Food Refusal Policy

Policy number and category	**C21**	**HMP Birmingham**
Version number and date	**5**	**May 2024**
Ratifying committee or executive director	**Clinical Governance Committee**	
Date ratified	**August 2024**	
Next anticipated review	**August 2027**	
Executive director	**Executive Director of Quality and Safety (Chief Nurse)**	
Policy lead	**Prison Deputy Governor** **Designated partner: Head of Healthcare**	
Policy author *(if different from above)*	**As above**	
Exec Sign off Signature (electronic)		
Disclosable under Freedom of Information Act 2000	**Yes**	

Policy context

- This policy is to ensure that prisoners who cease to take meals are properly identified, monitored and managed. It sets out the guidelines for the treatment and care of such individuals and provides guidance regarding consent to treatment in these cases.

Policy requirement

- This policy applies to staff from HMP, Birmingham & Solihull Mental Health NHS Foundation Trust (BSMHFT), Birmingham Community Healthcare NHS Foundation Trust (BCHFC) and Cranstoun.

- The policy will be located on the clinical shared 'Z' drive which provides access from all residential units, healthcare information room, 24-hour healthcare wings and primary care reception.

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1 INTRODUCTION

1.1 Rationale (why):

1.1.1 **Mental Health Act 1983.** Where a prisoner is suffering from a mental disorder of a nature or degree which makes it appropriate for him to be detained in hospital for medical treatment under the Mental Health Act 1983, then he may be transferred from prison to a mental health unit to receive treatment. Treatment under the Mental Health Act can only occur in an NHS hospital and transfer from prison to an NHS facility would need to be arranged.

1.1.2 **Mental Capacity Act 2005**. People who have capacity to take a particular decision are entitled to refuse medical treatment, even if it is clearly detrimental to their health. In law, no competent adult can be treated against their will. The use of artificial nutrition and hydration (ANH) constitutes medical treatment therefore the same legal principles apply. Therefore, capacious 'hunger strikers' cannot be force fed, even if it is to save their life. In a series of legal judgements, the courts have recognised that a competent individual has the right to choose to go on a "hunger strike" or refuse food. Towards the end of such a period an individual is likely to lose capacity (become incompetent) and the courts have stated that if the individual has, whilst competent, expressed the desire to refuse food until death intervenes, the person cannot be force fed or fed artificially once they have become incompetent. It has also been held by the courts that food and fluid refusal is not an attempt at suicide. An independent advocate should be offered and considered.

1.2 Scope (when, where and who):

1.2.1 This policy applies to staff from HMP, Birmingham & Solihull Mental Health NHS Foundation Trust, Birmingham Community Healthcare NHS Foundation Trust and Cranstoun.

1.2.2 The policy will be located on the practice clinical shared 'Z' drive and all residential units, healthcare information room, In-patients wards and primary care reception.

1.3 Principles (beliefs):

1.3.1 Any individual has the legal right to refuse food and fluid, provided they have capacity to make that decision. A person is always presumed to have capacity unless, on assessment, it can be established that they lack capacity.

1.3.2 Prisoners may refuse food for a number of reasons. They may have a medical condition affecting their appetite/ ability to eat or they may be suffering from an underlying mental disorder or they may be protesting about their incarceration.

1.3.3 The prisoner's refusal to eat may only last for a short period and before there is any threat to health. However, a prisoner faces a significant risk to his health or death if the food refusal is sustained for a long period of time.

1.3.4 The term "food refusal" will be used in this document, which will also cover circumstances in which the refusal is not total and minimal amounts of diet and fluid are being taken.

1.3.5 We positively support individuals with neurodiversity, and we will ensure that no-one is prevented from the application of this policy. Where a person has, or is suspected of having neurodiverse needs, staff will contact specialist services in order to ensure that service users and carers have a positive episode of care whilst in our services. Staff will ensure they obtain

specialist advice that specifically address issues such as, communication with patients, the meeting of physical health needs and issues involving restrictive practices. To achieve these principles information will be shared appropriately with specialist services and carers.

2 POLICY

The purpose of this policy is to ensure prisoners who cease to take meals are properly identified, monitored and managed. It sets out the guidelines for the treatment and care of such individuals and provides guidance regarding consent to treatment in these cases.

