Investigation into the circumstances surrounding the death of a man, formerly a prisoner at HMP Standford Hill, in June 2006

Report by the Prisons and Probation Ombudsman for England and Wales

July 2008

This is a report into the circumstances surrounding the death of a man at hospice, in June 2006. The man, who was serving a six year sentence at HMP Standford Hill, having been convicted in July 2004.

I extend my sincere condolences to the family of the man at the sudden and tragic loss of a son, brother, father, and grandfather.

Due to his deteriorating health, the man had been released on compassionate grounds from Standford Hill the day before he died. However, he was too ill to know that this was happening and his daughter signed the discharge papers on behalf of her father. A post mortem examination has been conducted and the cause of death was given as carcinomatosis of the right lung.

The Coroner for Mid Kent and Medway wrote to me reporting the circumstances of the man's death. He invited me to consider whether an investigation would be appropriate and I judged that it would be. I would like to thank the Governor at Standford Hill, and his staff for their help and assistance during the investigation. I would also like to thank a doctor of Swale Primary Care Trust for the clinical review he has carried out into the man's medical treatment.

I have made seven recommendations and noted two points of good practice in relation to the man's care at Standford Hill. In this final report six of the recommendations have been accepted and the seventh partially accepted by the Prison Service. The two points of good practice have also been accepted.

This is the second version of this final report, a transcript of an interview with a prison medic al officer has been added to the report.

This version of my report, published on my website, has been amended to remove the name of the man who died and those of staff and prisoners involved in my investigation.

Stephen Shaw CBE
Prisons and Probation Ombudsman **July 2008**

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SUMMARY

The man died in June 2006. He had been released from HMP Standford Hill on compassionate grounds the day before he died, and was receiving palliative care at a hospice.

The man had first complained of back pain in 2004. His back pain was believed to be sciatica, for which he was prescribed the appropriate medication. In September 2005, the man was transferred to HMP Standford Hill. His problems with sciatica were recorded in his medical notes.

In March 2006, the man complained of chest pain. In April, he was taken to hospital where he was diagnosed with pneumonia and returned to Standford Hill. Over the next two months, he continued to complain of back and chest pain and he was also losing weight. On 15 June, the man again attended hospital following an urgent referral. He was admitted and a few days later, his family was advised he was very ill.

In late June, the man was transferred to a hospice. The following day, his daughter signed for his compassionate release as he was too ill to receive the document himself. The man died the next day with his family at his bedside.

The man's family has raised issues concerning his medical care, the decision to serve his compassionate release papers less than 36 hours before he died, and the lack of communication between Standford Hill and the family. I have assessed each of these matters and made a number of recommendations. I have also commended two named members of Standford Hill's staff.

THE INVESTIGATION PROCESS

The investigation into the death of the man was opened by my colleague on 13 July 2006, when she visited HMP Standford Hill. Ms Gilbert met the Governor and his senior colleagues. My colleague handed over notices of the investigation for staff and prisoners and the Ombudsman's terms of reference for the investigation.

My colleague was given a copy of the man's medical notes and also reviewed his prison file. Copies of the documents were later forwarded to her.

A clinical review into the man's medical care was commissioned from Swale Primary Care Trust and undertaken by a doctor.

On 19 July, one of my family liaison officers met with the man's family. They raised two main issues during the visit:

- Why was the man not provided with appropriate medical care?
- Why did the prison decide to release the man on licence, knowing that he was due to die imminently?

The family was also unhappy with the way in which the Governor and deputy governor communicated with them prior to and after the man's death.

I hope this report provides the family with answers to the questions they have raised.

On 22 August, my colleague again visited Standford Hill and spoke to a member of the Independent Monitoring Board (IMB). Later, my colleague spoke with a representative of the Prison Officers' Association (POA). Over the next two days, she carried out interviews with several members of staff.

On 23 August my colleague visited HMP Swaleside and spoke with the man's son.

On 12 September, two of my colleagues visited Standford Hill. They interviewed the deputy governor and the Governor.

