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 on 4 January 2015, while a prisoner at HMP Northumberland

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 who died from multi-organ failure on 4 January 2015, while a prisoner at HMP Northumberland. He was 63 years old. I offer my condolences to those who knew him.

An investigator carried out the investigation. A pharmacist reviewed the clinical care the man received at HMP Northumberland. The prison cooperated fully with the investigation.

The man was sentenced to seven years in prison in August 2014 and had been at Northumberland since 10 September. He suffered from multiple chronic health conditions, but did not have a GP review when he arrived. The man lived on a wing for vulnerable prisoners, and spent most of his time in bed.

In September, shortly after he arrived at the prison, doctors prescribed the man antibiotics for a urine infection, but did not see him in person. The first time a doctor saw him was in early October, by which time his symptoms had improved. The doctor considered his urine infection had responded to the medication and did not investigate further. At a routine lung capacity test on 18 December, a healthcare assistant found that the man had lost almost 14kg since he had arrived at the prison. No one followed up the test results and this significant weight loss.

On 29 December, an officer reported that the man was unwell and in pain. A nurse examined him and noted he was dirty, dehydrated and malnourished. He had also been incontinent. The man was taken to hospital by ambulance and admitted to the intensive care unit where he was treated for a bacterial kidney infection. Although he was acutely ill, he was restrained for several hours in hospital, until a doctor asked for the restraints to be removed. On 3 January, officers re-applied the restraints when his condition improved a little. His condition deteriorated again and they removed the restraints. He died the next day.

I agree with the clinical reviewer that the man did not receive care in prison equivalent to that he could have expected to receive in the community. There was no systematic assessment of his health needs when he first arrived at the prison and he had no care plans for his long-term conditions. It took too long for him to see a GP. When he did, his symptoms were not investigated sufficiently thoroughly. I am very concerned that basic standards of care were overlooked and it is unacceptable that, in his last weeks, the prison appears to have neglected him. This poor care continued when he was taken to hospital, when the use of restraints was not justified by an appropriately considered risk assessment, a matter I have raised with the prison before.

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 **June 2015**

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SUMMARY

1. In August 2014, the man was sentenced to seven years in prison and moved to HMP Northumberland on 10 September. He suffered from many chronic health conditions, but when he arrived at the prison, he did not have a comprehensive health assessment and did not see a GP. He looked unkempt and had been incontinent of urine

2. The man lived on a wing with a number of other older prisoners and rarely left his cell. Staff described him as dishevelled and unkempt. On 20 September, the man was unwell and a nurse diagnosed a urine infection. A doctor prescribed an antibiotic but did not see the man. On 25 September, a urine sample showed the man still had an infection and another doctor prescribed an alternative antibiotic. Again, the doctor did not examine the man.

3. On 1 October, a doctor examined the man for the first time at the prison and noted he still had tenderness to his right side and told him to continue with the antibiotics. A week later, another doctor reviewed the man. Although he still had pain in his right side, his other symptoms had improved and the doctor considered his infection had responded to the antibiotics. The doctor diagnosed lumbar spondylosis (age-related degeneration of the spine) and noted no further action was necessary.

4. On 18 December, the man had a lung capacity test. The healthcare assistant conducting the test weighed him and recorded his weight as 67.1kgs, a loss of 13.9kgs (over 2 stone) in the three months since he had arrived at the prison. The healthcare assistant placed the test results, including the man's weight, in a tray for a qualified nurse to review. No one reviewed or took any action on the results.

5. On 29 December, an officer reported that the man was unwell. A nurse examined him and was concerned about his condition and asked for an ambulance to take him to hospital. The hospital admitted the man and found he had a bacterial kidney infection. At first, officers restrained the man by an escort chain, until a doctor asked them to remove it. The chain was used again on 3 January for a day, when the man came out of intensive care. The man did not recover and died in hospital on 4 January 2015.

6. The clinical reviewer concluded that the man did not receive care equivalent to that he could have expected to receive in the community. When the hospital admitted him, he was in neglected state. We are concerned that healthcare staff did not assess the man when he arrived and did not fully investigate his ongoing symptoms, including significant weight loss. There were insufficient checks on his general welfare and the use of restraints was not justified when the man went to hospital. We make five recommendations.