3 PROCEDURE

3.1 Capacity

3.1.1. Healthcare staff should refer to BSMHFT's Mental Capacity Act Policy (MHL 14) for all matters relating to Capacity.

3.2 Advanced Decisions

3.2.1 A Prisoner, when they have capacity, may make an advanced decision refusing treatment in the future when they may lack the capacity to consent or to refuse that treatment. Case law is clear that an advance refusal of treatment which is valid and applicable to the prisoner's current circumstances is legally binding.

3.2.2 Many patients refusing food or fluids who wish to make such an advance decision will want their own legal advisor to prepare the document and, where possible, this should be facilitated. A copy of any decision should be in the patient's record and SYSTM1.

3.2.3 Other forms of care, provided that they are consistent with the terms of the decision, should continue to be provided. An advance decision cannot refuse the provision of basic comfort or care. Basic comfort or care includes keeping the patient warm, clean, free from distressing symptoms such as breathlessness, vomiting and severe pain.

3.2.4 Legal advice must be sought at the earliest opportunity to determine if a prisoner's advance decision is valid and applicable. Failure to respect a valid and applicable advance decision could result in legal action against the practitioner.

3.2.5 BSMHFT Healthcare staff should refer to the BSMHFT Advance Statement and Decisions policy.

3.3 Identification and reporting of prisoners refusing food

3.3.1 When it appears to any member of staff that a prisoner is not taking food or fluids for a minimum of 3 days (and this is an active refusal rather than just missing a meal because they are not hungry) the following process must be activated:

Wing Staff (HMP)

3.3.2 The prisoner's details and information about the food refusal (i.e. is he taking any fluids, still eating canteen, duration of refusal so far and what meals have been refused) must be sent via email to the healthcare administration team on hmp.birmingham.nhs.net. It is sufficient to send one email per day indicating which meals have been refused that day.

3.3.3 A record must be entered on NOMIS of all meals refused plus any other observations of any other food taken (e.g. canteen) and the monitoring of fluid intake as far as possible (e.g. if prisoner observed drinking).

3.3.4 Inform Duty Governor Victor 1; a member of healthcare staff via Hotel 15 and other prison or appropriate support. This should also be recorded in the prisoner's NOMIS notes on the first day of the food refusal.

3.3.5 Guidance from the Safer Custody Group states that prisoners refusing food for 3 days should be put on an ACCT document. This ensures ease of recording and monitoring.

3.3.6 An email must be sent to the enquiry line as soon as the prisoner begins taking meals again. Victor 1 must also be informed. The patient should be monitored to ensure that they are having an adequate diet and not minimal eating.

Duty Governor

3.3.7 The Duty Governor must contact the senior primary care nurse daily to check if any food refusals have been reported.

3.3.8 After the third day of monitored food refusal the Orderly Officer would report this via IRS as self-harm and also report via telephone to NIMUA flow chart explaining this process is attached in Appendix 3.

3.4 Record keeping by Healthcare staff

3.4.1 Comprehensive and accurate written notes in SYSTM1 are required at all times by all healthcare staff involved with the management of a patient on Food Refusal.

3.5 Nursing Assessment

3.5.1 On weekdays, when the healthcare team is informed of a food refusal an urgent assessment (within the shift) will be made by the nurse holding Hotel 13 who will report the initial findings to the GP. This assessment will include how long the patient has been refusing meals, a baseline weight/height (for BMI), pulse, blood pressure testing; blood glucose monitoring (BM)and urine testing for ketones. With the information from the triage assessment the doctor will either arrange to see the prisoner that day or within the next 24-48 hours.

3.5.2 The assessing nurse should make an urgent referral to the Mental Health team. Consideration should be made as to whether re-location to the Ward would be beneficial.

3.5.3 At weekends Hotel 13 will be informed by HMP Staff and make an initial assessment and either contact the on call doctor if further medical assessment is thought to be urgent or arrange for the patient to be assessed by the doctor on the next working day. The assessing nurse should also consider whether a mental health referral is required.

3.6 Doctors Initial Assessment

3.6.1 For an adequate assessment the doctor will need a confidential and trusting relationship with the patient. The patient will need to be reassured that the doctor is independent of the prison and there to serve the patient's best interests – including respecting their decisions regarding medical treatment if they have capacity to make that decision. Sometimes prison doctors can be perceived by the prisoner to be part of the authority against which they are protesting.

