pm. The defibrillator's instructions were followed and several shocks were delivered during the efforts to resuscitate the man. The nurse used a hand-held suction device to remove fluid from the man's mouth and airway and then an electric one, as the hand-held devices were not as effective.

40. Two ambulances arrived at the prison gates, one at 4.10pm and the other at 4.15pm. There was then a delay in getting the ambulances into the prison. Prison staff at the gate asked the paramedics to hand them their mobile telephones. They insisted they remove some communications equipment (used to relay messages and medical readings taken from patients). All four paramedics arrived more or less at the same time at the man's cell at 4.19pm. The nurse used their suction machine because it was more effective than the ones she had been using. The paramedics attached their own equipment and then continued resuscitation efforts for another 20 minutes. The man's heart was in ventricular fibrillation (where there is uncoordinated contraction of the

heart muscle). The paramedics gave five more shocks but were unable to resuscitate him. One of them pronounced the man dead at 4.41pm.

41. An operational manager, held a hot debrief at 5.35pm. The prison's care team contacted the staff who had been involved in helping the man when he was found collapsed in his cell. A critical incident de-brief took place later, where staff had the opportunity to discuss what had happened in more detail.

Liaison with the man's family

42. The prison chaplain and operational manager acted as the prison's family liaison officers. They went to break the news of the man's death to his family who lived just over an hour's drive away and arrived at 7.00pm. They saw the man's wife and son. They explained to his family about the Coroner and inquest, and offered to pay reasonable expenses for the funeral, in line with national policy. The family asked the prison chaplain to help with the arrangements.

43. The man's funeral was held on 8 May and three members of staff from Elmley attended the service. The chaplain held a memorial service at the prison on 24 April.

Post-mortem report

44. A post-mortem examination on 24 April concluded that the cause of death was ischaemic heart disease, with diabetes as a contributing factor. Ischaemic heart disease is characterised by reduced blood supply of the heart muscle, usually due to coronary artery disease (where the artery wall thickens as a result of a build up of fatty materials such as cholesterol). The risk of the disease increases with age, smoking, high cholesterol levels, diabetes and hypertension.

ISSUES

45. The clinical reviewer, considered that overall, the general medical care given to the man was comparable to that which he might have expected in the community.

Management of the man's diabetes

46. The clinical reviewer's opinion considered that the man's diabetic control was "suboptimal". He felt this might have been due to the fact that the man was significantly overweight and had very poor mobility, compounded by arthritis in his back and knee. The clinical reviewer said the man should have been on a specific diabetic diet.

47. We confirmed with Elmley that they do offer a diabetic / healthy eating menu choice. However, this would not mean that the man selected this option every day, nor would it have prevented him from ordering other snacks from the prison shop.

48. To a large extent the man was responsible for controlling his diabetes and did not always comply with advice. However, it seems that the man's diabetic care was not always reviewed and followed up as it should have been. His HbA1c test results were very high and well above the target range and this meant that the man's diabetes was not well controlled. It was therefore important that appointments relating to his diabetes took place. On 31 August, a GP decided that the man should see the diabetes nurse "ASAP" because of a high HbA1c result. This was not followed up and the man did not have another review until 31 October. Similarly, an "urgent" referral to the podiatrist on 25 September does not appear to have been followed up – no appointment was made until 6 December (an appointment which the man did not attend). We consider that healthcare staff should have made a greater effort to ensure that the man's diabetes related appointments were held promptly to help gain greater control of his condition.

The Head of Healthcare should ensure that specialist referrals and reviews of blood test results are followed up and completed.

The man's non-attendance at medical appointments

49. When the clinical reviewer reviewed the man's SystmOne medical record, he found 18 missed appointments. These appointments were for a range of matters such as physiotherapy, optician, blood tests, GP appointments, chiropody and chest X-rays.

50. A nurse at the prison, said a lot of prisoners had written to complain that they had not been called for their medical appointments. He explained the expected process. The names of all the people who healthcare staff need to see the next day are put on a list on the prison's shared computer drive, which is then printed on the wings. Residential staff make sure that those on the list are informed and ready for their appointment. However, the prisoners who

complained said they were not told by staff why they had to attend an appointment.

51. The Head of Healthcare, said that in order to try and decrease the number of missed appointments, the movements officer on each houseblock now checks the appointments on the shared drive. The prisoner should be sent to their appointment at movement time. There is also now a movements officer based in the healthcare department who can collect prisoners who have not arrived for their appointment.

52. Some of the appointments that the man missed were for non-urgent care. However, some important appointments were missed. For example, four appointments for a chest X-ray in January and February 2012 were not kept. Chest X-rays can help doctors diagnose conditions such as pneumonia, heart failure and lung cancer. After the fourth missed appointment on 9 February, it was not rebooked. None of the GPs followed up to find out why it had not taken place and the man was not asked why he had not attended. It is possible that his non-attendance was because he did not know an appointment had been made.

