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 December 2014, while a prisoner at HMP Wymott

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, of bronchopneumonia, in December 2014, while a prisoner at HMP Wymott. He was 79 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at Wymott was undertaken. The prison cooperated fully with the investigation.

The man was sentenced to twelve years in prison in December 2007 and had been at Wymott since February 2008. He had a number of health problems, including a bone condition, osteoarthritis and high blood pressure. He had previously been treated for bladder cancer. Healthcare staff saw him frequently to monitor and treat these conditions. In 2014, he was diagnosed with inoperable renal cancer. In September and October 2014, he had a number of falls. On 11 October, he fell again and had an operation for a fractured femur. No one informed his family until a week later. He contracted an infection in hospital and his condition deteriorated. He remained in hospital and died in December.

The clinical reviewer considered that the man's care at the prison was not equivalent to that he could have expected to receive in the community. Medical record keeping was poor, which made it difficult to establish an exact sequence of events, but there appear to have been some delays in referring him to hospital. The extent of his pain was not always recognised and effectively managed, even after his cancer diagnosis. Despite his age and infirmity, until his final admission to hospital, he was always restrained for hospital visits, without appropriately considered risk assessments. This is a matter I have raised with the prison a number of times before. There is also a need for more effective family liaison for prisoners who are seriously ill.

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. On 21 December 2007, the man was sentenced to twelve years in prison. He had been at HMP Wymott since 22 February 2008. In 2004, he had been treated for bladder cancer, for which he had annual check ups.

2. In prison, the man had a number of health problems, including Paget's disease (a condition that causes brittle bones), osteoarthritis in his hips and knees and hypertension. His mobility was poor. Prison healthcare staff frequently reviewed his conditions.

3. From August 2013, the man complained of abdominal pain, weight loss, bowel and urinary problems. Some hospital appointments were delayed and prison healthcare staff did not clearly record the outcome of hospital tests. Because of this, it is not clear whether his diagnosis of renal cancer was as timely as it could have been. Hospital doctors diagnosed cancer in March 2014, but this was not noted in his prison medical records until August 2014. His condition deteriorated over time and his mobility became more limited.

4. In the last year of his life, the man went to hospital a number of times and staff used an escort chain to restrain him. He was often in pain, especially at night, which was not always well controlled.

5. In September and October, the man fell in his cell several times. On 11 October, he was admitted to hospital after a fall and had an operation for a fractured femur. Officers did not use restraints during this admission. No one informed his family that he had been admitted to hospital until they arrived to visit him at the prison, a week later. He had another fall in hospital. He contracted an infection and died in hospital in December.

6. The clinical reviewer considered that the man's care at the prison was not equivalent to that he could have expected to receive in the community. The prison did not keep up-to-date records to ensure effective and timely continuity of care. On occasions, he suffered severe pain because of restricted access to pain relief during the night. Healthcare staff should have assessed his risk of falls earlier, to help prevent them. We are concerned that prison managers authorised officers to restrain him for hospital appointments, without fully considered risk assessments. The prison took too long to notify his family that he was seriously ill. We make six recommendations.

THE INVESTIGATION PROCESS

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

8. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison record. On 5 February 2015, she interviewed three members of staff at Wymott. She informed the prison of her preliminary findings.

9. NHS England commissioned a clinical reviewer to review the man's clinical care in prison.

10. We informed HM Coroner for Preston and West Lancashire District of the investigation, who provided a copy of the post-mortem report. We have sent the coroner a copy of this investigation report

11. One of the Ombudsman's family liaison officers contacted the man's niece, his nominated next of kin, to explain the investigation. She was concerned that no one from the prison had let her know when her uncle was admitted to hospital in October and that the prison generally did not maintain good contact.

12. The man's family received a copy of the draft report and had no comments to make. The prison considered our draft report and recommendations, which they have accepted. The prison has also 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 WYMOTT

13. HMP Wymott is a medium secure prison holding over 1,100 adult men. Lancashire Care NHS Foundation Trust provides healthcare services at the prison. A private company provides GP services and out of hours medical cover. There are no inpatient beds, but there is 24-hour nursing cover.