3.6.2 At the initial assessment the doctor should try to establish the following:

- The reason the patient gives for refusing food (if any) and a preliminary view on the patient's seriousness of intent. Whether there is any indication of a mental health problem.

- The patient's capacity to give or withhold consent to medical treatment
- Whether there is any evidence that the patient may have made a relevant advance decision (i.e. advance refusal of treatment in the past and if not whether the patient wishes to make one now)

3.6.3 The doctor must clearly inform the patient of the risks and consequences of his actions in order that they can make an informed decision. This should include the physical consequences of starvation, the symptoms that the patient may expect, the risks of permanent damage to health including brain damage and death. The risks of re-feeding following a prolonged period of starvation should also be explained.

3.6.4 If the doctor establishes that the patient is refusing food as a way of pursuing a grievance, this should be discussed with the Offender Health Duty Manager (or in their absence the Duty Governor) to arrange for the prisoner to pursue that grievance through all legitimate channels. This may be sufficient action to persuade them to eat again. The patients must give consent for this to happen.

3.6.5 A psychiatric assessment must be arranged as soon as possible to confirm whether the patient has a mental illness and whether the patient has capacity. Capacity can fluctuate and should be reviewed and recorded regularly. The psychiatrist should be approved under section 12(2) of the Mental Health Act.

3.6.6 Prison authorities should also be informed whilst also, respecting medical confidentiality. Ask the patient if he consents to medical information being given to the prison authorities. Medical confidentiality can be breached under the GMC (General Medical Council) guidelines if "*failure to do so may expose the patient or others to risk of death or serious harm*".

3.7 Action to be taken if the prisoner continues to refuse food and/or fluids

3.7.1 Assessments of the patient should continue every 3 days by either the doctor or nurse, according to the patient's condition. The patient should be weighed each time and pulse and blood pressure recorded. If the patient refuses to comply this should be documented. The patient should be encouraged to maintain fluid intake, this will be recorded on the fluid balance chart. A fluid intake of at least 1.5 litres a day should be encouraged. If not already done, relocation to 24 hour healthcare (Healthcare 2) should be made

3.7.2 Triggers for further medical management should be a weight loss of 10% in lean healthy individuals or a total fast of 10 days or body mass index (BMI) of 16.5 if the pre fast weight is unknown.

3.7.3 Blood tests to monitor renal function and electrolytes should be offered.

3.7.4 Thiamine should be prescribed and the patient encouraged to take these to protect against permanent brain damage. Liquid nutritional supplements should also be offered – particularly if the fast is not total.

3.7.5 Where a competent patient refusing food and / or fluids continues to refuse medical treatment at a time when a doctor judges it is becoming necessary, whether or not an advance refusal of treatment has been made, the doctor should again explain the consequences of these refusals to the patient, in the presence of another registered clinical practitioner. A full record of what has been said should be recorded in the patients record on SYSTM1, signed by both the doctor and the second clinician to say that they were both present when this advice was given. Arrangements must be made to inform local hospital emergency consultants, psychiatric liaison team and ambulance service of the clinical situation and whether an Advanced Directive is in place.

3.7.6 A second assessment by a psychiatrist to give a second opinion about mental health issues and / or lack of capacity should be arranged and consideration given to the use of the courts to clarify the position if necessary.

3.7.7 If the patient does **not** have capacity and treatment of a patient against their will is being considered, take advice from a consultant experienced in nutrition/feeding e.g. gastroenterologist or consultant experienced in re-feeding patients with anorexia and arrange referral to an NHS hospital for treatment.

3.7.8 Try to avoid emergency admissions where the admitting doctors may not have experience in the consequences of starvation and re-feeding. At this stage contact should be made with the BSMHFT legal department for advice.

3.7.9 Ensure all treatment decisions in these circumstances are discussed widely with the multidisciplinary team. Consider using the courts to determine treatment in the patients best interests if required, taking into account the level of control and restraint that may be required.

3.7.10 The Offender Health Duty Manager and Duty Governor should be informed when this stage has been reached, with an indication of the likelihood of the need to transfer the prisoner to an outside hospital. The Duty Governor will complete a media interest form when the stage has been reached where the prisoner needs treatment/food to avoid significant harm to his health. Healthcare staff to record and notify appropriate parties when patient starts eating.