THE INVESTIGATION PROCESS

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

8. NHS England commissioned a phamacist to review the man's clinical care in prison.

9. The investigator obtained copies of the man's medical records and relevant extracts from his prison record. The investigator and the clinical reviewer interviewed prison and healthcare staff on 25 February.

10. We informed HM Coroner for North Northumberland of the investigation, who provided the cause of death. We have sent the coroner a copy of this investigation report.

11. The man had no contact with his family and did not identify a next of kin while in prison. We have therefore not been able to involve any family members in this investigation.

12. The prison has submitted an action plan detailing what they have done to address the issues we raised and this is included at the end of the report.

HMP NORTHUMBERLAND

13. HMP Northumberland was formed in 2011 by the merger of two separate prisons, HMP Acklington and HMYOI Castington. The prison can hold more than 1,300 men. Sodexo Justice Services has managed the prison since 1 December 2013. Until April 2015, Care UK provided healthcare services. G4S is now the healthcare provider.

HM Inspectorate of Prisons

14. The most recent inspection of HMP Northumberland was in September 2014. Inspectors found that identification of new arrivals with disabilities was poor. Many prisoners with disabilities were in the oldest accommodation but some reasonable adjustments had been made. The prison employed prisoner carers to look after men who needed extra support. Over 200 prisoners were over 50 and most prisoners over 55 were located on Houseblock 14 (where the man lived). Records of personal officer contact were very variable and often limited to basic wing behaviour. Inspectors found that health services were good overall, but noted that although healthcare staff saw new arrivals, they often did not have a comprehensive secondary health assessment to follow this up.

Independent Monitoring Board

15. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its most recently published report for year to December 2013, the IMB noted that, at a time of major change in the prison when the contract for health had been up for renewal over a prolonged period, there had been no increase in complaints about healthcare.

Previous deaths at HMP Northumberland

16. The man was the sixth person to die from natural causes at HMP Northumberland since January 2014. We have previously made recommendations about the use of restraints for prisoners being taken to hospital and the legal requirement to take their health and mobility into account in risk assessments. We have also made a recent recommendation about personal officers.

KEY EVENTS

17. On 13 August 2014, the man was sentenced to seven years in prison for sexual offences and sent to HMP Liverpool. The man's community GP indicated he had high blood pressure, heart disease, epilepsy, chronic obstructive pulmonary disease and poor mobility. The man refused to attend a new patient screening assessment with healthcare staff at the prison. On 10 September, he moved to HMP Northumberland.

18. A healthcare support worker assessed the man when he arrived at Northumberland. She noted he looked dishevelled and unkempt and had been incontinent of urine. The healthcare support worker gave him some clean clothes. There is no record that anyone referred the man for an incontinence assessment. A GP did not see the man and he did not have a secondary health assessment.

19. On 12 September, a prison GP reviewed the man and continued his medication, but without examining him. On 16 September, a nurse saw the man for a disability assessment. She noted he had had a cardiac bypass about eight years earlier, was unsteady on his feet and needed a walking stick or walking frame to get about. He was registered disabled. She recorded his weight as 81kgs. The nurse referred the man for an elderly person assessment.

20. Later that morning, a mental health nurse assessed the man and concluded that he did not need mental health support. The mental health nurse noted he was breathless and needed a wheelchair to get back to his cell. She advised him to rest and to carry his GTN spray (for angina) with him.

21. Around 9.15am on 20 September, a wing carer (a prisoner trained to help less able prisoners with day-to-day living) told a nurse that the man was unwell. The nurse went to see the man in his cell and he told her he had pain on his right side, was constipated and had been passing blood (rectal bleeding.) The nurse noted he had high blood pressure, a low pulse rate and poor oxygen saturation. The nurse asked an officer to take the man to the healthcare unit in a wheelchair.

22. Just after 10.00am, a nurse examined the man in the healthcare unit. He repeated his symptoms and the nurse took a urine sample, which indicated he had an infection. The nurse took the man's clinical observations again and found his blood pressure was still high, but his temperature was normal. A prison GP reviewed the man's symptoms from the medical notes and prescribed an antibiotic for the infection. The doctor did not examine the man in person, but advised that he should drink plenty of fluids and that a doctor should review him in two days. (It was a further ten days before a doctor examined him.)

23. On 21 September, a nurse went to see the man, who said he was still in pain, but he was not distressed and said he had managed to eat the previous

evening. The nurse advised him to carry on taking the antibiotics and to drink plenty of fluids and that a nurse would check him the next day.