HM Inspectorate of Prisons

14. The most recent inspection of HMP Wymott was in July 2014. Inspectors found that there was excellent care for older prisoners and those with disabilities who lived on the specialist facility in I wing. The quality of health care was reasonably good, but undermined by long delays and poor access to GPs and the dentist. The range of clinics provided reflected the needs of the prison population, including for chronic diseases. There were good palliative care and end-of-life procedures.

Independent Monitoring Board

15. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recently published report, for the year to May 2014, the IMB noted that waiting times for GP appointments was an issue, but the triage system operated by the nurse practitioner had ensured that urgent cases were seen promptly. They commented that managers and staff had worked hard to maintain Wymott as a prison that holds prisoners with safety, decency, respect and security.

Previous deaths at HMP Wymott

16. The man's death was the seventh from natural causes at Wymott since December 2013. We have previously made recommendations about the unjustified use of restraints and informing the next of kin when a prisoner is taken to hospital.

KEY EVENTS

17. On 21 December 2007, the man was sentenced to 12 years in prison for sexual offences. He began his sentence at HMP Preston and transferred to HMP Wymott on 22 February 2008. He lived on I Wing at Wymott, a specialist unit for older prisoners.

18. In 2004, doctors had treated the man for bladder cancer, for which he had annual check ups. In 2010, doctors diagnosed him with Paget's disease (a condition that causes abnormal, brittle bones) and osteoarthritis in his hips and knees. Prison GPs monitored him and referred him to rheumatology and orthopaedic specialists. Doctors prescribed pain relief and a calcium supplement. He used a walking frame and walking sticks.

19. In August 2011, the man had a disability assessment, which noted he had problems walking and could not go up and down stairs or dress himself without help. At first, he had a carer to help him, but a further assessment in October 2011 showed he could manage daily tasks with minimal assistance and did not need a carer.

20. Over the next two years, healthcare staff monitored the man's ongoing health conditions frequently.

21. In August and September 2013, the man reported abdominal pain, difficulty urinating and constipation. On 18 September, a nurse tested his urine but found nothing abnormal. She advised him to increase his fluid intake and rest. She referred him to a prison GP.

22. On 22 September, a locum GP examined the man. He diagnosed bursitis (inflammation and swelling of fluid-filled sacs under the skin, usually over the joints) and prescribed pain relief.

23. On 2 October, a prison GP examined the man and requested an ultrasound scan of his abdomen and kidneys. On 30 October, the prison received the results of scans completed on 21 October. The GP did not discuss the results with him until 14 November, and there is nothing in his records to show that a doctor had reviewed the results before then. The GP said he suspected a malignancy and made an urgent referral under the NHS pathway, which requires patients with suspected cancer to be seen by a specialist within two weeks. The hospital carried out a cystoscopy (an internal examination of the bladder) within two weeks and found an area of ulceration, which needed further examination. He was listed for a further cystoscopy and bladder biopsies under general anaesthetic.

24. On 20 December, the GP recorded that the man had had the cystoscopy and biopsy and was waiting for the results. He also referred him for a colorectal appointment because of abdominal pain. (Investigations, including a colonoscopy over the next few months, eventually showed nothing abnormal.) He had ongoing pain in January 2014 and began to use a wheelchair. On 7 February, he reported persistent blood in his urine and, despite the entry of 20

December, the GP noted that he was aware the man was waiting for a cystoscopy and biopsy and would refer him urgently again.

25. A healthcare administrator chased up the referral and found that the appointment had not happened because of organisational changes in hospital services. (These matters are outside the remit of this investigation.) A prison GP made a further referral and the man was admitted to hospital between 17 and 21 February for the investigations.

26. On 10 March, the man attended hospital, apparently for the results of the tests. The escort records noted that a hospital doctor had told him he had a cancerous lump, which needed surgery. Nothing was noted in his prison medical record, although there is a reference to a clinic letter to Wymott that day. On 4 April, he had a kidney biopsy by keyhole surgery. On 23 April, a letter from a consultant urologist referred to a possible blockage in his left kidney.