3.7.11 If the patient has capacity keep the patient under regular review by healthcare workers that he trusts. Continue to monitor capacity and frequently check the patient's wishes have not changed. Consider admission to the prison healthcare wing.

3.7.12 This should continue until either the patient requires transfer to an NHS hospital or starts to eat again.

3.7.13 Major medical problems arise with a weight loss of about 18%. A BMI of 12 or 13 is critical. Hunger strikers in the Maze prison in Belfast in the 1980s died after 45-61 days.

3.8 Re-feeding

3.8.1 Re-feeding can be hazardous if starvation lasts more than 3 weeks **and should be undertaken in an acute hospital.** Possible problems are Wernicke's encephalopathy, cardiac problems, acute oedema and hypokalaemia.

3.8.2 Ideally the patient should be admitted under the care of a consultant with experience of re-feeding. Try to avoid emergency admissions when inexperienced doctors may be on duty.

3.8.3 After transfer back to prison after re-feeding, continue to monitor the patient until normal weight is achieved, particularly if their underlying grievance is not resolved.

3.8.4 Healthcare staff should refer to the re-feeding guidelines included in the Enteral Feeding policy.

4 RESPONSIBILITIES

Post(s)	Responsibilities	Ref
Doctor	1. See the patient as soon as possible for initial assessment 2. Outline the risks and consequences of refusing foods / fluids over time to the patient. 3. Assess the reasons for refusing food and the seriousness of intent. If the prisoner's intention is serious inform the Healthcare and Duty Governor. 4. Assess whether there is any indication of a mental health problem	

	5. Arrange for a psychiatric assessment to take place as soon as possible to assess the patient's capacity to give or withhold consent. 6. Assess whether there is any evidence that the patient may have made a relevant advance directive 7. Use the courts if necessary to clarify issues of capacity and treatment in the patient's best interest. 8. If it is identified that a prisoner is refusing food as a way of pursuing a grievance liaise with Offender Health Duty Manager or Duty Governor to assist prisoner in pursuing this grievance through legitimate channels. 9. If food refusal continues explain the consequences of this refusal to the patient in the presence of another registered clinical practitioner and make a full record of what has been said in SYSTM1, with signatures of both doctor and a second professional. 10. When food refusal continues to such an extent that the prisoner's long-term health is at risk arrange a second assessment by a psychiatrist. 11. Inform the Duty Governor that this stage has been reached, particularly if the patient is to be transferred to an NHS hospital. 12. Continue to monitor the patient's physical condition until either the patient is transferred to hospital or starts to eat. If re-feeding is required after a prolonged period of starvation, refer to hospital.	
Other Healthcare Professionals	1. Hotel 13 to make an initial assessment of the patient once informed of a food refusal, including baseline weight, pulse, blood pressure and urine for ketones and to inform the doctor of the findings, 2. At weekends and bank holidays, if informed of a food refusal, to inform the Duty Governor and to make an initial assessment. If required arrange for the prisoner to be seen by the on-call doctor or arrange for the doctor to see on the next working day. 3. Provide monitoring and medical care as necessary in liaison with the doctor. 4. If we have prisoners within this establishment who are on food/fluid refusal or partial food/fluid refusal, or there is a suspicion that they are not eating or drinking adequate amounts. From the third day, we need to implement the food refusal process. We also need to be offering these individuals daily clinical observations, including blood monitoring and twice weekly weights even if they are refusing to co-operate. This then needs to be documented on all relevant systems. 5. If you have any concerns regarding other health care professional's involvement/care of these individuals, discuss your concerns with the Practitioner. If you are still unhappy, you can approach primary care nurses, Ward Managers or Healthcare Duty Manager. 6. With regards to SYSTM1 documentation, such as ICR, admission/discharge templates and shift evaluations - it has been agreed that more rigorous management checks will be put into place.	

