PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in March 2013 at HMP Risley

Our Vision

'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'

This is the investigation report into the death of a man HMP Risley in March 2013. The man was 73 years old and died from hypertensive heart disease. I offer my condolences to his family and friends.

The investigation was carried out by an investigator. A review of the man's healthcare was undertaken by a clinical reviewer. HMP Risley cooperated fully with the investigation.

The man had been diagnosed with several complex health issues before his imprisonment in 2002, including heart disease, hypertension and diabetes. He was prescribed medication for these conditions in prison and also received treatment at hospital. On the morning of 3 March, the man was discovered unresponsive in his cell. Prison staff did not attempt resuscitation as it was clear that he was dead. Although the man had been in poor and declining health, his death was sudden and unexpected.

Generally, prison and healthcare staff responded appropriately to the man's many health needs and referred him promptly for specialist treatment, although he did not always attend appointments. At Risley, as his health deteriorated, he engaged more with healthcare. Although, the clinical reviewer has suggested improvements to some aspects of healthcare at Risley she does not consider that any omissions contributed to the man's death. As in another recent case at Risley, I am not satisfied that the use of restraints on the man at hospital was always justified, given his very poor health, need for a wheelchair and low assessed risk. .

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

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SUMMARY

1. When the man went to prison in September 2002, he had already been diagnosed with several chronic health conditions, including high blood pressure, diabetes, thickening of the heart muscle and heart disease for which he had been prescribed warfarin. A chest X-ray in July 2008 confirmed that the man had heart failure.

2. The man spent time in several prisons and transferred to Risley in March 2012. When he arrived at Risley, staff conducted what the clinical reviewer regarded as an exceptionally thorough initial assessment. They put in place medical care to meet his needs and referred him to appropriate specialists.

3. In mid-June 2012, the man became unwell. He was taken by ambulance to the accident and emergency department of the local hospital, where he was diagnosed with pulmonary oedema (an excess of fluid in the lungs which can be caused by heart failure). A cardiac MRI scan a few weeks later confirmed his heart muscle had deteriorated.

4. During his time at Risley, the man had a number of falls, which the clinical reviewer attributes to a pause in his heartbeat leading to a temporary loss of consciousness. In view of his decreased mobility, the man was given a wheelchair, a carer, and modifications were made to his cell.

5. On 3 March 2013, night staff found the man unresponsive on the floor of his cell. The night duty nurse found no vital signs and did not attempt resuscitation as it was apparent that the man had been dead for some time. Paramedics arrived and verified his death. The post-mortem report indicated that the man died from hypertensive heart disease.

6. The man had several outpatient appointments during the last few months of his life, as well as two inpatient admissions to hospital in August and December 2012. On each occasion, he was escorted by prison officers who were instructed to use an escort chain in spite of the risk assessments concluding that he was a low risk of escape. We do not consider that this level of restraint was justified or adequately considered the man's condition and risk.

7. The man received a considerable amount of treatment at Risley and in hospital for complex medical conditions. The clinical reviewer considers that that, although some aspects of his care, such as the care planning and the management of chronic diseases could gave been better, this did not contribute to his death.

THE INVESTIGATION PROCESS

8. Notices announcing the investigation were issued to staff and prisoners at Risley, inviting anyone who might have information relating to the man's death to contact the investigator.

9. The investigator visited HMP Risley on 12 March 2013 and was briefed by the Governor and an operational manager about the circumstances of the man's death. He visited different areas of the prison, including the cell where he died. He also met other members of prison staff who knew the man, a prisoner who was his friend and carer, the Chair of the Independent Monitoring Board and a representative of the local POA (prison officer's union.).

10. The investigator obtained copies of the man's prison and medical records. Lancashire NHS commissioned a clinical reviewer to conduct a clinical review of the care he received in prison. A copy of her report is attached at annex 1.

11. On 23 May, the investigator and clinical reviewer returned to the prison and formally interviewed six members of prison staff. The clinical reviewer also spoke informally to members of the healthcare staff.

12. One of the Ombudsman's family liaison team spoke to the man's son on 27 March 2013, to tell him about the investigation and to offer the opportunity to raise matters that he wanted the investigation to consider. He had no immediate concerns about the care his father received in prison.

13. The man had nominated his ex-wife as his next of kin. It took some time to contact her but the Ombudsman's family liaison officer eventually spoke to her on 16 April. She raised the following issues:

    - The man had told her that he sometimes had blood stains on his pillowcase which he said were not caused by nose bleeds or shaving cuts. She wanted to know whether the man had ever reported bleeding to prison or healthcare staff.