27. Over the next three months, records show healthcare staff saw the man many times when he complained of severe abdominal pain. Staff noted that he was being followed up by a urologist. He was treated for a urine infection and continued to suffer ongoing pain.

28. On 31 July, the man told a nurse that he was still in pain. She noted that antibiotics had not helped clear his urine infection. The next day she examined him in the healthcare centre and noted that he had lost weight. She spoke to the GP and agreed to try to bring forward his next urology appointment.

29. The man attended an appointment with a urology consultant on 26 August. The consultant informed the prison by faxed letter that he had arranged for the hospital to admit him the next day for palliative care, as he had a diagnosis of an advanced left renal pelvic tumour. On 27 August, the hospital admitted him for care and pain relief.

30. On 8 September, a nurse noted that she had discussed the man with a palliative specialist care nurse at the hospital and that he had an advanced left renal tumour, which was too advanced for surgery. His pain was stable on oxycontin (opiod medication), which she arranged for the prison pharmacy to order in advance of his discharge, but noted that it would be difficult if he needed medication for breakthrough pain during the night. On 11 September, he returned to Wymott.

31. On 14 September, the man told a nurse that he had fallen in his cell a couple of times the previous night. She noted he had a small graze on his nose and bruising on his right hand and advised him to take it easy when he got up. The next day, a GP discussed with him the possibility of moving to the inpatient unit at HMP Preston. However, he wanted to stay at Wymott.

32. Early on 16 September, the man fell and banged his head and hip. At 4.30am, a nurse examined him and noted he had a small mark on his head but no other injuries. At 5.00am on 17 September, she went to see him as he was

complaining of rib pain possibly from his fall the previous day. She gave him pain relief and arranged for the GP to see him. The GP examined him in his cell later that day. He noted some mild tenderness of his right lower ribs. The GP said he should use the buzzer to summon help when he wanted to get out of bed.

33. On 25 September, a nurse completed a care plan and recommended a falls risk assessment as the man had fallen a number of times. On 28 September, a nurse noted he was hardly eating and used sticks to help him walk around the wing and a wheelchair when he needed to go off the wing. At 4.25pm on 29 September, a nurse noted that he had fallen on his bottom, but had no injuries.

34. During the night of 29 September and again on 1 October, a nurse went to see the man in his cell when he reported being in pain and needing pain relief. Doctors had prescribed opiod pain relief, which, as a controlled drug, had to be signed for by two members of staff. She said that the duty manager refused to sign for the medication, so she could not issue it. She did not record the reason for the manager's refusal.

35. The man had two more falls on 5 and 7 October. Records show a nurse referred him for a hospital falls assessment on 9 October. By this time, he had fallen at least five times. There is no record of whether the assessment took place or any outcome in his medical record.

36. On 26 September, the man went to hospital for a urology appointment. Two officers escorted him and used an escort chain to restrain him.

37. At 5.30am on 11 October, the man had another fall as he tried to leave his cell, which was kept unlocked, to ask an officer for more pain relief. A nurse attended and found him on the floor of his cell. He said he had a pain his hip. The nurse helped him back to bed, gave him paracetamol and told him to ask for healthcare staff again, if the pain continued. At 9.43am, a nurse noted he was in pain and gave him more pain relief. A nurse rang the on call doctor, who advised that they should take him to hospital for an X-ray. At 11.00am, he went by non-emergency ambulance to hospital and doctors found he had a fractured femur. Doctors operated the next day.

38. On 29 October, a nurse spoke to hospital staff, who told her the man's condition had stabilised. However, on 30 October, he had another fall in hospital. He contracted a bacterial infection and was nursed in isolation. On 5 November, a Macmillan nurse said that his condition had deteriorated considerably. His condition continued to get worse and he died in hospital.

Liaison with the man's family

39. On 18 October, the man's daughter and two sons had arrived at the prison to visit him, unaware that he had been taken to hospital on 11 October. They were allowed to visit him in hospital.

40. The man had initially named one of his sons as his next of kin. An officer acted as the prison's family liaison officer and helped arrange visits from several family members. On 13 November, the man told the officer that the prison should consider his niece as his next of kin. The officer agreed with his niece that she would ring her when he died.