	7. Care-plans must reflect all aspects of care being offered and the plan that is in place to address the issue (including physical health). They must be reviewed and updated on a regular basis, at least weekly, after ward rounds and the dates on these must reflect this. SystmOne shift evaluation template entries must reflect the plan of care being offered within the care plans as well as a summary of the day. 8. If a named nurse is not available for any length of time, due to Annual Leave, sickness etc, one of their colleagues will be tasked to update their care-plans. 9. All nurses have a responsibility to adhere to the standards set by their professional body.	
Residential Staff	1. When it becomes apparent that a prisoner is refusing meals the staff will email **hmp.birmingham@nhs.net** with all relevant details (what meals have been missed, what fluids are being taken, duration of refusal etc) 2. Record details of all meals missed (and whether prisoner is eating canteen items etc.) in prisoner's Nomis notes. Also inform Duty Governor. 3. After three days of food refusal open an ACCT document. 4. Continue to monitor and ensure prisoner is actively offered his meals and a note of this as well as any refusal is made in his Nomis / ACCT Document. 5. Email on a daily basis for as long as refusal continues, providing details as indicated above. 6. When food refusal ceases email the Healthcare team and inform the Duty Governor. 7. At weekends and Bank Holidays inform Duty Governor and Hotel 13. NB: This role will be maintained by in-patient staff if prisoner is admitted to 24 hour healthcare wings (H2/H3)	
Duty Governor	1. Contact the H13 to check if there are any prisoners reported to be refusing food. 2. Check the appropriate procedures are being followed correctly with wing prisoner is located on. 3. If informed by the Doctor that the prisoner's intentions are to be taken seriously, tell the prisoner that unless they specifically direct otherwise their next-of-kin will be informed 4. If this stage is reached Briefing and Casework Unit must be informed 5. Briefing and Casework Unit must also be informed if the patient is competent and refusing medical treatment at a time when the doctor judges it is necessary and when the prisoner is transferred to NHS facilities. 6. It is good practice to see prisoners on food refusal as part of Duty Governor rounds.	
Orderly Officer	1. The Orderly Officer would report Food refusal via IRS as self-harm and also report via telephone to NIMU	

5 DEVELOPMENT AND CONSULTATION PROCESS:

Consultation summary		
Date policy issued for consultation	May 2024	
Number of versions produced for consultation	1	
Committees / meetings where policy formally discussed	**Date(s)**	
HMP Birmingham Clinical Governance	July 2024	
Where received	**Summary of feedback**	**Actions / Response**
HMP Birmingham Clinical Governance	None – extensive consultation from committee members prior to tabling	N/A

6 REFERENCE DOCUMENTS

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10. World Medical Association (WMA) Declaration of Tokyo. Guidelines for physicians concerning torture or other cruel or inhuman or degrading treatment or punishment in relation to detention and imprisonment. 1975.
11. WMA Declaration of Malta. Declaration on Hunger Strikers. 1991.
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7 BIBLIOGRAPHY

As above

8 GLOSSARY

MDT	Multidisciplinary team
Hotel 13	Primary Care Nurse Emergency Response Radio
Hotel 10	Duty healthcare manager (Monday -Friday 09:00-17:00)
Oscar 1	Orderly Officer in charge on day
Victor 1	HMP Governor in charge on day
SYSTM1	Electronic recording system used in prisons to record healthcare
ICR	Integrated Care Record
NIMU	National Incident Management Unit
NOMIS	Computer system on HMP computer which holds prisoner sentence and all prisoner custody information
ACCT	A prison process for carrying out observations
'Z' drive	A drive on the HMP computer system. This is only accessible to HMP staff or any NHS staff that have access to the system (not all NHS staff are cleared for this)
H2	24-Hour healthcare wing for physical health
H3	24-Hour healthcare wing for mental health

9 AUDIT AND ASSURANCE

Element to be monitored	Lead	Tool	Frequency	Reporting Committee
Reporting of prisoner who is refusing food	H10 Weekdays H13 Weekends	Tracking of emails	Daily	Start of the Week
Food Refusal Log	Head of Healthcare	Check that log is completed	Monthly	Prison CGC
Standards of care are compliant with the policy	Head of Healthcare	Dip audits to check if prisoners who are refusing food received care in line with the policy	Annually	Prison CGC

10 APPENDICES

Appendix 1 – Equality Impact Assessment
Appendix 2 – Food Refusal Log
Appendix 3 – Reporting Procedures Flow Chart
Appendix 4 – Physical Consequences of Starvation