53. We are aware that this issue is now being monitored and a daily report of non-attendance at appointments, including reasons, is sent to the residential governors with the reasons for non-attendance. We consider that the reason for non-attendance should also be written on a prisoner's SystmOne medical record. This will help determine where the problem for non-attendance lies and whether systems need to be strengthened further to ensure prisoners know when they have a medical appointment.

The Governor and Head of Healthcare should ensure that prisoners are notified of their appointments and, if they do not attend, the reasons for non-attendance are written on the prisoner's SystmOne medical record.

The emergency response

54. The contingency plan form used by the prison instructed that an ambulance should be called automatically. The code blue was called at 3.48pm but the emergency call for an ambulance was not made until 3.56pm or according to the ambulance log, 3.59pm, so between eight and 11 minutes later. It should not have been necessary to wait for the nurse to get to the cell to request an ambulance. We consider that an ambulance should be called whenever there are serious concerns about the immediate health of a prisoner in line with guidance issued to prisoners which says it should not be necessary for a member of healthcare staff to attend first. Prison Service Instruction 03/2013 about medical emergency response codes now requires prisons to call an ambulance immediately a medical emergency is called over the radio network.

The Governor should ensure that an ambulance is called quickly whenever there are concerns about the immediate health of a prisoner and that one is called automatically when a code blue or code red emergency is called.

54. A guidance note issued from the Ministry of Justice and Department of Health in February 2011, concerns emergency access to prison establishments. It states:

> "It is … essential that internal procedures should not waste undue time in summoning emergency assistance. It should not, for example, be a requirement … for … the prison healthcare team to attend the scene before emergency services are called".

55. The guidance note goes on to say that establishments must agree an emergency access protocol with the NHS trust responsible for ambulance provision and that a mechanism must be in place to avoid any unnecessary delay in escorting ambulance staff to the prisoner. This guidance is now updated in Prison Service Instruction 3/2013.

56. The first of the ambulances arrived at the prison gate at 4.10pm and a second at 4.15pm. The paramedics did not get to the man's cell until 4.19pm. Therefore, it took nearly ten minutes for the paramedics to reach the man. Prison gate staff said that they searched the paramedics and took their mobile phones. They required the paramedics to remove communications equipment in their ambulance which further delayed them.

57. We do not know whether the arrival of the paramedics to the man's cell a few minutes earlier would have made a difference to the attempts to resuscitate him, but in an emergency situation where someone is unconscious, speed of response is a crucial factor. (The clinical reviewer's opinion was that it was unlikely to have made the difference between life and death in this case but that the delays were wholly unnecessary and change needed to be made.) Elmley should do all it can to reduce any unnecessary delay in paramedics gaining access to the scene of an emergency. We consider that searching paramedics, removal of their mobile telephones and unscrewing equipment in the ambulance all to have been unnecessary. The paramedics are accompanied by prison staff at all times and the ambulance is not left unattended. The security risk of such equipment falling into the hands of prisoners is very small and outweighed by the importance of speed to the patient's side. We therefore make the following recommendation:

The Governor should ensure that there is a clear protocol for emergency ambulances to enter the prison without delay and that paramedics are given immediate and easy access to the prisoner.

58. The medical response to the man's collapse from the staff at Elmley was carried out professionally. The clinical reviewer noted that the suction machine did not work properly. While he did not think this had any significant bearing on the outcome of the resuscitation attempt, he recommended that an

effective suction machine be placed in the emergency bag. We agree that emergency equipment should be in good working order.

The emergency bag and its contents should be checked regularly to ensure the equipment is in optimal working order.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that planned actions, such as specialist referrals and reviews of blood test results are followed up and completed.

   Accepted. Additional GP sessions have been provided (3 per week) in consultation with the Offender Health Commissioner, to enable better access and quicker reviews of patients with chronic diseases.

2. The Governor and Head of Healthcare should ensure that prisoners are notified of their appointments and if they do not attend, the reasons for non-attendance are written on the prisoner's SystmOne medical record.

   Accepted. The Health care provider and the Governor are working in partnership to improve the systems of notification of appointments to offenders. The Health care provider is currently increasing the staffing profile to enable more robust entries in medical records regarding non attendance. The new Health care provider is contracted to open clinical rooms on each house block which will enable access to a nurse on a daily basis.

3. The Governor should ensure that an ambulance is called quickly whenever there are concerns about the immediate health of a prisoner. An ambulance should be called automatically when a code blue or code red is called.

   Accepted. Notice to Staff 030-13 was published to all staff re-enforcing national guidance contained within PSI 03/13.

4. The Governor should ensure that there is a clear protocol for emergency ambulances to enter the prison without delay and that paramedics are given immediate and easy access to the prisoner.

   Accepted. Notice to Staff 17-13 was published to staff and Operations Group Staff briefed to ensure no delays occur and that emergency services are escorted with haste to the scene.

5. The emergency bag and its contents should be checked regularly to ensure the equipment is in optimal working order.

   Accepted. There are systems in place to check equipment on a daily basis to ensure it is in optimal order.