

**Investigation into the death of a man whilst in the custody  
of HMP Birmingham in November 2008**

**Report by the Prisons and Probation Ombudsman  
for England and Wales**

**June 2009**

This is the report of an investigation into the death of a 61 year old prisoner at HMP Birmingham. The man died on 28 November 2008 in outside hospital from natural causes. He had been admitted to the hospital on 17 November and was diagnosed four days later with terminal cancer. The man was serving a sentence of 33 months.

I would like to add my personal condolences to those already expressed to the man's family on behalf of this office by one of my Family Liaison Officers.

This investigation was undertaken by one of my investigators. In addition Heart of Birmingham Primary Care Trust was asked to undertake a review of the man's clinical care. I am grateful for the assistance they received from staff at HMP Birmingham and would ask the Governor to pass on these sentiments.

The man's family has expressed concerns about his care and treatment which I have considered carefully. However, the clinical reviewer concludes that the man's care was of an equivalent standard to that he would have received in the wider community. I hope that his family are reassured by the conclusions of my report. The clinical review raises a number of learning points that the prison health partnership will need to consider. He has made two recommendations which I endorse.

I make one recommendation of my own with regard to Birmingham's policy on the use of restraints on prisoners who are in hospital. I believe that restraints should have been removed from the man earlier than was in fact the case.

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.

**Stephen Shaw CBE**  
**Prisons and Probation Ombudsman**

**June 2009**

## **CONTENTS**

Summary	4
The investigation process	5
HMP Birmingham	6
Key events	8
Issues considered	12
Conclusions	16
Recommendations	17

## **SUMMARY**

The man was 61 years old when he died in outside hospital on 28 November 2008. The man's death was from natural causes as a consequence of bronchopneumonia and widespread cancer.

The man had been sentenced at Salford Crown Court in August 2007 to 33 months imprisonment. He was received into custody at HMP Birmingham the same day. At the man's first health screening interview it was noted that he suffered from high blood pressure, Type 2 Diabetes, and mobility problems from chronic back pain. The man was a smoker but he chose not to accept assistance to help him stop. Due to his mobility problems and limited disabled facilities on the vulnerable prisoners unit, the man was admitted to Birmingham's healthcare inpatient department.

The man was taken to the Accident & Emergency (A&E) Department at an outside hospital on 30 July 2008 as he had developed severe abdominal pains and bloating. After tests were carried out, the man was discharged and returned to the prison. He was next admitted to hospital on 17 November after he experienced problems with his bowels. A biopsy was performed on 21 November and the man was diagnosed with terminal cancer. Whilst the man was in hospital, a bedwatch was carried out by prison staff. The initial security risk assessment concluded that handcuffs were to be used with two officers present at his bedside. The risk assessment was revised later on 27 November and handcuffs were no longer used. Arrangements were made to apply for his compassionate release and for him to move to a local hospice on 31 November. Sadly, the man passed away during the morning of 28 November before his family were able to reach the hospital.

After the man died, the prison activated its death in custody contingency plan. The police were informed and visited the hospital. They found no suspicious circumstances and the man's body was released to the undertakers who removed him to the mortuary for post mortem examination. The coroner's officer informed the Head of Safer Custody who was managing the prison's response following the man's death that he had died from natural causes.

The clinical review that was carried out identified a number of issues relating to the care provided for the man. The review highlights areas of practice that could be improved, and makes two recommendations for service improvement.

I make one recommendation of my own relating to the use of physical restraints.

## THE INVESTIGATION PROCESS

1. The investigation was opened on 4 December 2008 by my investigator. He issued notices announcing the investigation to both staff and prisoners. The notices included an invitation to anyone who wished to submit information relating to the man's death to make themselves known. In the event, no one came forward. My investigator also studied all relevant prison records, which included the man's main prison record and his medical records. He also read through the man's personal diaries.
2. My investigator visited Birmingham on 30 January 2009 and discussed aspects of the man's treatment with staff. He met the Governor and also interviewed the Clinical Lead General Practitioner at HMP Birmingham and the Director of Healthcare Services.
3. The Heart of Birmingham Primary Care Trust commissioned the clinical reviewer, an Associate Dean General Practitioner/Reviewer, to carry out an independent review of the man's clinical care. I am grateful to him for undertaking the review most expeditiously.
4. My investigator contacted HM Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion, this report will be sent to the Coroner to assist in his enquiries into the man's death.
5. One of my Family Liaison Officers contacted the man's family. This gave them the opportunity to discuss the purpose of the investigation and raise any concerns or questions that they wanted to be addressed. The family told her that:
  - They felt that the man's pain relief medication, his blood sugar and his blood pressure levels were not appropriately managed.
  - The man had told them that healthcare staff had said that, if he was given a prescription whilst in hospital, it would be taken away from on his return to the prison.
  - The family was surprised by the rapid deterioration in the man's health and that they had not been informed that he had been taken into outside hospital.
  - They were also concerned that the man had remained handcuffed and under two officer escort until shortly before his death.