    - Was the man's dosage of warfarin correct and reviewed appropriately?

    - Was there any significant trigger in the days before his unexpected death?

14. The man's family received a copy of the draft report. The solicitor representing his son wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification to the solicitor by correspondence.

HMP RISLEY

15. HMP Risley is a category C training prison which holds over 1,000 adult male prisoners. Healthcare services are commissioned by Warrington Primary Care Trust (PCT). There is 24 hour healthcare cover. By day, there is a doctor in the prison and at night there are nurses on duty. There is no inpatient facility. Prisoners who require inpatient treatment are referred to other prisons (usually HMP Preston) or to hospital.

HM Inspectorate of Prisons

16. The last inspection of Risley was in February 2011. HMIP found that Risley was a safer, cleaner and more decent prison than when it was last inspected in 2008. Inspectors noted that the prison was much cleaner than had been the case at the previous inspection. It described Risley as a better place to be for prisoners and staff, that relationships between the prison and NHS agencies were good, with a range of primary care and life-long condition clinics.

Independent Monitoring Board

17. Each prison 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. The most recent IMB annual report for Risley covers the year to March 2012 and noted an improvement in healthcare provision.

Previous deaths at Risley

18. Four investigations were completed into deaths at Risley in the year before the man died. In this report we repeat a recommendation made after a previous death at Risley about security risk assessments and the use of restraints.

KEY EVENTS

19. The man was remanded to prison custody at HMP Wormwood Scrubs in September 2002 for charges of importing drugs. He later transferred to HMP HMP Long Lartin and HMP Lowdham Grange. He was 63 years old and this was his first time in prison. He was subsequently convicted and sentenced to 24 years imprisonment.

20. Before he went into prison, the man had longstanding heart disease. He had also been diagnosed with hypertension (high blood pressure), left ventricular hypertrophy (thickening of the heart muscle) and diabetes. One of the medications prescribed was warfarin and international normalised ratio (INR) blood tests were taken to monitor its effectiveness.

21. In January 2006, the man was diagnosed with an enlarged heart. He was referred to a specialist under the two-week rule (an NHS target for people with suspected cancer to see a specialist within two weeks). However, he refused further investigation as he did not wish to be handcuffed for consultations and treatment outside the prison.

22. During April 2008, the man repeatedly refused to attend hospital. However, in July, because of continuing chest problems he agreed to an X-ray, which confirmed that he had changes consistent with atrial fibrillation (irregular and often abnormally fast heartbeat in the upper chambers of the heart). This had caused a degree of heart failure and build up of fluid in his lungs resulting in coughing and breathlessness. He was prescribed furosemide to reduce the retention of fluid.

23. At an appointment at Nottingham City Hospital on 18 February 2009, a doctor confirmed that the man had heart failure. He increased his furosemide and prescribed bisoprolol to stabilise his heartbeat. During the next few months there was difficulty in stabilising these medications. The clinical reviewer noted that at this time there was little monitoring of the man's INR and when monitored, it was frequently outside the normal range of 2-3. The man continued to have problems with breathlessness and pulmonary oedema, which is linked to cardiac disease.

24. On 9 November 2010, healthcare staff recorded that the man might have had a seizure in the night. There are few healthcare notes available for this period despite indications that the man's physical health was deteriorating. In mid-December, he refused to attend for an echocardiogram (ECG – which provides a detailed image of the heart). No reason was recorded. On 5 January 2011, the man again declined referral to hospital.

25. During a screen for TB, which proved negative, an X-ray again indicated an enlarged heart and the man was referred to a chest specialist on 15 March 2012. Around this time, his weight was recorded as 12 kg heavier than when he went into prison, which is consistent with a build up of fluid in his body caused by poor cardiac function. This, in turn, indicated that his fluid retention medication was either ineffective or that he was not taking it as prescribed. At

about the same time, the man had problems with his memory which were reported by staff and his ex-wife. His speech was slow, he lost track of conversations and his ability to remember to take his medication was impaired. To help him take his medication regularly, it was placed in a dosette box (a container with individual timed compartments) and he was referred to the mental health team for memory assessment. He subsequently received screening for dementia which found that his periods of confusion were brief and that most of the time he was lucid.

26. On 16 August, a CT scan confirmed that the man had chronic pulmonary oedema. The clinical record shows that on 13 October, prison staff held a meeting to discuss support for the man and devise a daily care plan. He needed a walking frame and they planned to arrange a transfer to a prison with more suitable facilities. Over the next three months, he had several episodes of confusion and memory loss, usually related to his medication. In mid-January 2012, it was decided his medication would be administered under supervision.