Following the circulation of the draft report the family of the man instructed solicitors to act on their behalf. The final report has been subsequently delayed in addressing issues raised by the solicitor. Those issues raised were:

1. The interview techniques used during the investigation
2. The quality of the clinical review
3. The prison GP not being interviewed as part of the investigation
4. The number of prisoners not interviewed as part of the investigation
5. Disclosure of all prison paperwork
6. Disclosure of hospital medical records and x-rays from the hospital
7. Issues relating to article two of the European Human Rights Act
8. Police Investigation paperwork

I have disclosed all paperwork in my possession to the solicitors. There was no police investigation as the man was not a prisoner at the time of his death. My office's policy on interviewing techniques has been forwarded to the solicitor. I am

unable to obtain hospital records or x-rays that are not part of the man's prison file. Two prisoners were initially interviewed and one further interview was carried out in May 2007.

In relation to other issues raised by the solicitor, I have recommended that the solicitor make a request to Her Majesty's Coroner for the prison GP to be called as a witness at the man's inquest. The Coroner will also be able to access the hospital records from the hospital. I am happy with the quality of the clinical review provided by Swale Primary Care Trust into the man's care.

At the request of the family's solicitor on 18 March 2008, to of my colleagues visited Standford Hill and interviewed the prison GP. Also present was a doctor from the Medical Protection Society, as a legal representative, supporting the prison GP. Please note these transcripts were sent to the prison GP and his representative for their attention so that they could confirm the notes were a true and accurate record. At the time of circulation of this second final report, no amended or signed transcripts have been received from the prison GP.

HMP STANDFORD HILL

HMP Standford Hill is an open (category D) prison, part of the cluster of three adjacent prisons (Elmley and Swaleside are the others) on the Isle of Sheppey in Kent. It was originally opened in 1950 and became a category D prison in 1985.

Standford Hill can hold up to 435 prisoners, all of whom are expected to participate in work or education.

Swale Primary Care Trust is responsible for the delivery of the primary health services. There is a part time medical officer, and the prison has no inpatient facilities. Prisoners requiring 24-hour healthcare are transferred to HMP Elmley. A daily 'sick parade' is held in the healthcare unit for prisoners wishing to access primary care services. Healthcare also provides dental, optical, psychiatric and chiropody services.

Standford Hill was last inspected by Her Majesty's Chief Inspector of Prisons in August 2004. Her report was generally positive about healthcare services, but Ms Owers recommended that a greater priority should be given to establishing a new and purpose built healthcare centre. In the interim, the use of some portacabins at the rear of the centre should provide additional space for patients and offices. (The present healthcare centre is very compact with little space and is located away from the main body of the prison.)

The report noted two points of good practice:

- "Prisoners had good access to healthcare, with a 'drop in' approach, and relationships between prisoners and the small healthcare team were professional and respectful."

- "A medical officer was available for consultation every weekday and other health professionals, such as the dentist, chiropodist and optician, attended regularly. Healthcare at Standford Hill was a role model for the delivery of healthcare in prisons."

KEY EVENTS

The man had been in HMP Chelmsford for five months before his transfer to Standford Hill in 30 September 2005. At Chelmsford, the man had been seen by the medical officer who noted that the man had a skin condition, which required him to wear his own clothes and use his own bedding. He was given an extra mattress to help support his ongoing back problem.

On 1 July 2005, the man was seen by a psychiatrist. The psychiatrist recorded that the man had no diagnosable mental illness, but was frustrated by prison life and being around drug users. The man was noted to have feelings of agitation, depression, lack of sleep and tension. He was also requesting a transfer to HMP Coldingley. The psychiatrist supported this transfer, believing it would help the man's mental health. He also prescribed quetiapine to help until the transfer was affected.

On 19 September, the man was examined by a medical officer as he was complaining of pain. On 20 September, his medical record noted that he was despondent as he had not been transferred, although he had no thoughts of self harm. Nine days later, the man was transferred to Elmley, and then taken to Standford Hill the following day.

The man's reception health interview at Standford Hill documents his sciatica, and his skin complaint and medication (quetiapine) were recorded in his medical notes. There was also a request for a double mattress for his back problem.

On 11 October, the man's medical notes record that he was complaining of back pain and skin lesions. However, he declined to be examined by a chiropractor or physiotherapist. It was noted that the man could raise his left leg to 80 degrees and his right leg to 30 degrees.

On 3 November, the man was again seen by a medical officer after complaining of pain to the left side of his chest. The notes record that his lungs were clear. Later, the man was assessed by the mental health in reach team for a medication review. On 6 November, he was seen by a psychiatrist, who took him off quetiapine and prescribed trazadone.