My investigator has attempted to address the issues raised by the family. I hope that my report provides them with a better understanding of the events leading up to the man's death.

## **HMP BIRMINGHAM**

6. HMP Birmingham is a category B prison situated in the Winson Green area of the city. It was built in 1849. It serves the Crown Courts of Birmingham, Stafford and Wolverhampton. Additionally it serves the Magistrates Courts surrounding the city of Birmingham. In 2002, additional accommodation was built and provided a further 450 prison places. The prison now holds up to 1,450 adult male prisoners, both on remand and sentenced. HMP Birmingham has undergone significant improvement over the last few years, including the building of a new healthcare centre.
7. Healthcare at HMP Birmingham is provided by the Heart of Birmingham Teaching Primary Care Trust. It deals with the primary healthcare and contracts Birmingham and Solihull Mental Health Trust to provide mental healthcare services within the prison. Additionally, the Mental Health Trust provides staff for the 34 bed inpatient facility.
8. During 2008, there were two other deaths through natural causes at Birmingham. My investigator has found no common factors between the circumstances surrounding this investigation and those into previous deaths.

## **Independent Monitoring Board**

9. Each prison has an Independent Monitoring Board (IMB). IMB members are independent and unpaid. They monitor day-to-day life in their prison and ensure that proper standards of care and decency are maintained. Each IMB produces an annual report. The most recent annual report by the Birmingham IMB covers the period July 2007 to June 2008. The Board noted that overcrowding within the entire prison system, and at Birmingham specifically, remained a concern. Healthcare provision was recognised as having gone through significant changes over the year. The Board highlighted that healthcare facilities at Birmingham were viewed as both a local and national resource and that, as a result, "more robust partnerships" were necessary. Overall, however, they were "impressed ... with the dedication and professionalism of the staff".

## **Her Majesty's Chief Inspector of Prisons**

10. The most recent inspection of Birmingham by Her Majesty's Chief Inspector of Prisons, Dame Anne Owers, was in February 2007. In her report the Chief Inspector said that Birmingham prison was, once more, under "acute population pressure" which affected both staff and prisoners. Relationships between staff and prisoners were found to be problematic with residential staff having little input in prisoners' progress or resettlement. Entries in prisoners' personal prison files were "mostly poor". The personal officer scheme, which had been criticised during the previous inspection, remained "ineffective".
11. The Chief Inspector said that, like most local prisons, Birmingham struggled to find sufficient work or activity for its prisoners. Unemployed prisoners were found to spend over 22 hours locked in their cells.

12. Healthcare provision at the prison was found to be “mostly satisfactory”. It was mainly delivered from a “modern, purpose-built unit” by three distinct groups of staff working in primary care, inpatient care and in-reach. Relationships between healthcare staff and prisoners were identified as good, particularly on the inpatient wards.