27. On 7 March 2012, the man transferred to Risley from HMP Lowdham Grange. Healthcare staff had not been informed of his care needs before his arrival. At the initial reception medical screen, staff recorded that he had been diagnosed with atrial fibrillation, chronic pulmonary oedema, chronic renal disease, high blood pressure, cataracts and type 2 diabetes. They prepared a list of his medication for the prison doctor to review the next day. Staff observed that the man was unsteady on his feet, had a history of dementia and confusion and he was occasionally incontinent. To make things easier for him, he was allocated to a ground floor cell at the quieter end of D wing.

28. The next day, a doctor and nurse assessed the man's health needs to ensure appropriate care was arranged. They referred him to the cardiology and colorectal departments at Warrington Hospital and made arrangements for blood tests, including an INR test three days later. On 14 March, he had another ECG.

29. On 17 June, the man was unwell. His blood pressure and pulse were high, so healthcare staff arranged for an ambulance to take him to hospital, with a letter outlining his medical history. He was diagnosed with pulmonary oedema (which can be a sign of heart failure), given treatment and returned to Risley. The next day, the prison doctor and a nurse reviewed him and noted that his condition was much better. On 19 June the healthcare manager, recorded that he would check the man's care plan and refer him to both the falls assessment team (as he had had a number of falls) and the elderly persons' care team. Owing to his lack of mobility, he would also be assessed for a wheelchair. This all took place over the next few days. The healthcare manager also emailed the medical services commissioner to explore access to carers.

30. On 27 June, specialists at the cardiac unit of Warrington Hospital diagnosed ventricular enlargement and cardiomyopathy (deterioration of the heart muscle). They referred him to the Liverpool Heart and Chest Hospital for a

cardiac MRI scan, which took place on 9 August and confirmed cardiomyopathy.

31. At the beginning of July, after another fall, the man was advised to remain in his cell to reduce the risk of further falls. Later that month, the prison gave him a wheelchair. One of the man's friends who helped him on the wing, and another prisoner took short wheelchair pushing courses. They became "wheelchair buddies", taking the man to areas of the prison that he would otherwise not have been able to reach, such as the healthcare centre and visits room. The man's friend subsequently took on a full caring role for the man, entailing collecting meals, assisting with dressing, washing clothing and similar tasks. Owing to his unsteadiness and frailty, the friend accompanied the man whenever he walked anywhere.

32. On 25 September, the man asked the prison doctor if he could keep his medication in his cell to self-administer. The doctor explained that due to his poor memory he was unable to manage his medications and therefore he could not authorise this. The same day, the man's son called to speak to the doctor and, with the man's permission, they spoke about his condition and future medical and social needs.

33. Allied Medical Care was engaged to provide social carers and, on 19 October, a member of staff visited the prison to assess the man's care needs but he declined their help. One week later, healthcare staff received a letter from a consultant psychiatrist, confirming that the man was suffering from mild to moderate Alzheimer's dementia. As a result of the letter, the doctor discussed the possibility of early release on compassionate grounds and the healthcare manager began the application process. However, the man did not meet the criteria as he was subject to deportation at the end of his sentence.

34. The man had further falls and, on 15 November, he was assessed by the community falls team who recommended adjustments to his cell and the shower area, as well as a walking aid. These adaptations were completed by the end of November and the community falls team supplied additional specialist equipment, including a shower chair and grab rail, a toilet frame and hospital table. The falls team asked for the man's blood pressure to be monitored both lying down and standing to eliminate the cause of the falls as postural drop (an excessive fall in blood pressure when standing up) and to monitor his weight as he had lost two stones in two months.

35. A letter of 19 November from the cardiology clinic, after 24-hour ECG monitoring, showed that the man remained in atrial fibrillation. On 6 December, the staff nurse tested his blood pressure using a sphygmomanometer. The results were high and, when repeated manually, remained high. The nurse consulted a senior nurse prescriber at Risley, who advised that the measurement be taken again the next morning. A nurse took his blood pressure the next morning when it remained high. There is no record to indicate what the nurse did with this result or whether he sought advice.