41. After the man's death, another family liaison officer telephoned his niece to inform her, and offer condolences and support. The prison arranged and paid for the funeral in line with national guidance.

Support for staff and prisoners

42. A Governor's notice informed staff and prisoners of the man's death and offered support to anyone affected. Staff reviewed prisoners identified as at risk of suicide and self-harm, in case the news of his death had adversely affected them.

43. On 1 December, a manager held a debrief for staff involved in caring for the man at the end of his life and offered them support.

Post-mortem

44. A post-mortem examination concluded that the man had died of bronchopneumonia associated with a fractured femur (operated), osteoporosis (brittle bones), renal carcinoma and old age.

45. The pathologist noted that the man had died from a severe acute chest infection, to which he was at increased risk because of his underlying frailty from old age, cancer and the need to operate on his femur. The pathologist recorded that he had an increased risk of fractures because of osteoporosis.

ISSUES

Clinical care

46. The clinical reviewer concluded that the man's clinical care in prison was not equivalent to that he could have expected to receive in the community. She considered that there were delays in him having the appropriate medical investigations, which possibly held up his cancer diagnosis. However, she noted that she could not definitively reach that conclusion, as the prison medical keeping was so poor. Nevertheless, there was a delay of over two weeks at the end of October 2014, when the prison received the results of his ultrasound scans, and the urgent referral for suspected cancer on 14 November.

47. The clinical reviewer was concerned that poor record keeping also contributed to the delay in other medical investigations and appointments. In particular, between August 2013 and April 2014, there was conflicting information about which tests the man had had and information about this in his medical record was insufficient and unclear. There was a lack of clarity about who was responsible for following up delays with appointments and action was taken only when an individual doctor or nurse noticed that action was outstanding. The clinical reviewer did not consider this was a safe or satisfactory system. There were delays entering information in the records. Healthcare staff did not keep satisfactory records, which could have contributed to some of delays in referrals, appointments, investigations and treatment. The clinical reviewer noted that the first clear mention of renal cancer in his prison medical record was in August 2014, five months after the apparent diagnosis.

48. Information in medical records should enable healthcare providers to determine the prisoner's medical history and help provide informed care. The record should be the central repository for planning patients' care and documenting communication between clinicians contributing to their care. The man's records fell far below that standard and, without appropriate records, we cannot be assured that he had an appropriate standard of care. We are also concerned about the delay in his initial urgent referral for suspected cancer. We make the following recommendations:

    The Head of Healthcare should ensure that all healthcare staff follow professional guidance for record keeping, including making clear, prompt and accurate entries in the medical record which reflect all major diagnostic investigations and hospital discharge plans.

    The Head of Healthcare should ensure that there is full and timely scrutiny of investigation results. Where indicated, there should be an urgent referral for suspected cancer and this should be followed up.

Pain Relief

49. The clinical reviewer noted that the man reported severe pain for over a year. Although he had pain in his hip, it was mainly in his abdomen or back. Doctors eventually diagnosed inoperable renal cancer, but the clinical reviewer was concerned that the time it took to reach a final diagnosis resulted in inadequate pain relief before that.

50. Records show that in the last months of his life, the man often complained of pain through the night and his pain was not always adequately controlled. Nurses usually checked him twice in the night and often found him already in pain. On 11 October, he fell in his cell, after trying to see officers to ask for more pain relief. The administration of controlled drugs during the night, in a prison without a 24-hour in-patient facility and with only one nurse on duty at night, presented problems. Although records suggest that this was a difficulty on only a couple of occasions, his pain was not always well controlled and he did not always receive medication for breakthrough pain at night, although doctors had prescribed this.

51. Prisoners who are seriously ill need access to appropriate pain relief and there should be a system to ensure that they receive their medication when needed, including during the night. We make the following recommendation:

    The Head of Healthcare should ensure that seriously ill prisoners receive appropriate pain relief and that there are arrangements to provide this at all times, including at night.

