Investigation into the circumstances surrounding the death of a man at hospital, while a prisoner of HMP Guys Marsh, in August 2011

Report by the Prisons and Probation Ombudsman for England and Wales

December 2011

This is a report into the death of a man, a prisoner at HMP Guys Marsh. He had been ill for a long time before he was found having difficulty breathing in his cell on 7 August 2011. Although he was taken to hospital, he died as a result of natural causes there a few days later. He was 77 years old.

At the time of writing, no next of kin have been found for the man who, since 1962, had spent all but three years of his life in custody. Nonetheless, I would like to offer my condolences to all those who knew him.

The investigation was conducted by an Assistant Ombudsman. A clinical review was commissioned from the local PCT, who appointed a clinical reviewer to conduct the review. He found that the care provided to the man was equitable with that he would have received in the community.

I am grateful to the Governor and staff of Guys Marsh for their co-operation.

The man arrived at Guys Marsh in 2008. This investigation largely concentrates on the period after his arrival. He became increasingly frail during his time there, suffering from lung problems as well as a long standing injury to his neck, and was taken to hospital on several occasions. On 7 August, he was found slumped in his cell during a routine roll check at 6.50am in the morning. Staff administered first aid after he lost consciousness. Paramedics arrived and re-established a heart beat before taking him to hospital. His condition deteriorated further, however, and doctors decided to withdraw any artificial aids which were helping to keep him alive. He died shortly afterwards.

I make only one recommendation as a result of this investigation. This relates to the lack of provision of escort officers for visits to outside hospital. I note that this issue was previously raised by the Independent Monitoring Board in their 2009-2010 report and it is disappointing that the problem continues to reoccur. More positively, I add my commendation to that of my investigator and the clinical reviewer regarding the care provided by the officers who went to the aid of the man when he collapsed.

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.

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Prisons and Probation Ombudsman **December 2011**

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SUMMARY

1. The man was 77 years old when he died at hospital. He was a serving prisoner at HMP Guys Marsh, having been imprisoned in 1982 for an offence of murder. This was his second life sentence.

2. The man arrived at Guys Marsh in 2008. He was assessed regularly by healthcare staff during his three years at the prison. However, he missed several appointments at outside hospital, sometimes because there were not enough available escort officers to accompany him.

3. On 7 August 2011, the man pressed his cell bell to call for assistance. An officer went to his cell and, seeing him in distress, informed the Night Orderly Officer (who was in charge of the prison at the time) that he was going into the cell. Joined by colleagues shortly afterwards, the officer performed cardiopulmonary resuscitation until paramedics arrived. The man was taken to hospital but died three days later.

4. The clinical reviewer found that the care given to the man was appropriate and equivalent to that he would have received in the community. However, the lack of escort officers meant he missed some appointments. This issue was raised by the Independent Monitoring Board in their report of 2009-10. A recommendation has been made as a result of this investigation in order to ensure that the lack of escort officers is addressed.

THE INVESTIGATION PROCESS

5. The investigation was opened by an Assistant Ombudsman on 18 August 2011, when he travelled to Guys Marsh. After speaking earlier to the liaison officer, who had explained that there was a significant amount of paperwork about the man, he decided to spend the day reviewing the documentation to establish the scope of the investigation. As a result, he decided to limit the investigation to events after the man arrived at Guys Marsh in 2008. The description of events in this report has been compiled from prison and clinical records.

6. While at the prison the investigator also spoke to the Family Liaison Officer, who updated him on progress in establishing the man’s next of kin. Further details on this issue are contained in the body of the report. The Family Liaison Officer also took him to the Mercia Unit, where the man lived, so that he could see his cell. While there, he spoke to an officer who worked on the unit and who discovered the man ill in his cell on 7 August. The investigator produced a note of that conversation and sent it to the officer to agree. The Family Liaison Officer also took the investigator to the Chapel, where the man had spent much of his time.

7. A clinical review was commissioned from the local Primary Care Trust. They appointed a clinical reviewer to conduct the review, and we are grateful for his assistance and timely report.

8. The investigator contacted the Coroner for the Western Dorset District to announce the investigation and to request a copy of the post mortem report.

9. Following the issue of the draft version of this report, a response was received from NOMS. No factual inaccuracies were identified in the report. The recommendation was accepted, and the response is included in the recommendations section.