Appendix 1

Equality Analysis Screening Form

Title of Policy	Food Refusal Policy		
Person Completing this policy	Dave Austin	**Role or title**	Head of Healthcare
Division	Offender Health	**Service Area**	Offender Health
Date Started	02/02/24	**Date completed**	09/05/24
Main purpose and aims of the policy and how it fits in with the wider strategic aims and objectives of the organisation.			
This policy if required to ensure that all prisoners who refuse food at HMP Birmingham are managed in a clinically safe and consistent manner.			
Who will benefit from the proposal?			
All prisoners and staff at HMP Birmingham who re: involved with food refusal issues.			
Does the policy affect service users, employees or the wider community? ***Add any data you have on the groups affected split by Protected characteristic in the boxes below. Highlight how you have used the data to reduce any noted inequalities going forward***			
No			
Does the policy significantly affect service delivery, business processes or policy? ***How will these reduce inequality?***			
No			
Does it involve a significant commitment of resources? ***How will these reduce inequality?***			
No			
Does the policy relate to an area where there are known inequalities? (e.g. seclusion, accessibility, recruitment & progression)			

No				
Impacts on different Personal Protected Characteristics – *Helpful Questions:*				
Does this policy promote equality of opportunity? *Eliminate discrimination?* *Eliminate harassment?* *Eliminate victimisation?*				*Promote good community relations?* *Promote positive attitudes towards disabled people?* *Consider more favourable treatment of disabled people?* *Promote involvement and consultation?* *Protect and promote human rights?*
Please click in the relevant impact box and include relevant data				
Personal Protected Characteristic	**No/Minimum Impact**	**Negative Impact**	**Positive Impact**	**Please list details or evidence of why there might be a positive, negative or no impact on protected characteristics.**
Age			x	Ensuring we have inclusive assessment processes identifying needs and wishes irrespective of age. Being aware the physical decline may be more rapid with older patients.
Including children and people over 65 Is it easy for someone of any age to find out about your service or access your policy? Are you able to justify the legal or lawful reasons when your service excludes certain age groups				
Disability			x	Ensuring needs are assessed thoroughly to determine if food refusal is due to disability. If it is, care plans can be put in place to ensure the correct support is in place for the patient to be able to have a healthy diet and fluid intake.
Including those with physical or sensory impairments, those with learning disabilities and those with mental health issues Do you currently monitor who has a disability so that you know how well your service is being used by people with a disability? Are you making reasonable adjustment to meet the needs of the staff, service users, carers and families?				
Gender	X			Male population.
This can include male and female or someone who has completed the gender reassignment process from one sex to another Do you have flexible working arrangements for either sex? Is it easier for either men or women to access your policy?				

Marriage or Civil Partnerships	X			Not applicable
People who are in a Civil Partnerships must be treated equally to married couples on a wide range of legal matters Are the documents and information provided for your service reflecting the appropriate terminology for marriage and civil partnerships?				
Pregnancy or Maternity	X			Male population
This includes women having a baby and women just after they have had a baby Does your service accommodate the needs of expectant and post natal mothers both as staff and service users? Can your service treat staff and patients with dignity and respect relation in to pregnancy and maternity?				
Race or Ethnicity			x	Ensuring translators are used to communicate with non English speaking patients. Ensuring cultural needs are identified in relation to food preferences and exploring whether this could be a reason for food refusal.
Including Gypsy or Roma people, Irish people, those of mixed heritage, asylum seekers and refugees What training does staff have to respond to the cultural needs of different ethnic groups? What arrangements are in place to communicate with people who do not have English as a first language?				
Religion or Belief			x	Ensuring through assessment that religious and dietary requirements are offered and supported. Advocate for the patients to ensure that their needs are met i.e. halal, kosher, vegetarian. Explore through assessment whether fasting is part of the patients religious beliefs i.e. Buddhism.
Including humanists and non-believers Is there easy access to a prayer or quiet room to your service delivery area? When organising events – Do you take necessary steps to make sure that spiritual requirements are met?				
Sexual Orientation	X			Not applicable
Including gay men, lesbians and bisexual people Does your service use visual images that could be people from any background or are the images mainly heterosexual couples? Does staff in your workplace feel comfortable about being 'out' or would office culture make them feel this might not be a good idea?				

Transgender or Gender Reassignment	X			Not applicable
This will include people who are in the process of or in a care pathway changing from one gender to another Have you considered the possible needs of transgender staff and service users in the development of your policy or service?				
Human Rights			X	Will ensure that anyone who is refusing food is considered and monitored in the same consistent manner
Affecting someone's right to Life, Dignity and Respect? Caring for other people or protecting them from danger? The detention of an individual inadvertently or placing someone in a humiliating situation or position?				