Falls risk assessment

52. The clinical reviewer noted that the man was very vulnerable to having a fall. A fall resulted in a fractured femur, which was one of the causes of his death. He had a number of risk factors for fractures, including his age, the presence of Paget's disease, increasing frailty resulting from his cancer and the effects of his medication.

53. In September 2014, the man had at least three falls in prison, and then another two in early October, before he was taken to hospital after a fall on 11 October. The clinical reviewer considered that healthcare staff should have completed a falls risk assessment earlier. After his first fall, he should have been assessed with an emphasis of keeping him safe in the environment in which he lived. In line with the National Institute for Health and Care Excellence (NICE) guidelines dealing with assessment and prevention of falls in older people, an assessment after his second fall should have highlighted the hazards, interventions needed and the need for a medication review to determine what effect his medication might have had on his stability.

54. A nurse referred the man to the hospital for a falls risk assessment, but there is nothing in the record to show whether the assessment was ever carried out. No adjustments were made and there was nothing to alert staff to his very high

risk of falls. This was an omission in his care. We make the following recommendation:

The Head of Healthcare should ensure that prisoners at risk of falls have an appropriate risk assessment in line with NICE guidelines and the assessment is recorded and acted on.

Restraints, security and escorts

55. 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.

56. Between January and October 2014, the man attended hospital numerous times. On each occasion, two officers escorted him and restrained him with an escort chain. This was despite the fact that throughout this time he was frail and had poor mobility. Staff completing risk assessments assessed him as a medium risk to the public and a low risk to hospital and prison staff. Despite his frailty and poor mobility, his risk of escape was assessed as medium. There was limited healthcare input into the risk assessments, but this often noted his poor mobility, including that he sometimes needed to use a wheelchair. We are not satisfied that managers authorising the use of restraints fully took into account his mobility and health or an up to date assessment of his actual risk.

57. For his hospital admission on 11 October, healthcare staff again noted no objection to restraints, but said that the man was receiving palliative care and needed a stretcher. An operational manager decided that staff should not restrain him because of his lack of mobility, age and medical condition. We are pleased to note that staff did not restrain him from this point onwards.

58. However, we are concerned that for all previous hospital visits staff restrained the man. We spoke to an operational manager (who had signed many of the risk assessments) and the Head of Healthcare, and both said that they were unaware of the legal requirements when completing assessments and considered an escort chain the default position.

59. 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. We were concerned that some of the staff involved in risk assessments and escorts spoke of their fear of the consequences if things went wrong and it was apparent that as a result

they operated in a very risk averse way rather than taking appropriate account of the actual risks.

60. Ultimately, it is the Governor's responsibility to ensure that the process is managed properly, but healthcare staff need understand their responsibilities when assessing how health and mobility affects the risk of escape. We have made a number of recommendations to Wymott before about the unjustified use of restraints, and on each occasion the prison accepted the recommendation and undertook to make changes. In response to a recommendation made in the investigation report into a death at the prison in June 2014, the prison issued new instructions to staff in September 2014 and we recognise that many of the man's appointments pre-dated this. Nevertheless, we are concerned that some managers were still unaware of the legal position. We make the following recommendation:

The Governor should take active steps to ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position. Assessments should fully take into account the health of a prisoner and be based on the actual risk the prisoner presents at the time.

Liaison with the man's family

61. Prison Rule 22(1) requires that when a prisoner is seriously ill "the governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed". In addition, Prison Service Instruction (PSI) 64/2011, Safer Custody, requires prisons to have procedures to engage with the next of kin when prisoners have a terminal illness of suffer an unpredicted and/or rapid deterioration in their physical health.

62. The man's family were concerned that the prison did not keep them informed about his hospital admissions. In October, his family only discovered that he was in hospital when they came to the prison to visit him. By this time, he had been in hospital a week. We consider the prison should have notified them when the hospital first admitted him. Afterwards, members of his family visited him in hospital a number of times and the hospital kept his son (who he had originally listed as his next of kin) updated about his condition.