## KEY EVENTS

13. On 16 August 2007, the man was sentenced by Salford Crown Court to 33 months imprisonment for indecent assault. He arrived at HMP Birmingham the same day. This was not the man's first experience of prison although he had not been in custody since 1989. It was decided that he should have vulnerable prisoner status due to his age and the nature of his offences.
14. During the man's first reception health screening interview, it was recorded that he had diabetes (Type Two), high blood pressure and mobility problems. Prior to coming into custody he had used both crutches and a wheelchair to help him move around. The man told staff that he used a wheelchair when he needed to walk any distance as he found it quite tiring. The man was a smoker but he chose not to accept help to stop. Due to his health problems, he was admitted to the healthcare centre and remained there for most of his time at Birmingham. The man received medication for his heart problems (Doxazosin, Fenofibrate and Aspirin), diabetes (Glucophage), insomnia (Lacidipine and Amitriptyline) and his back problems (Codydramol).
15. In the middle of September 2007, the man began to complain that the pain in his lower back was not properly controlled. On 15 September, his Amitriptyline was increased by the prison doctor. Five days later, on 20 September, he was seen by a physiotherapist who reviewed him for a wheelchair as the chair he was using was the wrong size. He was seen later on the same day by another prison doctor who prescribed Diclofenac (another pain killer) as the increased dose of Amitriptyline had not helped the man's back pain.
16. On 22 October, it was recorded in the man's medical record that he complained he had not received his evening dose of Amitriptyline and was in some discomfort. It is not clear why the omission occurred, but the next day the man reported that he felt much better after he received his medication.
17. Healthcare at Birmingham was informed on 20 November that the Heart of Birmingham Primary Care Trust would not provide a new wheelchair as they had insufficient funds.
18. On 5 December, the ward nurse manager spoke with the man's Community Probation Officer. The Probation Officer expressed surprise that the man was using a wheelchair as she said that he had previously managed to walk around independently. This information was passed onto the physiotherapist.
19. A month later, on 2 January 2008, the man was again seen by the prison doctor as he was still suffering from back pain. The doctor increased both the Amitriptyline and Tramadol (a synthetic opiate painkiller) to help manage his pain. On 15 January, the man was seen by the prison doctor as his blood pressure appeared a little high. The doctor decided to increase the man's medication and this successfully stabilised his blood pressure.

20. On 14 April, the physiotherapist undertook a comprehensive examination of the man. The physiotherapist managed to see that he had a good range of movement and was able to move around unaided and without apparent pain.
21. The man's next contact with healthcare was on 20 July 2008 when he complained of discomfort around his waist. He also expressed concerns that his blood pressure medication had lowered his blood pressure too much. Three days later, on 23 July, the man complained of back pain. He had a temperature and had not opened his bowels for three days. He was given Diclofenac for pain relief and clinical observations were undertaken. The man was seen by a prison doctor the next day by which time his temperature had settled, and he was given Lactulose (a laxative used for constipation).
22. On 30 July, the man developed severe abdominal pain and bloating. He had not moved his bowels despite taking laxatives. He was seen again by a prison doctor who was concerned that he might have a bowel obstruction. He was immediately taken by ambulance to the Accident & Emergency (A&E) Department at an outside hospital. The man was discharged later the same day after being given treatment for constipation. Whilst he was in hospital, further tests were carried out. The man's liver function, renal function and blood count were all normal. An x-ray of his bowel was also reported as normal.
23. During September, the vulnerable prisoners unit moved to a larger wing with some facilities for disabled prisoners. On 11 September, as the man's health appeared to be stable and he had no apparent need of additional nursing care, he was transferred to the vulnerable prisoners unit. By transferring to the vulnerable prisoners unit, the man was able to have more frequent exercise and fresh air. It also opened up a range of new activities to him and allowed him a wider social network.
24. After the man moved, he was given responsibility for managing all of his medication except for Tramadol and Amitriptyline (these are given under supervision by nursing staff as they are inappropriate to be kept in possession). The man was seen by nursing staff twice a day to receive his supervised medication, and he was also seen when his in possession medication was delivered.
25. On 6 November, the man complained again of constipation. He was seen by a doctor and given a stronger laxative. Over the next few days, the man's abdomen became swollen and he continued to be in discomfort.

26. Just over ten days later, on 17 November, the man was again taken to outside hospital as he had not moved his bowels. The man was kept in hospital with what was thought to be a gastro-intestinal malignancy. In her letter to my investigator dated 12 January 2009, the Clinical Lead General Practitioner, wrote:

“I spoke with the consultant on several occasions and explained the need for a diagnosis and prognosis in order to start the process of application for compassionate release or ROTL (Release on Temporary Licence). A CT [Computerised Tomography] scan showed a tumour in the pancreas and other tumours ... within the abdomen. Unfortunately, [the man] was felt to be in too unstable a condition to undergo biopsy until 21/11/08. The biopsy confirmed metastatic adenocarcinoma [cancer], a terminal condition.”