24. On 22 September, the man told a nurse that he was still in pain and feeling unwell but had been passing urine and drinking plenty of fluids. His blood pressure was normal. The nurse gave him paracetamol for pain relief and made an appointment for a doctor to see him nine days later. She told him a nurse would review him on 25 September.

25. On 23 September, the man's personal officer noted that the man had been lying on his bed all day and had not engaged with staff.

26. On 24 September, a nurse saw the man for an elderly person's assessment. His clinical observations (blood pressure, pulse, and oxygen levels) were all within normal range. She noted he weighed 79kgs.

27. A nurse reviewed the man on 25 September. He was still in pain around his back and a urine sample indicated he still had an infection. The nurse discussed this with a doctor, who prescribed another antibiotic but did not examine the man. The nurse gave him paracetamol.

28. On 1 October, a doctor examined the man, the first time he had seen a GP since he had arrived at the prison. The doctor noted some right sided spinal tenderness and advised the man to continue taking the antibiotics. On 8 October, the doctor examined the man again, when he said his pain had improved. As he had completed the course of antibiotics, the doctor considered his infection had responded to the treatment, but did not ask for a urine test to confirm this. The doctor examined the man's spine, noted it was still tender, and diagnosed lumbar spondylosis (age-related degeneration of the spine). She did not consider any follow up action was necessary.

29. The man's offender supervisor (responsible for implementing his sentence plan at the prison) introduced herself to him on 8 October. She noted he had no family. He spent most of his time in his cell, because of mobility problems. She recorded that staff had told the man how he could get help on the wing and that healthcare staff regularly reviewed his medication.

30. On 22 November, a new personal officer noted in the man's case notes that he had no concerns about him. There is no record of any interaction with him.

31. After 8 October, there is no record that healthcare staff had any further contact with the man until 18 December, when a healthcare support worker carried out a routine lung capacity (spirometry) check. The man was concerned he had lost weight and, as part of the standard check, the healthcare support worker recorded his weight as 67.1kg. This was a loss of 13.9kgs since he had arrived at Northumberland in September. The healthcare support worker noted the results of the tests, including his weight, on a form, which she placed in the nurses' in-tray for a qualified nurse to check the results. This never happened.

32. Around midday on 29 December, a wing carer told an officer that the man was unwell. The officer found him in bed, with his legs drawn up to his abdomen and struggling to breathe. The officer asked a nurse, who was dispensing medication nearby, to see the man. The nurse checked the man's medical record and went to his cell with a healthcare support worker.

33. The nurse examined the man and noted that he was very pale, his skin was dry and he looked dehydrated. He was very unkempt, his clothes were dirty and he had been incontinent. His hands and feet were cold. Another nurse also attended and asked the communications room to telephone an ambulance to take the man to hospital. North East Ambulance Service records confirm they received the request at 12.27pm. Based on the information given, they did not treat it as an emergency.

34. The second nurse noted that the man seemed severely dehydrated, anaemic, and malnourished. He had been incontinent and the second nurse and the healthcare support worker washed the man and changed his dirty clothes. The nurses had to cut his fingernails before they could place a pulse oximeter on his finger to test his oxygen levels. His toenails were also long and dirty and the first nurse described him as being in an 'awful state'.

35. While waiting for the ambulance to arrive, the nurses had difficulty getting a blood pressure reading and were unable to test his oxygen levels. There were signs that the man's organs were shutting down. The second nurse then asked for an emergency ambulance. The ambulance service received the emergency request at 1.47pm.

36. At 1.56pm, an emergency paramedic arrived and treated the man for dehydration and very low blood sugar. At 2.47pm, an ambulance left the prison and took the man to Wansbeck Hospital. The man was restrained by an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). At the hospital, doctors asked the officers to remove the escort chain. The officers sought permission from a prison manager, who agreed and the officers removed the chain at 5.40pm.

37. At 7.10pm, the man was taken to the intensive care unit of the Freeman Hospital in Newcastle, for specialist treatment of a bacterial infection in his kidney. The man told prison escort staff that he did not have any next of kin.

38. On 30 December, the prison asked an officer to support the man. Later that morning, the officer and a nurse visited the man in hospital; he was unconscious and gravely ill.

