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 May 2013 at HMP Isle of Wight

Our Vision

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

This is the report of an investigation into the death from rectal cancer of a man at HMP Isle of Wight in May 2013. He was 56 years old. I offer my condolences to his family and friends.

A review of the clinical care the man received in custody was undertaken. HMP Isle of Wight cooperated with this investigation.

The man had been in prison since 2006. In May 2011, he first complained of bowel problems, but hospital investigations did not identify any concerns. His symptoms abated but returned later that year. He would not initially allow a rectal examination but, later in November 2012, he was diagnosed with rectal cancer. His condition was terminal and no active treatment was possible. Although initially given a six week prognosis, he lived for another six months.

The clinical reviewer considers that the man's care in HMP Isle of Wight was equivalent to that he could have expected to receive in the community and I agree. However, there was one occasion when his pain relief was delayed because there was no out of hours pharmacy provision at the prison. I am also not satisfied that the use of restraints for hospital visits was always fully justified by appropriately considered risk assessments. It is a particular concern that an officer refused a doctor's request to remove restraints for treatment, without consulting a senior manager at the prison. Staff need to be reminded of their responsibilities in this regard.

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 **December 2013**

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SUMMARY

1. The man was sentenced to 16 years imprisonment in December 2006. He went initially to the HMP Parkhurst and, in 2007, moved to HMP Albany. (Both prisons now form HMP Isle of Wight.)

2. The man first complained of stomach pain in May 2011. His symptoms soon disappeared and it was thought he had been constipated. The pain came back that July. He also reported passing a black stool.

3. Medical investigations continued, but as the man had an ongoing digestive condition which could have caused similar symptoms and because he initially refused to have rectal examinations, it was not until November 2012 that a diagnosis of rectal cancer was made. His condition was terminal and no active treatment was possible.

4. At that time, the man was given a six week prognosis and the prison appointed a family liaison officer. His family were allowed visits without the need to pre-book them.

5. The man moved to the palliative care suite in the prison's impatient unit and was referred to palliative care services at a local hospice on 16 November. From this point, hospice staff maintained good contact with him and the prison about his care.

6. The man seemed to improve significantly after his prognosis although he decided that he did not want any palliative treatment, such as chemotherapy. He felt well enough to move out of the palliative care suite into the main part of the healthcare unit.

7. When the man initially received his diagnosis and prognosis, in November 2012, the prison considered compassionate release. However, the application was not supported because of his assessed risk to the public. When his health deteriorated significantly, the Governor considered compassionate release again on 24 May 2013, but he decided that the risks were still too high. He died in the palliative care suite at Albany in May.

8. Although it took some time for the hospital to diagnose the man's terminal illness, his pre-existing conditions confused the picture and he refused to be fully examined. He was dealt with compassionately by staff and was aware of the implications of his illness and the treatment options available. He did not miss any hospital appointments. Albany contacted his family almost as soon as he was diagnosed and considered compassionate release twice. We are satisfied that overall he received a good standard of care but we are concerned that on one occasion his access to prescribed pain relief medication was delayed and we are not satisfied that his level of risk always justified the use of restraints for hospital visits. We make two recommendations about these issues.

THE INVESTIGATION PROCESS

9. The investigator issued notices to staff and prisoners at HMP Isle of Wight informing them of the investigation and inviting anyone with any relevant information to contact her. No one came forward.

10. The local PCT commissioned a review of the man's clinical care in prison.

11. The investigator went to HMP Albany on 6 June 2013. She met the family liaison officer, two nurses and a prisoner friend of the man's. She spoke to representatives from the POA (a union for prison officers) and the Independent Monitoring Board. She obtained copies of his prison and prison healthcare records.

12. The investigator interviewed the Head of Healthcare and the Head of Pharmacy by telephone on 28 August 2013.

13. HM Coroner for the Isle of Wight was informed of the investigation and provided the cause of death. The Coroner has been sent this investigation report.