HMP GUYS MARSH

10. Guys Marsh is a category C training prison. (A category C training prison holds prisoners deemed as medium risk of escape who can gain work experience to prepare for their possible release.) The prison has grown considerably over the years, is modern in design and takes prisoners from a large catchment area including London, the Midlands and the South West.

11. Healthcare services are commissioned by the local Primary Care Trust (PCT). Guys Marsh does not have 24 hour nursing cover. Healthcare staff are on duty from 8.00am to 6.00pm daily, including weekends. Access to healthcare appointments is through an application system; however special arrangements are made for emergencies. A local doctor holds seven consultation sessions a week and there is usually a wait of 48 hours for an appointment.

HM Chief Inspector of Prisons

12. Her Majesty's former Chief Inspector of Prisons carried out a full announced inspection of Guys Marsh in January 2010, said of healthcare services:

> "The healthcare department was generally well maintained, but an increase in clinics meant that there were often difficulties in providing enough clinical and interview rooms. The staff group was well trained and motivated, and prisoners were generally content with most health services. Primary care was good and there was speedy access to the GP and dental services … Relationships between health and prison staff were very good."

Independent Monitoring Board

13. Each prison has an Independent Monitoring Board, made up of members of the local community who monitor standards to ensure prisoners are held safely and humanely. In their 2009 -2010 report, the Independent Monitoring Board, said:

> "The Board continues to view HMP Guys Marsh as a decent and humane environment in which to hold men during their period of imprisonment. There are a high number of good quality, well trained professional staff who seek to work constructively with those under their charge."

On healthcare matters, the IMB commented that

> "The provision of escorts for outside hospital appointments has proved challenging for the Prison on occasions. That said it appears that to date no prisoner has been disadvantaged to the detriment of his health. However the Board remains concerned that, as both the Prison Service and the NHS will experience cuts in their budgets, this problem may become more acute."

Previous deaths at Guys Marsh

14. The man’s death was the second death at Guys Marsh in 2011. However, none of the issues raised as a result of the earlier investigation are relevant to the circumstances of this case.

KEY EVENTS

Before the man’s arrival at Guys Marsh

15. The man was born in 1934 in North Yorkshire. He left school at the age of 15 before working in various shops and factories. He completed National Service, and served three years in the Royal Warwickshire Regiment.

16. He married in 1953 and had one son and one daughter. However, he separated from his wife in the early 1960s. In 1962, he was convicted of the murder of his tenant. He received a life sentence.

17. After his release on licence in 1977, he was swiftly recalled for breaching his conditions. He appealed against the recall and was released again in 1979. He began working in an office kitchen and formed a new relationship. However, after this relationship broke down in 1982, he murdered his ex-partner. He received a second life sentence, this time with a minimum tariff of 20 years.

18. During the next 26 years, the man moved to various establishments. He was described as being difficult to deal with, and it is clear from various applications to the Parole Board that he did not engage with sentence planning or offending behaviour programmes. He spent several years at HMP Bristol before transferring to Guys Marsh in 2008. Although he initially received visits from his sister and brother in law, after they both died (he was allowed to attend their funerals) he had little contact with family or friends. There is no record that he had any contact with his children.

At Guys Marsh

19. On 9 May 2008, the man arrived at Guys Marsh. He was given a full induction, with staff explaining how to use his telephone PIN account and how to meet his sentence plan targets. Staff assessed his suitability to share a cell (a Cell Sharing Risk Assessment helps staff to assess whether someone will present a risk to a potential cellmate). He was assessed as presenting a low risk to others. No disability needs were noted during his induction.

20. All prisoners undergo a reception health screening when they arrive in a new prison. The man saw a Healthcare Support Worker (HSW) when he arrived at Guys Marsh. The HSW recorded that he was a smoker and had seen a doctor in the previous few months. However, he also noted that he did not have any concerns over his physical health, and was fit to move onto a normal wing, work and share a cell

21. On 15 May, the man was given a salbutamol inhaler, to help with his breathing. At an appointment with the doctor the next day, he was prescribed two different inhalers, containing seretide and beclometasone.

22. Over the next few months, the man saw healthcare staff regularly, usually to collect medication but also complaining of acid reflux (which occurs when

stomach acid goes up the oesophagus). On 8 August, he saw the doctor with a cough, and was found to be “slightly wheezy”. He was prescribed antibiotics.

23. The man then saw Nurse A on 22 August to monitor his asthma. The nurse told him how to improve his inhaler technique and gave him information about stopping smoking. He was also producing green phlegm when he coughed.