If a negative or disproportionate impact has been identified in any of the key areas would this difference be illegal / unlawful? I.e. Would it be discriminatory under anti-discrimination legislation. (The Equality Act 2010, Human Rights Act 1998)

	Yes	**No**		
What do you consider the level of negative impact to be?	**High Impact**	**Medium Impact**	**Low Impact**	**No Impact**
				X

If the impact could be discriminatory in law, please contact the **Equality and Diversity Lead** immediately to determine the next course of action. If the negative impact is high a Full Equality Analysis will be required.

If you are unsure how to answer the above questions, or if you have assessed the impact as medium, please seek further guidance from the **Equality and Diversity Lead** before proceeding.
If the policy does not have a negative impact or the impact is considered low, reasonable or justifiable, then please complete the rest of the form below with any required redial actions, and forward to the **Equality and Diversity Lead.**

Action Planning:
How could you minimise or remove any negative impact identified even if this is of low significance?
There are no negative impacts identified. This policy will ensure each individual is assessed and offered the appropriate care.

How will any impact or planned actions be monitored and reviewed?
As outlined in the policy we will review and complete dip audit to monitor impact.
How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic.
Once we have reviewed the impact of this policy through internal CGC we can consider sharing good practice.
Please save and keep one copy and then send a copy with a copy of the policy to the Senior Equality and Diversity Lead at bsmhft.edi.queries@nhs.net. The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Divisional or Service planning and monitored on a regular basis

Appendix 2

FOOD REFUSAL LOG

SHEET NUMBER _____

FOOD REFUSAL LOG

Prisoners Name:	Prisoners Number:

Location:		

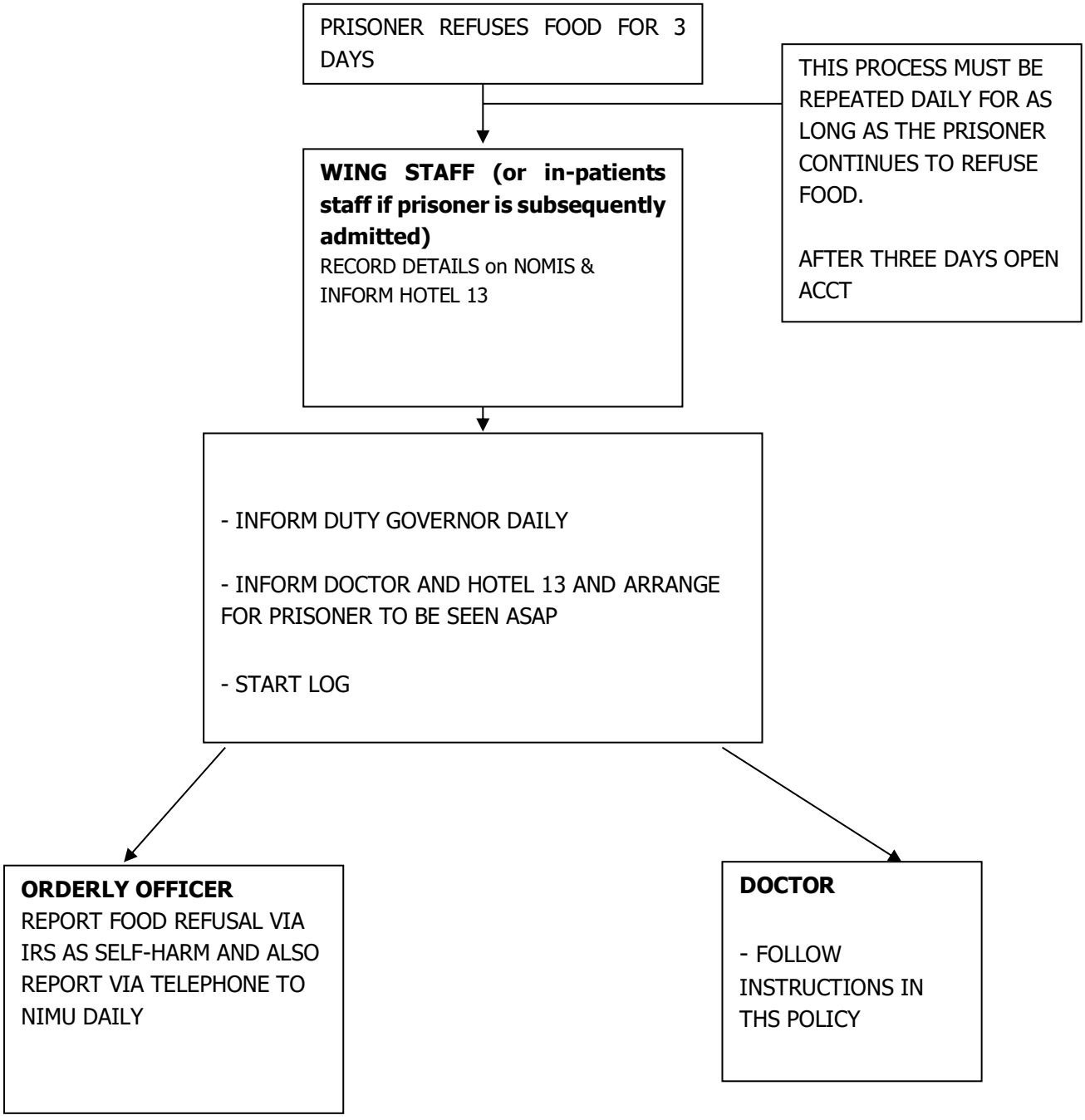
(Update if prisoner moved e.g. admitted to in-patients)