39. The man remained in the intensive care until 11.30am on 3 January 2015, when he transferred to another ward, as his condition had improved a little, although he remained seriously ill. Officers then restrained him again, using an escort chain. At 11.30pm, the intensive care unit re-admitted the man following abnormal blood test results. His condition deteriorated and officers removed the escort chain. He died in hospital staff at 9.21pm on 4 January.

40. As the man had listed no next of kin or other person he wanted contacted, the prison informed the man's solicitor of his death. They had no information about any family. The prison arranged the man's funeral, which a prison chaplain conducted, on 5 February.

Support for staff and prisoners

41. The Director posted notices to staff and prisoners informing them of the man's death and the support available for anyone who needed it.

Cause of death

42. The Senior Coroner for North Northumberland issued a death certificate recording the man's death as from natural causes, caused by multi-organ failure due to acute left pylonephritis (a severe bacterial infection in the kidney) with a contributory factor of coronary artery atheroma (blocked arteries).

ISSUES

Clinical care

43. When the man arrived at HMP Northumberland, he already had significant health problems and suffered from a number of chronic illnesses. The clinical reviewer concluded that, although there is evidence that the man received some compassionate care from prison nurses, overall, he did not receive a satisfactory standard of nursing and medical care at Northumberland, equivalent to that he could have expected to receive in the community.

Health assessments on arrival

44. When the man arrived at Northumberland in September, a healthcare support worker noted that he had been incontinent of urine, but did not make any referral to establish whether this was an ongoing problem. Although the man had a number of long-term conditions, there was no detailed assessment of his conditions when he arrived and a GP or qualified nurse did not review him. His conditions appear to have been stable at the time, and managed by medication, but there were no care plans for COPD or for his heart condition. At the time he arrived, his medical record indicated there was a query about an outstanding hospital appointment for a lung test, but this was not followed up. No one made any subsequent appointments to review the man's cardiac condition.

45. Prison Service Order (PSO) 3050 Continuity of Healthcare for Prisoners, gives guidance on the clinical management of prisoners. As well as initial health assessments, the PSO requires prisons to offer every prisoner a general health assessment to gather and provide further information and check how the prisoner is settling. They should do this in the week following first reception.

46. In the report of an inspection of Northumberland in September 2014, HM Inspectorate of Prisoner noted that prisoners did not have comprehensive health assessments after they arrived and recommended these should be done within 72 hours. Although the man had disability and elderly prisoner assessments, these were not comprehensive reviews of his medical conditions. We consider that the lack of such an assessment was one of a number of missed opportunities at the prison to investigate the man's conditions and symptoms and put in place appropriate care plans to manage his health conditions. We make the following recommendation:

The Head of Healthcare should ensure that newly arrived prisoners have comprehensive secondary health assessments to identify and meet ongoing health needs and that healthcare staff implement care plans for long-term conditions.

Investigation of ongoing symptoms

47. On 20 September, when a urine sample revealed a urinary tract infection, a doctor prescribed an antibiotic, but did not see the man in person. Earlier that day, a nurse had noted that the man had also reported rectal bleeding, but there is no record that this was brought to the doctor's attention or followed up. The doctor noted that a GP should review the man on 22 September, but a nurse saw him instead.

48. On 25 September, another doctor prescribed a second course of antibiotics, as a further urine test had showed the man still had an infection. The doctor did not examine the man. The man had reported ongoing pain and this was a missed opportunity to investigate this further. Healthcare staff appear to have assumed the pain was related to his ingoing infection.

49. It was not until 1 October, that a doctor examined the man and told him to keep taking the antibiotics. Although nurses had seen the man frequently since the urine infection had been diagnosed, the clinical reviewer considered that he should have seen a GP earlier and there should have been more active examination of the man's symptoms. This appointment was another missed opportunity to do that. When the doctor saw him again on 8 October, his symptoms suggested that the infection had cleared, but there was no further urine test to confirm this.

50. As well as pain and other symptoms associated with the urine infection, the man also had significant weight loss, which can indicate a serious underlying condition. On 16 September, the man's weight was 81kgs and on 24 September, a nurse noted his weight was 79kg. Over the next two weeks, no one asked the man about his diet and appetite or considered his weight loss, which might have resulted in a referral to a dietician or for further investigation. By 18 December, the man had lost 13.0kg since he had arrived at the prison in September. A healthcare assistant noted this in a spirometry assessment, but no one followed this up, as should have happened.