On 15 November, the man was again seen by the medical officer as he was still complaining of chest pain. On examination, it was noted that his chest was clear and a muscle strain was diagnosed. The notes further record, "no other signs or symptoms seen, signs don't match symptoms." Pain killers were prescribed.

On 17 November, the man was seen by the mental health in reach team. During the interview the man said that he felt he could cope without his medication and requested that the GP reduce his trazadone. It was noted that no further mental health in reach input was required, although he was advised he could self refer at any time.

On 7 December 2005, an entry in his medical records states, “physio for the chest.” No other information was recorded. The man was also prescribed diclofenac (a non steroidal anti-inflammatory) for his bad back.

There are no other significant entries in the man’s medical notes until 29 March 2006. On that day, the man saw the medical officer, again complaining of chest pain and a cough. The medical officer recorded that his chest was clear and he was still waiting for the physiotherapist.

On 6 April, the man was taken to hospital. He had a chest x-ray which showed no abnormalities, and he was diagnosed with pneumonia. The man returned to Standford Hill.

On 14 April, the medical officer examined the man who said he was “full of aches and pains.” The notes record his chest was clear and again that the signs did not match the symptoms. A referral to a chest physician was documented in the notes.

On 19 April, the man was again examined by a medical officer. He was unable to move from his bed and said the back of his chest and the left side of his chest had “seized”. The medical officer arranged for the man to be transferred to Elmley for bed rest. He returned to Standford Hill the following day.

On 4 May, the man is known to have attended hospital as an emergency. However, there are no details of this visit in his medical notes. The man saw the medical officer the next day. Notes of this examination record him as being argumentative and using bad language. They also say he refused to be sent to hospital and declined inpatient care at Elmley. The notes end with the man’s request to see “the specialist”.

On 9 May, the medical officer recorded in the medical notes that the appointment for the man should be expedited. A telephone call was made at 10.30 am to request the appointment.

On 19 May, the man attended hospital to see a chest consultant. The report from this appointment indicated that investigations would take place, with blood tests and a physical examination. A suggestion on the report documents that the man would require increased analgesia to help with pain management. On return from hospital, he was prescribed co-dydramol.

Over the next five days, the man was seen by the medical officer and healthcare staff. He was continuing to complain of pain and on 24 May was prescribed Transtec patches, to improve his pain relief.

On 30 May, the man’s pain relief was improving with use of the patches. He received his medication and a change of patches by attending the healthcare centre, which is located a short walk from his residential wing.

At the beginning of June, healthcare staff tried to arrange an emergency appointment for a consultation, by making contact with the chest consultant’s secretary at hospital.

On 15 June, the man attended hospital, unaccompanied, and was admitted to a ward. A letter from a consultant in respiratory medicine, to the medical officer at Standford Hill, described the man as “looking awful, in severe pain, pale and sweaty.” The consultant also said in the letter that the physical examination was unremarkable and a previous myeloma screen was negative. The man was admitted for pain control and investigations that would include a bone scan and a CT.

By 20 June, it was known that his condition was terminal. On 21 June, the man was transferred to a hospice for palliative care.

The man died three days later at 8.10pm with his family at his bedside.

A letter of condolence from the Governor was sent to the man’s family.

A post mortem examination revealed the cause of death to be carcinomatosis of the right lung (cancer). Histology results of biopsy specimens taken at the post mortem, may determine whether the malignancy arose in the lungs or whether the lung tumour was a secondary, spread from a ‘silent’ primary tumour elsewhere in the body.

ISSUES

Clinical Review

A clinical review into the man's medical care was carried out by a doctor on behalf of Swale Primary Care Trust.

The doctor has considered the man's medical notes and his review sets out a chronology of events from April 2004 to July 2005, before concentrating on the terminal stages of the man's illness

As the doctor rightly records, the time between the man's first complaint of chest pain on 3 November 2005 and his death in June 2006 was distressingly short. He reports that the man undoubtedly had a highly virulent tumour, concluding that, in view of his history of cigarette smoking, the primary tumour was most likely to have arisen in the lung.

Chest x-rays initiated by the prison doctor on 23 November 2005, and a casualty officer on 6 April 2006, failed to reveal any chest abnormality. An abnormal chest x-ray on 15 June 2006 revealed a lesion in the left seventh rib when the man was admitted into hospital.

The doctor says that it is regrettable that the man declined to be admitted to hospital when offered the chance on 5 May 2006, although it was highly unlikely that admission at that stage would have affected the outcome of his illness.