			INFORMED (please initial)		
Day	Date	Comments	Duty Governor	Doctor	DG Check
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

Use Continuation Sheets as necessary

Appendix 3

REPORTING PROCEDURES FLOW CHART



NB – At weekends as well as informing via the Food Refusal email, wing staff must also inform Duty Governor and Hotel 13 directly.

When food refusal has ceased H13 will then inform Healthcare Duty Manager, the Doctor and the Duty Governor. Duty Governor must then record this on IRS and complete media interest form.

Appendix 4

PHYSICAL CONSEQUENCES OF STARVATION

In the first few days of total starvation the body uses stores of glycogen in the liver and muscles. A glucagon nature is occurs with marked weight loss.

The next phase lasts 10-14 days during which glycogen stores are used up and amino acids are used as an energy source. This is associated with the loss of muscle, including heart muscle.

In the final phase protein is protected. Fatty acids are broken down producing ketones which are used as an energy source. When all the fat stores are used up catastrophic protein breakdown occurs.

Triggers for medical management should be a weight loss of 10% in lean healthy individuals or a fast of 10 days or body mass index (BMI) of 16.5 if the pre fast weight is unknown. Major problems arise with a weight loss of about 18%. A BMI of 12 or 13 is critical. Weight loss will occur faster in patients who are already lean.

Hunger strikers in the Maze prison in Belfast in the 1980s died after 45-61 days.

Symptoms and signs

Bradycardia and a drop in blood pressure occur early on. Orthostatic hypotension is almost always present after 20 days and can be very disabling. Patients complain of feeling faint, dizzy, weak and lightheaded.

Effective thyroid function is reduced leading to feelings of weakness and cold.

Abdominal pain is common, occurring early in the fast.

Patients may lose the feeling of thirst and become dehydrated. A fluid intake of at least 1.5 litres a day should be maintained.

Other symptoms include vomiting, constipation, diarrhoea, headaches and dysuria. Depression, anxiety, insomnia and nightmares can occur.

Permanent physical and psychological complications can occur even if re-feeding occurs.

Biochemical abnormalities

Ketonuria will be found that persists until re-feeding starts.

Urea synthesis falls so measurement of urea can be normal during dehydration. Creatinine concentrations should be used to monitor hydration.

Hypokalaemia can occur. This may be precipitated by ingestion of larger amounts of salt or from the ingestion of glucose.

Hyponatraemia may be found.

Re-feeding meaning
The process of reintroducing food after malnourishment or starvation.

Re-feeding syndrome

Re-feeding can be hazardous if starvation lasts more than 3 weeks and should be undertaken in hospital. Possible problems are Wernicke's encephalopathy, cardiac problems, acute oedema and hypokalaemia.

Health staff should refer to the Trust's Enteral Feeding Policy