14. One of the Ombudsman's family liaison officers contacted the man's sister to explain the purpose of the investigation and invite his family to identify relevant matters they wished the investigation to consider. She was satisfied that he had received good care and that they were well looked when they visited. However, she was concerned that when she left the prison the evening before he died, she had been told that she would not be able to get back in to see him irrespective of his condition and questioned whether it was appropriate that families should not be able to stay at the bedside of dying prisoners at night.

15. The man's sister received a copy of the draft report. She made a number of comments that do not impact on the factual accuracy of this report.

16. The prison considered our draft report and recommendations and has accepted these. No factual inaccuracies were raised. The prison has also submitted an action plan detailing what they have done to address the issues we raised and this is included here, after the recommendations section.

17. The investigation has assessed the main issues involved in the man's care including his diagnosis and treatment, liaison with his family, his location and security arrangements, whether compassionate release was considered and whether appropriate palliative care was provided.

HMP ISLE OF WIGHT

18. HMP Isle of Wight is formed of the previous HMP Parkhurst and HMP Albany. The man was at the Albany site, which holds up to 567 men, mostly convicted of sex offences.

19. At the time of the man's death, health services at HMP Isle of Wight were provided by the Isle of Wight NHS Trust. An inpatient healthcare unit at the Albany site caters for prisoners with a wide range of mental health, general medical, rehabilitative and health-related respite needs.

Her Majesty's Inspectorate of Prisons

20. HM Inspectorate of Prisons (HMIP) conducted an announced follow-up inspection of HMP Isle of Wight in May 2012. They found that health services had improved considerably from their previous inspection, although there were some delays in accessing primary care services for prisoners at Albany. Inspectors found that there were good care arrangements for men with palliative care needs. The inspection found that prisoners with chronic diseases (long term conditions) were reviewed regularly.

Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure prisoners are treated fairly and decently. In their latest published annual report the IMB noted that a range of treatments and care programmes were delivered to a very high standard. The IMB also noted that the relationship between prison healthcare services and prison service staff was good, and that healthcare staff were engaged in all aspects of the prison community.

Previous deaths at Albany

22. There were 14 deaths from natural causes at the Albany site between 2011 and the man's death. We have previously made recommendations to the Governor about risk assessments for the use of restraints and do so again in this report.

ISSUES

The diagnosis of the man's cancer

23. On 31 May 2011, the man complained to a nurse of pain in his stomach. He had no other symptoms and said he had regular bowel movements. A prison doctor saw him on 6 June but his symptoms had gone. The doctor noted that the original problem was likely to have been constipation.

24. The man saw another prison doctor on the 12 July and reported further symptoms of bowel discomfort. On 18 July, he told the doctor that he had passed a black stool. The doctor arranged for laboratory tests, which showed no significant quantity of blood in the stool, and the cause was not considered to be serious. He was given mild laxatives. The clinical reviewer notes that as he suffered from chronic non-ulcer dyspepsia, a digestive condition which can be characterised by internal bleeding (which can result in black stools), this symptom would probably not have been considered alarming.

25. During May 2012, the man's overall condition deteriorated and he suffered a number of falls. A prison doctor examined him on 28 May and found that his strength was reduced in both upper legs, but his bowel habit was normal. The doctor concluded that one of his medications, atorvastatin (to reduce the risk of heart attack or stroke) was causing his leg muscles to inflame.

26. Atorvastatin was stopped and various blood tests were carried out the same day. The results were generally normal, except the erythrocyte sedimentation rate test which was raised. The test shows how quickly red blood cells sediment. A high rate indicates inflammation and that an underlying illness is present. Because of the man's other symptoms and a lack of any other physical findings, polymyalgia rheumatica (a condition that causes pain, stiffness and inflammation in the muscles around the shoulders, neck and hips) was diagnosed and prednisolone (a steroid) was prescribed. By 6 June, his mobility had improved, and he reported feeling much better. His steroid medication was reduced and eventually stopped.

27. On 17 August, a doctor noted that the man's blood count and iron test results were abnormal and sent blood samples for laboratory tests. He saw the doctor on 28 August about constipation. The notes do not show the results of the laboratory tests.