51. Ten days after the spirometry test, the man was taken to hospital in a very serious condition. We are concerned that healthcare staff missed several opportunities to investigate the man's symptoms, including rectal bleeding, ongoing pain and significant weight loss. We make the following recommendations:

    The Head of Healthcare should ensure that prisoners with ongoing symptoms such as significant weight loss, ongoing pain and infection have their symptoms properly examined and investigated at a timely GP review to determine their root cause.

Wellbeing and social care

52. From the time the man arrived at Northumberland on 10 September, until he was taken to hospital on 29 December, there were only three entries in his prison case notes: two by his personal officers and one by his offender

supervisor. An officer was initially the man's personal officer when he arrived at the prison. The officer made the first entry on 23 September; nearly two weeks after the man arrived. It was an observational entry about him staying in his room and did not indicate any engagement with him or that she had introduced herself to him.

53. On 22 November, a new personal officer noted in the man's case notes that he had no concerns. Again, there is no record that he had introduced himself to the man and there is no reference to the man's wellbeing.

54. The prison has a personal officer policy, which states that personal officers are expected to get to know about the prisoners they are responsible for, including their personal circumstances. Personal officers are supposed to have fortnightly interviews with the prisoners and to make entries in their prison records of their discussions. A senior officer told the investigator that personal officers should make entries in prisoners' records at least every two weeks, yet there were only two personal officer entries in the 15 weeks the man was at the prison. The two entries made do not indicate any significant interaction with the man or any awareness of his needs and how they should be met.

55. The senior officer told us that prisoners in Houseblock 14, where the man lived, have five well-being checks throughout the day, when officers check that prisoners are okay, by obtaining a verbal response. These checks are not recorded, unless there are concerns that need to be followed up.

56. The prison told us that the well-being checks were to check for a prisoner's physical well-being, but not welfare issues like personal hygiene. However, there should be an effective check put in place to refer prisoners for help. On the day the man was taken to hospital, his condition was poor. Before he went, healthcare staff felt it necessary to change his clothes, wash him and cut his finger and toenails. An officer told the investigator that he knew the man spent most of the day in bed and had to be cajoled to attend to his hygiene, yet there was no note of this in his records or that anyone took any action about his social care needs. No one referred him for help.

57. The man had a disability assessment and an elderly prisoner assessment not long after he arrived at the prison, but these did not result in any care plans. He had a mental health assessment on 16 September, but no further mental health input after that. The clinical reviewer noted that healthcare staff had often recorded that the man spent periods in bed, isolated himself from other prisoners and was not eating or drinking. Wing staff were also aware of this, yet no one considered referring him for a further mental health assessment to determine whether he was suffering from depression.

58. Staff should have identified that the man had ongoing care needs, before he was taken to hospital on 29 December, when a nurse described him as severely dehydrated and malnourished and in a very dirty condition. We make the following recommendations:

The Director and Head of Healthcare should implement a coordinated multi-disciplinary approach to ensure that prisoners with physical, mental and social care needs receive appropriate standards of care.

The Director should ensure that officers have meaningful contact with every prisoner, through an effective personal officer scheme, which ensures that officers get to know prisoners and identify their needs, backed up by regular case history notes

Restraints, security and bed watch

59. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. 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 takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between the prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgement indicated that prison staff must take into account medical opinion about the prisoner's ability to escape and keep this under review as circumstances change.

60. When the man was taken to hospital in 29 December, a member of healthcare administrative staff completed the healthcare section of the escort risk assessment and noted there were no healthcare objections to the use of restraints and that the man could escape unaided. There was no information about how his medical condition or lack of mobility affected his risk of escape. (The Head of Healthcare told the investigator that only qualified staff would complete healthcare assessments in future.) An orderly officer decided that officers should use an escort chain to restrain the man. There was no input from security staff and a senior manager did not countersign the assessment.

61. The escort chain was not removed until later that afternoon, when a hospital doctor requested this. However, officers used a chain again on 3 January, after the man transferred from the intensive care unit to a general ward. The restraints were not removed finally until after the man was admitted to the intensive care unit again at 11.30pm that day.

62. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances, which must be fully considered, taken into account and balanced against the security risks. When the man went to hospital on 29 December, he was extremely unwell and in a very poor physical state. In hospital, he remained bed-bound and very ill. There is no evidence that his limited mobility or serious condition was considered when assessing his risk of escape, as required by the 2007 High Court judgement. Nor was there anything to justify the further use of restraints again in hospital on 3 January. Although the man was no longer in intensive care, he was still very seriously ill.