24. The next month, on 9 September, the man saw the doctor again, and was referred to hospital as he had a hernia. Ten days later, the doctor recorded that he had chronic obstructive pulmonary disease (COPD, a disease that affects breathing). He was prescribed another inhaler, using tiotropium bromide. Three days later, he told the doctor that he felt better with the new inhaler, but was still having gastric trouble. The doctor prescribed omeprazole to help with this and, after examining him, decided to also conduct an electrocardiogram (ECG) test (which measure electrical activity in the heart). This did not show any abnormalities, but the doctor advised him to call for help if he had any chest pain.

25. The man continued to receive his medication. On 22 October, he complained to Nurse B that he had not received all his medication. She spoke to the pharmacy technician, who advised that he had been receiving the correct medication. The technician advised that future medication be given in weekly blister packs. He was not happy about this, but saw the doctor on 11 November and agreed to try them for one month. He later agreed to continue receiving his medication in this way.

26. An appointment for the man to see a general surgeon at hospital on 18 November was cancelled because there were no escort officers available. On 30 December, he had another appointment, but this time refused to attend, as he said that he had not had enough time to prepare (this was recorded in the electronic clinical record on 13 January 2009, when a letter was received from the hospital. It is not clear why no record was made on the day. In a letter to the doctor on 9 January 2009, a consultant surgeon at the hospital also noted that the man had not attended on 18 November 2008. (There is no record of this in the electronic clinical record.) The man refused to sign a disclaimer that it was his decision not to attend. He was referred again by the doctor on 26 January.

27. Three days later, the man saw the doctor again to review his medication. The doctor believed that he had been overusing his beclomethasone inhaler and they agreed that it would be used as prescribed. The doctor next saw him on 24 February, when he complained of hip pain. He was prescribed a pain killer, codeine.

28. On 18 March, the man was taken to hospital and was diagnosed with an umbilical hernia (an umbilical hernia occurs when part of the bowel pokes through the lining of the abdomen near the navel). He agreed to surgery at a future date. (This appointment was not noted in the clinical record, although a letter explaining this was scanned to the record on 7 April.)

29. Two weeks later, on 18 March, the man saw the doctor as he was short of breath and coughing up green phlegm. The doctor believed that his COPD had got worse, and referred him to the respiratory medicine service. The doctor also prescribed an antibiotic, amoxicillin, and prednisolone, an anti-inflammatory steroid which can help asthma.

30. However, at 8.15am on 20 March, Nurse A was called to see the man as he was having difficulty breathing. The nurse helped him to use his salbutamol inhaler and called for an ambulance. When the ambulance crew arrived, they gave him more salbutamol through a nebuliser (a machine which administers medicine in a mist). He recovered and did not need to be admitted to hospital (although the nurse believed that he was refusing to go in any case). He also said that he had not taken his prescriptions for prednisolone or amoxicillin. He later asked to start on nicotine patches to help him control his smoking.

31. Nurse A saw him again on 27 March. He again did not use the inhalers properly, despite being shown how. On 15 April, the doctor saw him and completed a note about his fitness to travel, in which he wrote that he could only walk 30-40 steps before needing to stop to catch his breath. Three days later, Nurse C was called to his cell as staff were concerned about his shortness of breath. After she had taken appropriate observations, he told her he was cold because the heating had been turned off.

32. On 27 May, the man saw a Consultant in Respiratory Medicine at Salisbury District Hospital. She noted that there was some shadowing in the upper part of the right lung, and referred him for a computerised tomography scan (CT scan, which uses x-rays to build up an image of the inside of the body).

33. The CT scan took place on 7 June. The Consultant found a small mass in the lower lobe of the right lung, and some inflammation in the upper part of the right lung. She agreed that the man should have a CT-guided biopsy to examine the mass. He was also prescribed some antibiotics for a chest infection. The CT biopsy took place on 1 July, and no malignant masses were found. In the meantime, a planned hernia operation for 2 July was cancelled while his respiratory problems were investigated. He told a nurse that he was pleased with this as he was worried about the risk associated with anaesthetic.

34. On 2 August, the man refused to attend a planned appointment at hospital as he said that he had not been given any notice (he said that the Governor had agreed to this). The Lead Nurse at Guys Marsh wrote to him on 11 August (when the first note of this incident was made in the electronic clinical record) to explain that, for security reasons, it would not be possible to give him any notice of appointments. The doctor saw him on 21 August and strongly advised him to attend any further appointments.