27. After the man’s diagnosis, the GP spoke with prison managers about the possibility of ROTL. Arrangements were made for his release on temporary licence (ROTL) on compassionate grounds to a hospice on 31 November.
28. A bedwatch was carried out whilst the man was in hospital. The initial risk assessment was that restraints (an escort chain) were to be used and two officers should remain on duty at his bedside. A log of activities was maintained by the officers on bedwatch duty and this was checked on a regular basis by a visiting duty governor.
29. Whilst the man was in hospital his health continued to deteriorate. Around 9.35am on 27 November, the staff on bedwatch duty were informed by the hospital doctor that the man’s prognosis was very poor. An officer wrote in the bedwatch log:

“Seen by doctor, prison also informed that the doctor feels [the man] only has a few days to live as no treatment would work. They also informed us that they [the hospital] are looking to move the man to a hospice.”

30. At 11.00am, the duty governor gave permission for the restraints to be removed from the man. She had spoken to a hospital doctor who confirmed that the man’s prognosis was very poor and that he was unlikely to survive more than two days. The man’s restraints were removed and were not re-applied. Two officers continued to be at his bedside.
31. In his statement to the Governor, a second officer wrote:

“On Friday 28 November 2008 I commenced duty at 0715 hours, at this time I was briefed by the duty manager in relation to a prisoner [the man] was on ward D15 ... My colleague and I then attended ward D15 and commenced the bedwatch ... My colleague and I relieved the two Prison Officers. At about 0815 hours the Staff Nurse briefed my colleague and I regarding [the man’s] medical condition. We were told

that his condition was becoming poor and that [the man] would possibly as a result pass away during the day. At about 1150 hours the Staff Nurse conducted observations on [the man] and told me that he had died. The prison doctor then attended to [the man] and at 1200 hours life was pronounced extinct.”

32. Unfortunately, the man’s family did not arrive at the hospital until after his death. They were met by a Principal Officer who had arrived at the hospital shortly after the man’s death. The Principal Officer informed the family that the man had passed away and offered his condolences and support.
33. The prisoners on the vulnerable prisoners unit were told the following morning about the man’s death. Staff on the unit asked prisoners whether they required anything or wanted to speak to a Listener. (Listeners are trained by the Samaritans to provide confidential emotional support to fellow prisoners in distress.) When the bedwatch officers returned to the prison they were offered support from the prison’s care team.
34. The Principal Officer was appointed as the prison’s Family Liaison Officer. He maintained contact with the family and assisted with the funeral arrangements. Birmingham also offered financial assistance with the costs of the funeral. The man’s funeral took place on 23 December.
35. The post mortem report records the man’s death as due to natural causes, as a consequence of bilateral bronchopneumonia caused by carcinomatosis (widespread cancer in many different organs). The verdict of the Coroner’s inquest into the man’s death, which was held on 15 May 2009, was that he died from natural causes.

## ISSUES CONSIDERED

### Clinical care

36. The man's family have had a number of concerns relating to his clinical treatment while in custody which I set out in the paragraphs that follow. As noted above, a review of the man's medical care was undertaken on behalf of Heart of Birmingham Primary Care Trust. My investigator informed the clinical reviewer of the concerns raised by the man's family.
37. In the first place, the man's family suggested that his pain relief medication, his blood sugar and his blood pressure levels were not appropriately managed.
38. In his review, the clinical reviewer records that staff at Birmingham carried out regular reviews and monitoring of the man's condition and medication. Neither my investigator nor the clinical reviewer could find any evidence that the man's pain relief medication, blood sugar levels and blood pressure levels were not appropriately managed. Both the clinical reviewer and my investigator noted that regular tests were carried out to check the man's blood sugar levels and his blood pressure. The man's pain relief medication was also increased as and when required.
39. My investigator also noted that tests were carried out after the man was admitted to outside hospital on 30 July. An x-ray of his bowel was reported as normal. Blood tests, the man's liver function, renal function and full blood count were also all normal.
40. Secondly, the man's family said he had told them that healthcare staff had said that, if he was given a prescription whilst in hospital, it would be taken away on his return to the prison. When interviewed as part of this investigation the Director of Healthcare at Birmingham said:

“... he wouldn't have drugs taken off him, if they're prescribed by an outside consultant he would have them but we'd have to confirm with pharmacy that we've got them in stock.”
41. Also when interviewed for this investigation, the Clinical Lead General Practitioner at Birmingham told my investigator that some of the medication prescribed by the hospital is not given to prisoners to hold in their own possession. She explained that these were mostly the opiate based medications. Some are not issued due to security issues as they could be used illicitly. The GP said:

“So on the whole, if somebody is prescribed an opiate based medication in the hospital, also many of those medications are three and four times a day that you need to take them and we're not in a position in the majority of the prison where we can provide medication three or four times a day. We replace them with slow release opiate based medication of ... similar or the same dose equivalent.”