63. In November, the man told the family liaison officer that he wanted the prison to consider his niece as his next of kin from then on and that she should be kept informed of his condition. The family liaison officer remained in contact with her and agreed to inform her of his death by telephone, in line with her preference.

64. We are satisfied that, after 18 October, both the hospital and prison kept relevant members of the man's family informed and they were able to visit him. However, we consider that the prison should have informed his next of kin when he went into hospital on 11 October for surgery. We have raised this issue with the prison before. We make the following recommendation:

The Governor should ensure that the next of kin of seriously ill prisoners are informed as soon as possible when they are admitted to hospital and kept informed of their progress.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that all healthcare staff follow professional guidance for record keeping, including making clear, prompt and accurate entries in the medical record which reflect all major diagnostic investigations and hospital discharge plans.

2. The Head of Healthcare should ensure that there is full and timely scrutiny of investigation results. Where indicated, there should be an immediate urgent referral for suspected cancer with all referrals followed up.

3. The Head of Healthcare should ensure that seriously ill prisoners receive appropriate pain relief and that there are arrangements to provide this at all times, including at night.

4. The Head of Healthcare should ensure that prisoners at risk of falls have an appropriate risk assessment in line with NICE guidelines and the assessment is recorded and acted on.

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

6. The Governor should ensure that the next of kin of seriously ill prisoners are informed as soon as possible when they are admitted to hospital and kept informed of their progress.

ACTION PLAN

No	Recommendation	Accepted / Not Accepted	Response	Target date for completion & Function Responsible
1	The Head of Healthcare should ensure that all healthcare staff follow professional guidance for record keeping, including making clear, prompt and accurate entries in the medical record which reflect all major diagnostic investigations and hospital discharge plans.	Accepted	All healthcare staff have been given access to mandatory training (including online training) in relation to record keeping and are responsible for completing this. This covers information governance training and all nurses at HMP Wymott adhere to the Nursing and Midwifery Council code of conduct.	30/06/15 Head of Healthcare
2	The Head of Healthcare should ensure that there is full and timely scrutiny of investigation results. Where indicated, there should be an immediate urgent referral for suspected cancer with all referrals followed up.	Accepted	Protocols have been put in place for General Practitioners (GP) and Nurse Practitioners (NP) to follow up urgent referrals in accordance with NICE guidelines. A procedure has also been put in place for the administration of urgent referrals.	30/06/15 Head of Healthcare
3	The Head of Healthcare should ensure that seriously ill prisoners receive appropriate pain relief and that there are arrangements to provide this at all times, including at night.	Accepted	GP/NP and non-medical prescribers will follow NICE guidelines for providing appropriate pain relief. Lancashire Care NHS Foundation Trust's (LCFT) Controlled Drug (CD) policy is in place for all staff to access and implement when issuing CD medication, including at night time.	30/06/15 Head of Healthcare
4	The Head of Healthcare should ensure that prisoners at risk of falls have an appropriate risk assessment in line with NICE guidelines and the assessment is recorded and acted on.	Accepted	A risk assessment template is accessible on SystmOne for staff to complete for patients at risk of falls. Appropriate referrals will be made for relevant prisoners upon the completion of risk assessments.	30/06/15 Head of Healthcare
5	The Governor should take active steps to ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position. Assessments fully take into account the	Accepted	The Head of Healthcare will remind all healthcare staff of the legal position that a distinction needs to be made between the risk of escape (and the risk to the public in the	Completed Head of Healthcare & Governor

	health of a prisoner and are based on the actual risk the prisoner presents at the time.		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. A Governor's Order (05/2014) was issued in September 2014. The order instructs staff to ensure that the new escort risk assessment forms are used with immediate effect when completing all escort risk assessments. The hospital escort risk assessment states that '*A new risk assessment is required for every escort / appointment*', and the Healthcare section within the assessment records the current condition and risks posed by each prisoner.	
6	The Governor should ensure that the next of kin of seriously ill prisoners are informed as soon as possible when they are admitted to hospital and kept informed of their progress.	Accepted	Where possible, an operational Governor will undertake this task with the relevant appointed Family Liaison Officer and they will inform the next of kin at the earliest opportunity.	Completed Governor