63. Ultimately, it is the Director's responsibility to ensure that the risk assessment process is managed properly. However, healthcare staff also need to understand their responsibilities, and have appropriate and considered input into the risk assessment process. We have made recommendations to Northumberland before about this issue, and the prison undertook to make changes. The use of restraints in the man's case does not suggest that practice has changed. We make the following recommendation:

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

RECOMMENDATIONS

1. The Head of Healthcare should ensure that newly arrived prisoners have comprehensive secondary health assessments to identify and meet ongoing health needs and that healthcare staff implement care plans for long-term conditions.

2. The Head of Healthcare should ensure that prisoners with ongoing symptoms such as significant weight loss, ongoing pain and infection have their symptoms properly examined and investigated at a timely GP review to determine their root cause.

3. The Director and Head of Healthcare should implement a coordinated multi-disciplinary approach to ensure that prisoners with physical, mental and social care needs receive appropriate standards of care.

4. The Director should ensure that officers have meaningful contact with every prisoner, through an effective personal officer scheme, which ensures that officers get to know prisoners and identify their needs, backed up by regular case history notes

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

ACTION PLAN: The man – HMP Northumberland

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible
1.	The Head of Healthcare should ensure that newly arrived prisoners have comprehensive secondary health assessments to identify and meet ongoing health needs and that healthcare staff implement care plans for long-term conditions.	Accepted	All prisoners will be seen by a nurse on arrival into the prison. A second health assessment will be completed within 48 hours of arrival. During the clinical reception screen, long-term conditions will be highlighted and an appointment made to a virtual clinic. A senior nurse will go through prisoners on the virtual clinic on a daily basis and arrange a follow-up and a review with the most appropriate clinician. Care plans will be implemented for long-term conditions. Since 1 April 2015, a weekly audit of initial healthcare appointments, secondary healthcare appointments and appointments made to virtual clinics are completed by the healthcare senior management team (SMT) to ensure compliance.	1 July 2015 Head of Healthcare
2.	The Head of Healthcare should ensure that prisoners with ongoing symptoms such as significant weight loss, ongoing pain and infection have their symptoms properly examined and investigated at a timely GP review to determine their root	Accepted	Any prisoners identified by nursing staff with ongoing symptoms will be routinely referred to a GP for an assessment and further investigations. The GP will decide whether a consultation is appropriate and the timings of any appointments. The prisoner may be further referred to a consultant who will then determine the timings of ongoing reviews carried out by either nursing staff	30 June 2015 Head of Healthcare

	cause.		or GPs. A notice will be issued reminding all healthcare staff of the process for making referrals to the GP for ongoing symptoms. A monthly audit of all nursing referrals to GPs will be completed by the healthcare SMT.	
3.	The Director and Head of Healthcare should implement a coordinated multi-disciplinary approach to ensure that prisoners with physical, mental and social care needs receive appropriate standards of care.	Accepted	A multi-disciplinary approach was introduced on 1 March 2015 to address the needs of individuals who may have social care and/or complex needs. This includes a pathway referral, following which a multi-disciplinary panel linked to safer custody will convene (urgently if required). The panel assess the needs of the individual, consider involvement from specialist agencies and develop an individualised care plan. The panel then implement and evaluate the service/care provided. There is a comprehensive package of paperwork to support this process, including reviews and care plans, and the process will be reviewed by all parties at each case review.	30 June 2015 Head of Healthcare
4.	The Director should ensure that officers have meaningful contact with every prisoner, through an effective personal officer scheme, which ensures that officers get to know prisoners and identify their needs, backed up by regular case history notes.	Accepted	The personal officer scheme has been reviewed and re-launched. Staff information notices have been issued outlining the requirements of the scheme. Quality assurance checks of case note entries will be made weekly and managers have been reminded of their responsibilities.	Completed and ongoing Head of Residence

5.	The Director and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and those assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.	Accepted	All staff undertaking risk assessments will be reminded of the process for completing assessments for prisoners being escorted to hospital. Risk assessments will take into consideration information about the health of the prisoner and the actual risk posed by the prisoner at the time.	30 June 2015 Head of Healthcare / Head of Security