42. Neither the clinical reviewer nor my investigator could find any evidence that medication was withheld from the man.

43. Thirdly, the man's family have said they were surprised by the deterioration in his health and that they were not been informed when he was been taken into outside hospital. In her written response, the Head of Safer Custody, wrote:

"The reason [the man's family] was not informed on the day of his admission is that we do not inform relatives until the third day of a prisoner being in hospital. This is down to the security implications which occur in bed watches. In the case where it is identified that the prisoner has a critical illness/condition then in those circumstances the relatives would be contacted - with agreement from the prisoner. However, in the man's case it was not identified that his condition was critical at the point of admission to healthcare."

44. I presume this general approach will be moderated depending on the individual prisoner's situation. As I have said in previous investigation reports, I expect each prison to immediately inform the family when a prisoner is very poorly. This enables family members to make arrangements for a visit that may be far from their home town. After the man's family received the draft investigation report they commented that they felt the delay in notifying them about his hospital admission was unacceptable. The family said that if the man had not contacted them directly they would not have been aware that he was in hospital. The family also disputed that the prison did not know the seriousness of the man's condition when he was admitted to hospital.

45. In her letter in response to the issues raised by the man's family, the GP wrote:

"If an advanced cancer had been present at this time one would expect that some of the blood results, such as haemoglobin, would have been abnormal at this time. The man continued to use Lactulose when he needed it and his constipation was much improved. Had a significant cancer been present at this time one would have anticipated the constipation or abdominal symptoms to persist or recur frequently. The Tramadol medication is known to cause constipation but this was effectively managed by Lactulose. The man was well and appeared to have no concerns. He was seen regularly by nursing staff and by the doctors who visited the ward twice weekly if concerns were raised."

46. In her interview with my investigator, the GP said:

"... his [the man's] terminal illness was remarkably fast I think for somebody who was up and around and normal and on the wing, doing things to becoming seriously unwell was a space of weeks. And the latter phase even faster."

47. The clinical reviewer reviewed the man's medical notes and the interventions of healthcare staff. From the medical records, he says it was clear that the man was seen regularly by healthcare staff and referred to secondary care when

appropriate. The clinical reviewer judges that the care provided to the man by staff at Birmingham was entirely appropriate. He had blood tests when necessary and action was taken appropriately on the results. The clinical reviewer concludes that the man had good nursing care and prison doctors were informed when necessary.

48. My investigator asked the clinical reviewer whether the man's condition could have been diagnosed earlier. The clinical reviewer confirmed that he could not find any entries in the man's records to suggest that any early symptoms or signs of cancer had been overlooked.
49. The clinical reviewer notes that, although computerised prisoner medical records add clarity to medical notes, the identity of the medical practitioner was not always recorded. The clinical reviewer recommends that the name and status of the medical practitioner should be added to entries on the computerised medical records.

**The Director of Healthcare should ensure that medical staff enter their name and status when they make entries on a prisoner's medical record.**

50. The clinical reviewer notes that there was no written communication from the outside hospital with HMP Birmingham, apart from a prescription in July 2008, and no summary when the man was discharged from hospital. He recommends that a discharge summary should have been issued by the outside hospital.

**The Director of Healthcare and Heart of Birmingham Primary Care Trust should develop a protocol with the outside hospital to ensure that written care plans are provided when prisoners are discharged.**

### **Use of restraints**

51. The final concern raised by the man's family was that he remained handcuffed and escorted by two officers until shortly before his death.
52. The use of handcuffs for prisoners on escort to hospital has been the subject of recent case law in relation to the issue of decent and humane treatment. (Judgment by Mr Justice Mitting on 23 November 2007 in the case of (1) Graham (2) Allen v Secretary of State for Justice.) I know that the Prison Service is currently drawing up new guidance in relation to this matter. Birmingham's decision that the man should be handcuffed in the first instance was in line with the standard procedures. At the time the handcuffs were applied, the man was conscious and was judged to pose a security risk.
53. According to the policy for performing hospital bedwatches adopted by Birmingham at the time that the man was in hospital, the following options were available to the Governor:
  - i. Escort and bedwatch with two officers or more, with restraints.
  - ii. Escort and bedwatch with two officers or more, without restraints.