28. On 2 October, the man told a doctor that he had suffered from pains in his shoulders and constipation for the preceding six weeks. The doctor noted his obvious weight loss and examined him and recorded an abdominal hernia. He would not allow the doctor to carry out a rectal examination. A provisional diagnosis of a reoccurrence of polymyalgia rheumatica was made, blood tests and an X-ray were arranged and prednisolone re-started.

29. A doctor saw the man a week later on 9 October. He again declined a rectal examination but the doctor noted his continued weight loss and made an urgent gastroenterology referral under the 'two-week cancer rule'. (This is a

target for suspect cancer patients to be seen by a specialist within two weeks.)

30. On 19 October, the man attended hospital for a gastroscopy, which involves a fibre-optic tube being passed down the gullet into the stomach to detect any abnormalities. The results were normal and it was decided that no further gastroenterology appointments were necessary. However he continued to deteriorate.

31. On 25 October, the man saw a doctor again but once more he declined a rectal examination, but agreed the next day. The doctor found a lump in his rectum which he was concerned could be cancerous. He arranged for him to be admitted to the healthcare unit, and he contacted the hospital for an urgent appointment. On 27 October, a doctor recorded that his bloods were abnormal and it was possible that he had cancer.

32. On 29 October, the man was admitted to hospital for a surgical assessment. He had a number of tests including a CT scan which shows detailed images of the internal organs. This showed what appeared to be a lower large bowel cancer with an apparent significant spread into the lymph glands and other glands in the abdomen. Biopsies were taken for further tests.

33. The man was discharged from hospital on 2 November 2012 with a provisional diagnosis of rectal carcinoma with local invasion and possible bony metasteses. This means that cancer had been found and it might have spread to areas other than the main tumour site. This diagnosis was confirmed on 7 November, following further examination of biopsy specimens.

34. The clinical reviewer concludes that it would have been difficult for the man's diagnosis to have been reached more quickly, because of his non-specific symptoms, his pre-existing non-ulcer dyspepsia and his refusal to have a rectal examination. We are satisfied that the doctor made an urgent referral as soon as he suspected cancer and that once he was able to make a rectal examination and found a lump which he considered might be cancerous, he appropriately referred him to hospital for assessment.

Informing the man about his condition and treatment

35. The hospital informed the man of the provisional diagnosis of rectal cancer before he was discharged on 2 November. On 3 November, a doctor and a nurse discussed treatment options with him, and he told them that he didn't want any active treatment. He also completed a Do Not Attempt Resuscitation form (DNAR – this means that in the event of cardiac or respiratory arrest, no attempt at resuscitation will be made).

36. On 9 November, a doctor explained to the man that the hospital wanted to discuss surgical options with him, and that these options would be palliative not curative. The hospital confirmed his terminal diagnosis later that day. He made it clear that he did not want surgery. On 15 November, a doctor

discussed the possibility of a colostomy (an operation to divert a section of the colon through an opening in the abdomen), but he said he did not want this.

37. The man had frequent appointments with healthcare staff. There are a number of examples of discussions taking place about his condition and available treatments, although he consistently refused active treatment. The notes also indicate he joined a support group.

38. We are satisfied that the man was fully informed and supported about his condition and treatment. The clinical reviewer notes that a multidisciplinary approach was used with prison healthcare staff and the hospital all involved in his care.

The man's medical appointments and treatment

39. The man had a number of hospital appointments, particularly during the investigative stages of his illness. There is no evidence in the records that any of these were missed. There was very good liaison between the hospital and prison. As noted above, he decided against any treatment.

40. We are satisfied that the man was able to attend all his hospital appointments and was fully informed of the treatment options available by the hospital and prison healthcare. We are satisfied that he understood the consequences of refusing treatment and had the mental capacity to make this decision.

The man's pain relief and medication

41. When the man was discharged from hospital on 2 November, he was prescribed oramorph (liquid morphine) to help control his pain. A nurse noted on his record at 5.30pm that there was no oramorph in stock at the prison and he was in a great deal of pain. A supply was obtained from an emergency community pharmacist, which he received later that evening.