36. Just after midday on 25 December, healthcare staff went to see the man as he had apparently bitten his tongue in his sleep. His vital signs were recorded and showed his blood pressure was high. At 6.50pm, his tongue was still swollen and bleeding so he was taken by emergency ambulance to the accident and emergency department at Warrington Hospital. His tongue was sutured and he was admitted to the intensive care unit (ICU) for airway and warfarin management. He moved from ICU to a general ward the next day. It was unclear what had caused him to bite his tongue but as it might have been linked to a seizure or collapse, he remained in hospital and was discharged on 29 December.

37. After a fall in his cell during the early morning of 19 January, the duty nurse went to assess the man. He was uninjured and declined to be examined or have any further intervention. The review is not documented in the SystmOne medical record. According to the medical notes, his next contact with healthcare staff was 28 January, when his INR was measured.

38. The man attended an appointment at the cardiac clinic at Warrington Hospital on 8 February, when his blood pressure was found to be high. On 28 February, he attended an appointment to have an ambulatory blood pressure monitor fitted (a device that provides a 24 hour blood pressure recording).

39. At around 5.55am on 3 March, the night officer was unable to see the man in his cell during an early morning check of prisoners. He radioed the control room to alert them and request assistance. The Assistant Orderly Officer (the second in charge during the night) responded and went into the cell with the night officer, where they found the man unresponsive under a pile of bedding on the floor beside his bed. The night officer radioed a ‘code black’, the emergency code then used at Risley to indicate a person is not breathing (this has since been changed to code blue in line with a new Prison Service instruction). The emergency code automatically triggered the control room to call an ambulance.

40. The night orderly officer, in charge of the prison at night, and a nurse arrived at the cell shortly afterwards and tried, unsuccessfully, to rouse the man. The nurse found no vital signs and noted that there was a small amount of blood around the man’s nose and mouth and on the floor. He was cold to the touch and rigor mortis was apparent. The man’s pupils were fixed and dilated and his corneas were opaque. The nurse believed that he had been dead for some time, therefore he did not attempt resuscitation. The first paramedics arrived at the cell at 6.15am. Another crew arrived at 6.35am. They verified the man’s death.

41. Shortly after confirmation of the man’s death, the control room contacted the prison chaplain and family liaison officer. He arrived at the prison at around 8.10am and attended a debrief session held by the deputy governor. As there had been difficulties in contacting the man’s ex-wife, his named next of kin, prison managers asked the chaplain to visit his son at his home to break the

news. However the man's friend, told prison staff that his son was due to visit that day.

42. When the man's son arrived at the prison at 9.10am, the Chaplain met him at the visitors' centre and broke the news that his father had died. They then went to the prison chapel to meet the deputy governor and Head of Healthcare, who offered condolences and explained the circumstances of his father's death. They told him about the formal procedures and that the prison would contribute to the cost of the funeral.

43. A post-mortem examination on 7 March 2013, confirmed that the man died from hypertensive heart disease which was likely to have caused an arrhythmia (a problem with the rate or rhythm of the heartbeat) that led to his death.

44. The Chaplain facilitated a visit by the man's family to his cell, on 10 March. He subsequently arranged a Mormon funeral service with the local Mormon bishop, which was held on 20 March.

ISSUES

The man's clinical care

45. The man had a number of complex and chronic medical conditions of which he had a good understanding. The clinical reviewer reviewed his care throughout his imprisonment. She found that, generally, he engaged with healthcare teams but at times this was difficult when he refused to attend hospital appointments.

46. The clinical reviewer considers that the reception screening and assessment of needs carried out at Risley by the doctor and nurse was exceptional. They comprehensively identified all the man's previous health-related problems, resulting in a referral pathway directly to specialist secondary care interventions. At Risley, the man engaged better with healthcare staff and settled into the prison regime. As his health needs increased and his condition deteriorated he was appropriately referred to hospital and local community services.

47. The man died from hypertensive heart disease. The clinical reviewer explains the condition - persistent high blood pressure causes the heart muscle to thicken. It also leads to thickening of the blood vessel walls. The man had been diagnosed with left ventricular hypertrophy (thickening of the heart muscle) and as the muscle began to fail, he suffered breathlessness and pauses in his heart rate at night.

48. The clinical reviewer found some aspects of the man's care during his time at Risley where there was room for improvement. However, she concludes that none of the failings contributed to his death.

Care planning

49. The clinical reviewer highlights the importance of care planning for prisoners with complex medical conditions, to enable them to maintain independence in their daily lives. Planning should be a partnership between prison healthcare staff and other prison departments. At Risley, healthcare staff are not part of the care planning process. As the man became more prone to falls, to reduce the risk of falling, he was advised to remain in his cell. He was later given a wheelchair and carer. Healthcare staff would have been able to provide guidance to prison staff about assisting the man's mobility. We therefore make the following recommendation.