- iii. Escort and bedwatch with one officer, without restraints.
- iv. If eligible, release on temporary licence under Prison Rule 9 (YOI Rule 6).
- v. ... exceptionally temporary release for remand prisoners if they are so seriously ill or incapacitated as to be incapable of escaping and for who there is no danger of assisted escape (this power is allowed under Section 22(2)(b) of the Prison Act 1952).

The level of security necessary for all prisoners should be kept under review to take into account their medical condition, the physical surroundings in which they are located, and any new information.

- 54. When the man was taken to hospital on 17 November 2008, the security risk assessment was that an escort chain should be used and two officers needed to be in attendance. Although the prospects of the man making a determined escape attempt were frankly remote, this decision was entirely in line with current practice throughout the Prison Service. The use of an escort chain enabled the nursing staff to have easy access to the man when they carried out their duties.
- 55. The risk assessment for the man was revised on 27 November after the duty governor, was informed that his death was likely to occur within 48 hours. The restraints were then removed and the man died just over 24 hours later.
- 56. The over-use of physical restraints on prisoners in hospital is a recurrent theme in my reports, although I understand why decision-making has become so risk-averse. Nevertheless, I believe there are many occasions when decisions to remove restraints earlier would be more consistent with the Prison Service's own 'decency' agenda. I consider that this is one such case.
- 57. After he entered hospital, the man's condition deteriorated rapidly. It was also clear from the action taken by medical staff that his prognosis was very poor. He had two officers at his bedside and I suggest that action to review the use of restraints could and should have been taken more quickly. I appreciate that, once the duty governor was informed that his death was imminent, permission was given to remove restraints. However, in other cases I have investigated, restraints have been removed once a terminal diagnosis was made. In the man's case, arrangements had already been made for him to move to a hospice. I therefore think that the duty governor should have made the decision to remove the restraints sooner. I recommend that there is a review of the bedwatch and escort instructions to ensure that this situation does not arise in the future.

**HMP Birmingham should conduct a review of bedwatch and escort instructions. This should include improved guidance and training for staff on the action to be taken when a prisoner is seriously ill.**

- 58. I am pleased to report that my investigator found that the bedwatch notes were concise, legible and appropriate. The Governor may wish to relay that positive finding to the staff concerned and their managers.

## **CONCLUSIONS**

59. The man arrived in HMP Birmingham in August 2007. Just seven days after he was diagnosed with terminal cancer in November 2008, the man died in outside hospital.
60. From the bedwatch log, it was clear to my investigator that the staff involved with the man's care behaved with compassion and sensitivity. The security arrangements at the hospital were in line with current policy and expectations, although my view is that a revised risk assessment should have been carried out at an earlier juncture.
61. Although I judge that the man's care was equivalent to what he would have received in the wider community, the findings of the clinical review and my own investigation highlight the need for some improvements to healthcare practices.

## RECOMMENDATIONS

1. HMP Birmingham should conduct a review of bedwatch and escort instructions. This should include improved guidance and training for staff on the action to be taken when a prisoner is seriously ill.

Accepted - A training needs analysis has taken place of staff requirements for escorts and bedwatches and we are currently formulating a training package for appropriate staff. This will be delivered within the next three months. In addition written guidance will be incorporated in the Escort and Bedwatch packs to highlight to staff the expected actions and requirements when a prisoner is seriously ill.

2. The Director of Healthcare should ensure that medical staff enter their name and status when they make entries on a prisoner's medical record.

Accepted – All staff have individual log-ons to the clinical system. Notice to all healthcare staff to be re-circulated.

3. The Director of Healthcare and Heart of Birmingham Primary Care Trust should develop a protocol with the outside hospital to ensure that written care plans are provided when prisoners are discharged.

Accepted - Daily duty roster implemented April 2009. Named nurse to follow up and be accountable for a number of duties including ensuring receipt and compliance with discharge planning.