The doctor concludes that the man's care and treatment was at least equal to that likely to have been offered in the community. His death was from natural causes, the only contributory factor likely to have been his former cigarette smoking habit.

In his review, the doctor notes that the quality of the medical notes and record keeping in general was extremely poor. The entries were frequently illegible, confusing and open to misinterpretation. The status of those writing in the notes was often not clear and difficult to assess whether the individual is displaying an appropriate level of competence. I share his recommendation:

The recording of accurate, detailed and contemporaneous record keeping of notes is mandatory. Healthcare staff must ensure that all entries on prisoner's medical notes adhere to a standard of professional competence and expertise.

The doctor says that basic health care measurements such as height, weight blood pressure, urine check, smoking habit, medical history summary and family history should be regularly updated and placed in a prominent position in the medical notes. This information could then be easily accessed by medical staff. For example, if a regular record had been made of the man's weight, it might have been realised that the chronic back pain, thought to be due to osteoarthritis, and the presenting weight loss were likely to have had different explanations.

In a number of previous investigation reports, I have made reference to the need to ensure that prison healthcare has access to appropriate computerised medical

records to improve patient care. I strongly endorse the recommendation made by the doctor:

The computerisation of medical notes should be regarded as a matter of urgency.

Finally, the doctor judges that care pathways were poorly defined, and the follow up of medical problems did not make clear who was to see the patient and when the follow up was due. The doctor says it was not clear from the medical notes who was ultimately responsible for the man's overall health care.

A staff member should be designated as holding responsibility for quality care within the custodial environment, as happens in the community.

Family concerns

The clinical review offers a comprehensive account of the man's medical care. I hope this provides the family with answers to the clinical issues they have raised.

So far as the man's release on compassionate licence was concerned, I can report that the rules governing Early Release on Compassionate Grounds (ERCG) are set out in Chapter 12 of Prison Service Order (PSO) 6000. The summary at the beginning of the chapter explains that, "the Secretary of State may release a prisoner on licence at any point in the sentence if he is satisfied that this is justified by 'exceptional circumstances'. Early release on compassionate grounds may be considered on the basis of a prisoner's medical condition or as a result of tragic family circumstances."

Appendix A at the end of chapter 12 explains that the compassionate release criteria to be followed in medical cases are as follows:

- the prisoner is suffering from a terminal illness and death is likely to occur soon: or the prisoner is bedridden or similarly incapacited; and
- the risk of re-offending is past; and
- there are adequate arrangements for the prisoner's care and treatment outside prison; and
- early release will bring some significant benefit to the prisoner or his/her family.

The same appendix adds that some other factors must be considered. These include:

- whether temporary release under the Prison Rules could significantly reduce the prisoner's and/or family's suffering;
- the length of the sentence still outstanding; the effect on the overall sentence passed by the court if early release is granted;
- the wishes of the prisoner and his/her family and the level of benefit which would derive to the prisoner and/or the family from permanent release;

- in medical cases, the diagnosis and prognosis; in particular whether there is a specific estimate of life expectancy; and the degree of incapacitation.

The deputy governor applied for a compassionate licence for the man on 21 June. The application and a letter from the consultant, describing the man's diagnosis were faxed to the Early Release and Recall Section of the National Offender Management Service at the Home Office. The application was fast tracked as it was understood the man was very ill.

The discharge licence was faxed back to Standford Hill on 22 June at 10.30am. The Governor spoke to a Principal Officer (PO) who agreed to take the licence to the hospice where the man was now a patient. (On 22 June, the Governor was the only senior manager on duty.)

The PO arrived at the hospice at around 11.30am and spoke to hospice staff. He asked for a quiet room to talk to the man's family. The PO then saw the man's daughter and sister in a private room.

Both family members were upset and distressed. They told the PO they were unhappy with the care the man had received at Standford Hill and felt his medical problems had not been addressed. The PO listened to their concerns and then told the family why he was at the hospice and the reasons for issuing the compassionate discharge.

The man was heavily sedated and unable to receive the licence personally and thus his daughter was asked to sign for the licence on behalf of her father. She did so while understandably in a state of emotional turmoil.

After the licence had been signed for, the PO spent some time with the family. He then telephoned the Governor , asking him to make contact with the Governor of Swaleside to try to arrange an escort for the man's son (a prisoner at Swaleside) to enable him to visit his father. This escort was arranged and his son was escorted to the hospice later that day.