42. The Head of Pharmacy explained that the inpatient unit does not keep oramorph or morphine in stock, but that the prison pharmacy does. However, after office hours the pharmacy was locked and closed. We were told that usually, when a prisoner is discharged from hospital, they return to the prison with enough medication for their needs. However, the man had already been prescribed oramorph and morphine before he was admitted to hospital which had been stored in the prison pharmacy so the hospital did not supply him more.

43. On 15 November, a prison doctor noted that the man's pain control was inadequate and he required fentayl patches (a very strong pain killer). These administer pain relief in a more consistent way in an attempt to combat the breakthrough pain that can occur with other types of pain relief. A nurse also noted that day that at times his pain control seemed poor. Records show that he frequently refused additional pain relief and preferred to wait until his pain was more severe.

44. The man was referred to palliative care services on 16 November and attended an appointment at a hospice on 7 December. There was regular contact between staff at the hospice and the prison about his pain relief from this point.

45. A hospital surgeon and palliative care nurse saw the man on 14 December, because his pain and nausea were getting worse (and his renal function was deteriorating). When he returned to the prison, medication was administered through a syringe driver to provide more effective control of his nausea and pain. The man's pain relief continued to be managed by the palliative care team until his death.

46. The clinical reviewer said that at times the man's pain and nausea proved difficult to control but this often arose from attempts to comply with his wish that he should not be given any analgesia until his pain was more severe. Once the hospice palliative care team took over in December, we are satisfied that his pain relief was adequately managed. However, we are concerned that he had to wait several hours for pain relief when he returned from hospital on 2 November. Prison service performance standard 22 – health services for prisoners - states that there should be an 'out of hours' pharmacy cupboard for healthcare staff only, containing medication that might be required for urgent prescribed treatment. Such a provision would have enabled him to receive his prescribed oramorph quickly when he needed it.

The Head of Healthcare and Head of Pharmacy should ensure that there is appropriate access out of hours to urgent prescribed treatment so that pain relief is not delayed.

Liaison with the man's family

47. A prison family liaison officer was appointed on 7 November. On 8 November, the liaison officer contacted the man's sister and arranged for family members to visit him in the healthcare unit. Their first visit took place on 13 November and his family were able to speak to healthcare staff about his diagnosis and treatment options. They also spoke to someone from the chaplaincy team.

48. Records show that there was frequent contact between the man's sister and the prison and that the family were able to visit without the need for a visiting order. His sister was concerned that when she visited him the day before he died she had been told that regardless of his condition she would not be able to stay with him at night.

49. The Head of Healthcare explained that they have to fit in with the prison's security regime. The Governor said that night security arrangements are very strict and it would be difficult for family members to visit after hours. Apart from the security implications he would be concerned that staff he would like to be there such as chaplains and the prison family liaison officer might not be available.

50. The man died towards the end of May. The prison's family liaison telephoned his sister with the news. It had been agreed in advance that when he died his sister would be telephoned with the news as she wanted to hear it as soon a possible rather than wait for the prison staff to travel to her home. The family liaison officer spoke to her again on 28 May to offer support and guidance. In line with national guidance, the prison offered a contribution towards funeral expenses. A memorial service was held at the prison on 14 June.

51. We are satisfied that the prison made good arrangements for the man's family to visit him easily and that there was effective family liaison. The issue of allowing them to visit while the prison was in night secure state did not arise, but as the prison has a palliative care suite this is something the Governor will need to consider for the future. It is difficult to imagine that a family would be asked to leave the bedside of a dying relative because of the time. We do not consider the difficulties insuperable and other prisons have made arrangements to allow family members to stay at night time when a prisoner is dying.

The man's location

52. After returning the prison from hospital on 2 November, the man was readmitted to the prison's healthcare. The unit has two enhanced care rooms for individuals with palliative needs known as the King's Fund Suite. The rooms are purpose built, furnished with soft chairs and adjustable beds and look out onto gardens.

53. The man moved to one of the King's Fund rooms on 3 November but back to a standard cell in healthcare on 28 November as his health had significantly improved. On 24 January 2013, he said he wanted to discharge himself from healthcare and return to his wing. He did so on 13 February, but returned two days later acknowledging that he needed the support the unit was able to offer. He moved into one of the King's Fund rooms again afterwards and remained there until he died.