    The Governor and the Head of Healthcare should implement joint care planning between prison and healthcare staff, as well as other partnership agencies, for prisoners with complex health and social care needs.

The management of the man's cardio-vascular disease

50. On his reception to prison, the man had significant heart disease, including risk factors of high blood pressure and cholesterol. The monitoring and investigations carried out at Warrington Hospital showed that his heart condition had deteriorated significantly. He also had several falls which were probably linked to his deteriorating cardiac function, where the heart rate dipped and he lost consciousness. Significantly, he had a 24-hour electrocardiogram (ECG) recording in November 2012, which showed that his heart rate dipped markedly at night.

Hypertension (raised blood pressure)

51. The National Institute for Health and Care Excellence (NICE) guidance for the management of hypertension recommends that patients are reviewed regularly, in the case of cardiovascular disease to target organ damage. The guidance also recommends monitoring of atrial fibrillation (when one of the chambers of the heart does not beat effectively). The clinical reviewer found that, in spite of the man's significant heart disease, there was no routine proactive monitoring of his blood pressure or atrial fibrillation. At Risley, blood pressure readings were carried out reactively when he became unwell or attended doctors' appointments. There is no evidence that the man was referred to or attended a clinic specifically for hypertension. We make the following recommendation:

The Head of Healthcare should ensure there is proactive monitoring of prisoners with chronic diseases in line with NICE guidelines.

Warfarin

52. Before he went to prison, the man had been prescribed warfarin (a medication that thins the blood) because of his risk of stroke arising from his heart disease and his weakened heart muscle. Symptoms of excessive dosing of warfarin include severe bleeding or multiple bruising, eg bloody stools and nosebleeds. At Risley, healthcare staff gave the man his warfarin daily, but there was no proactive assessment of the man's skin for signs of bruising or bleeding. Patients taking warfarin are supposed to have regular blood tests to measure its effectiveness. The measure is known as the international normalised ratio (INR). In order to ensure safe use of warfarin, NICE guidelines recommend that the INR result and warfarin dose is recorded, referred to as the 'yellow book' record. The clinical reviewer considers that Risley did not follow the advised procedure for monitoring the prescription of warfarin. We therefore make the following recommendation

The Head of Healthcare should ensure that the care of prisoners taking warfarin is in line with NICE guidelines, with a protocol for monitoring, titration and prescription of warfarin as well as INR testing.

Record keeping

53. The clinical reviewer found few entries in the man's medical record relating to his physical health, nursing care or observations. She therefore concludes that nurses (who are reported to have seen the man frequently on the wing) did not record interventions, observations and care. This is not good practice and does not comply with the standards of record keeping set out in the Nursing and Midwifery Council (NMC) guidelines. In addition, there is no reference in his medical record to the man's 'yellow book' results and the templates on the SystmOne electronic medical record for monitoring atrial fibrillation, diabetes and hypertension were not used to monitor the man. We therefore make the following recommendation:

The Head of Healthcare should ensure that all clinical care or information is recorded on SystmOne and that staff use the chronic disease specific templates on the system to monitor those with chronic diseases.

Emergency response

54. Staff did not attempt resuscitation after the man was found in his cell as it was clear that he had been dead for some time. However, the clinical reviewer found that clinical staff at Risley had no access to resuscitation training at the time of the man's death and that the resuscitation policy was out of date. Training records confirm that staff have since been given resuscitation training, so we make no further comment on this issue.

Restraints

55. The Prison Service has a duty to protect the public when escorting prisoners to hospital, and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes into account factors such as the prisoner's health and mobility.

56. A High Court judgement in 2007, made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion regarding the prisoner's ability to escape must be considered as part of the assessment process.

57. Towards the end of his life, the man had two emergency admissions to hospital, one in late August 2012 for a chest infection, when he remained in hospital for six days and on 25 December 2012, for four days for lacerations to his tongue and bleeding exacerbated by warfarin. He also attended several outpatient clinics at local hospitals. Security risk assessments were completed on every occasion. Although the documents for his stay in August

2012 were not provided, there is no reason to believe that the risk was assessed differently to the other occasions. Each risk assessment specified that the man should be restrained using an escorting chain.