The PO did not see the man at the hospice. He made the decision that it would not be appropriate to visit his bedside whilst the family were there and the man was in the final stages of his life. I judge this to have been a proper and respectful decision by the PO. The family appreciated the PO's kindness to them, and their father.

The issuing of the compassionate release licence, taking into account the extracts from PSO 6000 detailed above, seems to have served little or no practical purpose in the man's case. The man was a category D prisoner. He was not required to have a prison escort with him in the hospice and was already released on a temporary licence. However, the prison acted with the best intentions in arranging early release and he died a free man, and not as a serving prisoner. Nevertheless, I understand that the man was unconscious when the licence was given to his daughter, and he died unaware that he had been granted a compassionate release.

PSO 6000 is silent on the way in which the compassionate release licence should be given to a prisoner or his/her relatives. If family members are reluctant to sign for a licence or refuse altogether, I recommend that their wishes should be respected.

The third issue raised by the man's family was communication with Standford Hill.

The man became unwell a few months before he died. The man's daughter has told this office that she tried to contact the prison on several occasions to speak to a member of staff concerning her worries about her father's health. She says she was unable to make any contact.

Nevertheless, the fact that the man was in ill-health was noticed by an officer on Standford Hill's B wing. The officer made entries on his personal file to the effect that the man was worried about his health. The chaplain was also aware that he was unwell and concerned.

When the man was admitted to hospital on 15 June, it was obvious that he was seriously ill. However, no member of the prison management team had any contact with the man's family before the compassionate release licence was served. I believe this was a failing by the prison.

Following the man's death, a letter was sent to the family by the Governor offering his condolences. The deputy governor, also met with family members shortly after the man's death to return his property. This was a difficult meeting, as the family was angry about what they believed was the deficient care and support he had received at Standford Hill.

A staff member should be appointed as family liaison officer when a prisoner is admitted to hospital so that good communication between the family and prison is established at an early stage.

I commend the wing officer for her observations and understanding in relation to the man's care and welfare.

Issues relating to the man's care at Standford Hill

A telephone message left by the man to his sister on 14 June records him telling her about his hospital appointment the following day. The man also refers to a cancelled community visit, because he had lost his paperwork. In the telephone message the man takes some responsibility for this loss of documentation, but admits he is unable to concentrate due to feeling so ill. An extract from the staff observation book also records him losing the paperwork for this visit.

On 15 June, A Principal Officer (PO) was the orderly officer for the prison. The PO saw the man whilst in reception that morning overseeing prisoners leaving the establishment. The man was waiting for transport to take him to hospital for his outpatient appointment. The prison transport was unavailable and a taxi had been ordered.

The PO noticed how ill the man appeared to be. In interview, he described him as being grey, shivering and looking poorly. The PO was concerned that the man was going to the hospital without the support which he felt was necessary due to his condition. The PO contacted the detail office and requested an officer to accompany the man to hospital for his appointment.

An officer was detailed to go to reception and accompany the man. On arrival in reception, the officer made contact with healthcare to ascertain that the man needed support, as he was a category D prisoner and it was unusual for a category D prisoner to have an officer for support for outside appointments. A member of healthcare staff told the officer there was no need for an escort and the man's hospital appointment was for a back problem. The officer then left reception and the man went to hospital on his own.

I am disappointed that the man was not accompanied to hospital given his condition. The PO had rightly recognised that the man was very ill and made contact with the detail office for an officer to support him. The fact that the support did not take place raises issues in terms of respect and dignity in the care of prisoners.

On admission to hospital later that day, the consultant recorded in his notes that the man "looked awful, was pale, sweating and very unwell." This underpins the PO's observation of the man earlier in the day.

If a prisoner is attending an outpatient appointment, and in the opinion of the discharging orderly officer the prisoner requires support, that should be provided.

I commend the Principle Officer for his actions on 15 June. His recognition of the man's pain and vulnerability was compassionate. In addition, the same Principle Officer showed a sensitive approach on 22 June when he met with the man's family in what was a distressing and difficult situation for all involved.

During her investigation, my colleague spoke to two friends of the man who were fellow-prisoners at Standford Hill. Both friends said how ill the man became over the last few months before he died. They both said that his personality changed from a friendly and settled man to becoming withdrawn, not socialising and being in obvious pain. His physical deterioration was obvious to them.