54. We are satisfied that the man was appropriately accommodated once his terminal illness was diagnosed.

Compassionate Release

55. Release on compassionate grounds is a means by which prisoners, who are seriously ill, usually with a life expectancy of less than three months, can be permanently released from custody before their sentence has expired. The criteria for early release for determinate sentenced prisoners are set out in Prison Service Order (PSO) 6000. Among the criteria is that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of the National

Offender Management Service (NOMS). However, where the Governor does not support the application, it is rejected at local level.

56. The man was considered for compassionate release on two occasions, 7 November 2012 and 24 May 2013. On the first occasion, when he was first diagnosed with cancer, his community offender supervisor stated that he had previously denied his offences and had said he had no intention of complying with any licence conditions. His risk remained high as he still voiced strong feelings against victims.

57. The man's prison offender supervisor noted that his level of denial made him unsuitable for sex offender therapy. However, the doctor's opinion was that he had less than two months to live and was no longer capable of reoffending. (Although he lived for a further six months.) The Governor at the time did not support this first application as he considered his risks remained too high so his application did not proceed.

58. The new Governor said he reconsidered the original request on 24 May 2013, three days before the man died. Because of victim issues and lack of appropriate arrangements for his care he did not consider the risks to be low enough to recommend compassionate release.

59. We are satisfied that compassionate release was appropriately considered as soon as the man's diagnosis was known and again six months later. On both occasions, the application was not progressed further by the Governor, who considered his risks remained too high.

Palliative care plans and end of life care pathway

60. The NHS document 'The route to success in end of life care – achieving quality in prisons and for prisoners' sets out how an end of life care pathway might be implemented in prisons. Among the benefits of an end of life pathway are that it helps carers plan when and how care will be delivered and helps patients make choices about how they are cared for towards the end of their lives.

61. The man was referred to palliative care services on 16 November and attended an appointment at a hospice on 7 December. There was frequent contact between staff at the hospice and the prison about his care and pain relief from this point.

62. The man died in the prison's enhanced care unit. Three care plans were drawn up by staff to help manage his care towards the end of his life. The first care plan was opened when he was diagnosed and was to ensure he was given appropriate emotional support. The second care plan was opened on the 4 May 2013 to monitor pressure areas and the third on 23 May to provide care as guided by an end of life pathway (designed to assist with delivery of care for people nearing the end of life and includes discussions with the patient and relatives, coordination of care, assessment and review, care in the final days and after death).

63. The man and his family were involved in discussions about plans for his care. On 13 November 2012, his sister and other family members were invited to the prison's healthcare unit and told about the palliative treatment options available. They thanked staff for involving them**.**

64. On 23 May, a nurse and a prison doctor explained the care being provided including what an end of life care pathway entailed. Syringe drivers and anti-sickness medication were explained to family members. They also discussed the man's religious and spiritual preferences with staff.

65. We are satisfied that appropriate care plans were put in place and the man and his family were fully informed and involved in discussions about his care.

Restraints, Security and bedwatch

66. 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. 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 regarding 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.

67. On 29 October 2012, the man was admitted to hospital for a surgical assessment. He was there four nights. His risks were assessed as low for hostage taking and receiving outside assistance to escape, medium for escaping unassisted and towards hospital staff and high in terms of risk posed to prison staff and the general public. The overall risk was deemed to be medium. The medical assessment, part of the risk assessment, was completed and said that his medical condition restricted his ability to escape unassisted. Reference was also made to his mobility issues and need to use a stick and a wheelchair.

68. The senior manager's decision was that, because of the man's medical condition, an escort chain (a long chain with a handcuff at each end attached to the prisoner and an officer) should be used to restrain him and he should be accompanied by two officers. The prison's policy is that escort chains should be removed for treatment only when the escorting officer has checked this is appropriate with the duty governor. It can be removed for medical emergencies and the duty governor informed as soon as practicable.