58. The man was 73, and in very poor health, reliant on a wheelchair and assessed as a low risk in all areas (including risk of escape and risk to others) except for an emergency admission on Christmas day 2012, when he was assessed as a medium risk to the public. We do not know why staff thought that his risk to the public was higher on that occasion. Whether or not his risk to the public was assessed correctly, this risk would apply only if the man escaped which, in the light of his medical condition and mobility, was highly improbable. Despite the low level of risk and the man's serious medical condition, senior managers instructed that staff use an escort chain throughout his stay in hospital and on visits to outpatient clinics.

59. In view of the low level of perceived risk on the risk assessment, the man's state of health and his lack of mobility we do not consider that the use of restraints was justified or that the risk assessments had appropriately balanced security with humanity. We make the following recommendation:

The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents.

RECOMMENDATIONS

1. The Governor and the Head of Healthcare should implement joint care planning between prison and healthcare staff, as well as other partnership agencies, for prisoners with complex health and social care needs.

2. The Head of Healthcare should ensure there is proactive monitoring of prisoners with chronic diseases in line with NICE guidelines.

3. The Head of Healthcare should ensure that the care of prisoners taking warfarin is in line with NICE guidelines, with a protocol for monitoring, titration and prescription of warfarin as well as INR testing.

4. The Head of Healthcare should ensure that all clinical care or information is recorded on SystmOne and that staff use the chronic disease specific templates on the system to monitor those with chronic diseases.

5. The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents.

ACTION PLAN

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Governor and the Head of Healthcare should implement joint care planning between prison and healthcare staff, as well as other partnership agencies, for prisoners with complex health and social care needs.	Accepted	Joint care planning arrangements are in place for all prisoners / patients who have complex health and social care needs. Care plans are initiated by the prison service and include joint planning with the relevant healthcare leads, the personal officer and other relevant prison personnel. Care plans are situated with a prisoner's core record on the relevant residential unit, where prison staff and nursing staff have equal access to it. Referrals are then made to the relevant service (such as the falls service and Allied Healthcare, which is employed to provide social care arrangements). If a prisoner refuses to engage with social care services this information is recorded in the care plan.	Completed	
2	The Head of Healthcare should ensure there is proactive monitoring of prisoners with chronic diseases in line with NICE guidelines.	Accepted	A system for pro-active monitoring exists within healthcare at Risley for Long Term Conditions. The practice nurse/team leader, supported by staff nurses, runs a Primary Prevention Clinic (PPC) to support and monitor those with diagnosed Long Term Conditions. Conditions include: Diabetes, Epilepsy, Asthma, COPD, Heart Disease, Cardio-vascular risk assessment and Hypertension. There are currently three clinic sessions per week but depending on need of a fluctuating population, could increase up to six per week. All interventions are based on NICE Guidance,	Completed	

			which is updated monthly by the provider through the clinical governance strategy.		
3	The Head of Healthcare should ensure that the care of prisoners taking warfarin is in line with NICE guidelines, with a protocol for monitoring, titration and prescription of warfarin as well as INR testing.	Accepted	Patients taking Warfarin are managed in line with NICE Guidance. There is a procedure for monitoring, titration and prescription of Warfarin as well as INR testing When an INR is carried out by nursing staff they: • record INR • document in patient's yellow book • document on patient's individual INR sheet • read code 42QE • enter INR in patient record • Prescription chart goes to GP for review • Prescription is re-written by GP • Patient record is updated • Yellow book returned to patient • Prescription sent to pharmacy for dispensing • INR entered on patient record in pharmacy • Prescription is dispensed - NIP, weekly or monthly depending on individual risk assessment This procedure is available in a written protocol.	Completed	
4	The Head of Healthcare should ensure that all clinical care or information is recorded on SystmOne and that staff use the chronic disease specific templates on the system to monitor those with chronic diseases.	Accepted	Clinical care and information is recorded in systmOne. There are templates available for nurses to use to work with those who experience chronic diseases and attend clinics. In light of the recommendation, the health team ensures that where a patient with a long term condition declines to engage with the PP clinic, the lead nurse will pro-actively ensure that every effort is made to structure ad hoc care into the appropriate template, so that information is consistently available within a template accompanied by an appropriate plan of care.	Completed	

5	The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents	Accepted	Risk assessments have been amended and there is an option for managers to consider no restraints. The risk assessment has also been reviewed and there is a new version awaiting approval which flows better, ensuring the manager has all the information they need to make an informed decision about the level of restraint used. All managers will be reminded that when considering cuffing arrangements, they must be proportionate to the risks posed by the individual prisoner, having full regard to his or her clinical condition. It must also be regularly reviewed to take account of the prisoner's changing circumstances.	31 August 2013	To review January 2014