The walk from his wing to healthcare to collect his medication must have been very demanding upon the man. Indeed, given that Standford Hill is a prison where prisoners are expected to be able to participate in the regime, and where there is no 24 hour healthcare facility, it must have been very difficult for him to remain at Standford Hill at all. However, he was aware that if he was unable to maintain his mobility, he would have to return to closed conditions and lose most of benefits of his status as a category D prisoner.

I make no formal recommendation on this point, because individual circumstances will differ so much. However, the Governor of Standford Hill will wish to ensure that those prisoners who are obviously unwell are allowed to remain in the prison until

they are unable to carry out their own physical care. They should not feel obliged to cover their symptoms for fear of being returned to closed conditions.

During a conversation between my colleague and a member of Standford Hill's Independent Monitoring Board, it was made clear that the IMB had not been informed of the man's death until several days later. The IMB was disappointed that they had not been able to support staff and prisoners in the immediate days following his death.

One of the man's friends told my colleague that there had been no notices displayed on B wing informing prisoners of his death. His friends had found out that he had died when one of them made contact with the man's family. This is confirmed in an extract from the staff observation book which noted that a rumour had been circulating that the man had died. In response to the draft report, the Governor is clear that notices were indeed published, although it may be that the news of the man's death had leaked out, unofficially before staff had the opportunity to act. The entry in the observation book was made the morning after the man's death.

The man's friends and fellow prisoners at Standford Hill raised a collection for flowers for his funeral. The balance of the collection was passed to his family.

In the unfortunate circumstances of the death of a prisoner at Standford Hill, the IMB should be informed immediately.

Recommendations

1. The recording of accurate, detailed and contemporaneous record keeping of notes is mandatory. Healthcare staff must ensure that all entries on prisoner's medical notes adhere to a standard of professional competence and expertise.

Accepted – The healthcare cluster manager to regularly sample and audit all prisoner's medical note documentation and report to the Governor that he is satisfied with record keeping post instruction to the healthcare team. This will be carried out monthly with the first report submitted after three months

2. The computerisation of medical notes should be regarded as a matter of urgency.

Partially accepted – Whilst the benefits are understood the urgency needs to be introduced at a pace the PCT can realistically manage and implement. Cluster healthcare manager to raise and feedback to the Sheppey board in the New Year.

3. A staff member should be designated as holding responsibility for quality care within the custodial environment, as happens in the community.

Accepted – With immediate effect, the Deputy Governor will assume this responsibility but this will pass to the new residential principal officer who takes up post in the New Year. The Deputy Governor will establish a system with healthcare to be regularly notified of prisoners with serious illnesses or due to undergo serious medical procedures to liaise with families.

4. PSO 6000 is silent on the way in which the compassionate release licence should be given to a prisoner or his/her relatives. If family members are reluctant to sign for a licence or refuse altogether, I recommend that their wishes should be respected.

Accepted – The National Offender Management Service Parole and Public Protection Policy Section will look to include a suitable line in the next revision of Prison Service Order 6000 giving advice on the types of circumstance in which it might not be necessary to serve a release licence, for example if the offender has lost his cognitive functions or if an offender is unconscious and there is no prospect of recovery.

5. A staff member should be appointed as family liaison officer when a prisoner is admitted to hospital so that good communication between the family and prison is established at an early stage.

Accepted – The Deputy Governor will take on this role pending the arrival of a new residential principal officer.

6. If a prisoner is attending an outpatient appointment, and in the opinion of the discharging orderly officer the prisoner requires support, that should be provided.

Accepted – Orderly officers advised to notify healthcare when they consider this action to be necessary as the breakdown on this occasion was simply due to communication

7. In the unfortunate circumstances of the death of a prisoner at Standford Hill, the IMB should be informed immediately.

Accepted – Formal existing practice was overlooked on this occasion with over reliance on informal communication. The IMB were able to read global notices but the establishment will work to ensure the formal duty governor checklist is followed.

Good Practice

1. I commend the wing officer for her observations and understanding in relation to the man's care and welfare.

Accepted – Governor will write and formally acknowledge actions.

2. I commend the Principle Officer for his actions on 15 June. His recognition of the man's pain and vulnerability on 15 June was compassionate. In addition, the same Principle Officer showed a sensitive approach on 22 June when he met with the man's family in what was a distressing and difficult situation for all involved.

Accepted – Governor will write and formally acknowledge actions.