69. Although the man's risk to the public was assessed as high, it is evident from the medical assessment that he was unable to escape unassisted as his mobility was poor and he relied on a walking stick and wheelchair. He was escorted at all times by two prison officers so it is difficult to see how his risk was such that restraints were needed.

70. During his stay, the man remained restrained by an escort chain, but this was removed for treatment. Records show that on each occasion permission was sought and given by the duty governor.

71. The man had a further appointment at hospital on 9 November when his terminal diagnosis was confirmed. The medical assessment concluded, contrary to the earlier assessments, that his condition did not restrict his ability to escape unassisted but all the other security risks remained the same. The escorting arrangements were the same as previously.

72. The man had four more appointments to hospital. In three out of the four appointments, his condition was considered to restrict his ability to escape unaided and his requirement for a walking stick and a wheelchair was mentioned. In all cases, his security risks remained the same, yet his assessed lack of ability to escape did not affect any of the decisions about the level of restraints or escorts.

73. We are particularly concerned to note that on the last of the appointments on 14 March at hospital, a doctor asked one of the escorting officers to remove the man's restraints for an examination. The officer noted that removal was not necessary and declined. There is no record of the officer referring this request to the duty governor as he was required to do.

74. Although the risk assessments before the man's appointments took into account his physical condition and lack of ability to escape unaided, this information did not seem to affect the level of escorts or restraints applied and we are not satisfied that the use of restraints were fully justified for a dying prisoner whose mobility was poor. It is unacceptable that an officer should have declined to remove the restraints at the request of a doctor without discussion with the duty governor. We make the following recommendation:

The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances, are based on the actual risk the prisoner presents at the time, and that escort staff understand their responsibilities when medical staff request the removal of restraints.

RECOMMENDATIONS

1. The Head of Healthcare and Head of Pharmacy should ensure that there is appropriate access out of hours to urgent prescribed treatment so that pain relief is not delayed.

2. The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances, are based on the actual risk the prisoner presents at the time, and that escort staff understand their responsibilities when medical staff request the removal of restraints.

ACTION PLAN: The Man – HMP Isle of Wight

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1.	The Head of Healthcare and Head of Pharmacy should ensure that there is appropriate access out of hours to urgent prescribed treatment so that pain relief is not delayed	Accepted	The provision of urgent medication prescribed out of hours is currently being reviewed by the Head of Health and Justice Commissioning for NHS England (Thames Valley). The pharmacy located in the prison is locked and closed during out of hours. Care UK is not contracted to supply an out of hours general pharmacy within the prison site. The out of hours emergency pharmacy cupboard located in the clinical area of the inpatient healthcare unit is accessible to nurses out of hours. Oramorph is not a medication generally prescribed for use in an urgent/emergency situation. Where patients returning from an outside hospital out of hours are prescribed medication that may not normally be held in the prison ward stock, they should be given any medication that they may require by the hospital. In order to achieve this improved liaison with prison health services prior to discharge is needed so immediate health needs can be met in a timely manner. There is a clear set of guidance in place that is updated as and when required. The latest updated version of this guidance will shortly be supplied to the Isle of Wight NHS Trust. The	30 November 2013	

			prison has requested that the Healthcare Trust make a presentation to senior managers and clinical staff on the particular needs surrounding the discharge of prisoners from hospital to prison. HMP Isle of Wight has also instigated a more 'assertive outreach', whereby the prison's inpatient healthcare unit nurses visit prisoners while they are in hospital. Since this matter has been brought to the attention of the local Healthcare Trust, improvements have already been seen and prisoners are arriving back into the prison from outside hospital with all medication required in place.		
2.	The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances, are based on the actual risk the prisoner presents at the time, and that escort staff understand their responsibilities when medical staff request the removal of restraints.	Accepted	A revised risk assessment process, including a management checklist, has now been introduced to ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and the actual risk the prisoner presents at the time. As part of the management check there is now a prompt to managers to consider the appropriateness of restraints and consultation with medical staff. Managers have been provided with written advice to reinforce this process. Staff have also been provided with guidance regarding prisoners who are seriously ill. It is part of the management check that they should be conversant with this instruction.	Completed and ongoing	