35. The doctor requested a new mattress for the man in September, after he fell and hurt his back. He also saw another prison doctor on 24 November, when

he was still receiving pain relief for his back. The doctor advised him to stop smoking.

36. On 12 January 2010, the man refused to leave for an appointment at the Chest Clinic at hospital. Again, he said that he had not been given enough time to prepare for the appointment. The doctor saw him on 20 January and reinforced the importance of attending hospital. He also prescribed cream for a fungal infection.

37. The man saw the Lead Nurse on 18 February to discuss the missed hospital appointments. The nurse agreed to speak to the Head of Security to get a full explanation as to why he could not be given more notice of appointments. On 24 February, the Governor replied, agreeing that, if healthcare staff notified the wing the day before the appointment, wing staff would wake him at 7.00am so that he could prepare to leave.

38. On 23 March, he went to hospital and saw the Consultant. After a chest x-ray, she decided that a further CT scan was required as the shadowing in the upper lobe of the right lung was denser. The CT scan was booked for 13 April. She noted that he had reduced his smoking with the aid of nicotine patches.

39. In the meantime, the doctor had also referred him to a rheumatologist at the hospital because of recurrent joint pain. The rheumatologist saw him on 7 June, and found that he had rheumatoid arthritis. He prescribed sulfasalazine, an anti-inflammatory drug.

40. A blood test conducted at the rheumatologist's request showed that the man had previously been exposed to Hepatitis A. The doctor reviewed the results and believed that no further treatment was required.

41. The man missed an appointment at hospital on 31 August (it is not clear from record why this was, other than because of a "rapid case escort"). On 8 October, the doctor was called to his cell as he was struggling to breath. He was given a salbutamol inhaler and taken to hospital, where he remained overnight.

42. Later that month, staff discussed the possibility of moving the man to HMP Kingston in Portsmouth, which frequently dealt with older lifer prisoners with health problems. The doctor discussed the move with him, who was adamant he did not want to move.

43. On 23 October, he had another asthma attack. He was seen by Nurse B and a doctor, who noted that he was taking all of his medication. On 13 November, staff called Nurse A to the wing as he was having breathing problems. The nurse recorded that his breathing difficulties had started at 5.30am, but that he had not allowed discipline staff to call the healthcare team until 4.40pm. On the advice of the doctor, the nurse administered salbutamol through a nebuliser. The doctor saw him on 15 November and recorded that he was responding well to the nebuliser. One of the wing officers agreed to

organise regular checks throughout the night, and was advised to call an ambulance if necessary.

44. The man next had an appointment with the Consultant at hospital on 23 November. She noted that his ability to exercise had reduced since she had last seen him, and that he had a chest infection. She prescribed an antibiotic and arranged to see him again four months later. The doctor visited him in his cell on 8 December, and found him much improved and in good spirits.

45. In March 2011, the man complained of further back pain, which caused him difficulty walking. The doctor prescribed codeine to relieve the pain, and also arranged for a blood test to be done as he had been found to have hyponatraemia (a lack of salt in his blood).

46. On 11 March, the man reported that his hernia had enlarged in the previous 24 hours. The doctor monitored this over the next few weeks, but also noted that he had not responded fully to the codeine for his back. He arranged for an urgent x-ray examination, which was conducted on 31 March at hospital. This found that there was pronounced scoliosis (a curvature from side to side) in the spine and that the lumbar (lower discs in the back) were narrowed.

47. The man had another asthma attack on 2 April. An ambulance was called, but he declined to go to hospital and signed a disclaimer. Although he was supposed to go to hospital for an urgent appointment at the Chest Clinic on 5 April, the prison could not provide escort officers. An officer rearranged the appointment for 11 April, and spoke to a Senior Officer (SO) to emphasise the importance of the appointment.

48. The next day, 6 April, the doctor spoke to the man, who told him that he had no nominated next of kin but had made a will. The same day, the nurse manager met the man to discuss concerns he had about the delivery of his medication. They also discussed his family, and he confirmed he had not had contact with them for many years. The manager asked him to write down any thoughts he had about his funeral, and arranged for the disability liaison officer to see him because of his lack of mobility.

49. Two days later, however, he experienced severe abdominal pain. He said that he was constipated, was eating little and still had symptoms of a large umbilical hernia. On 11 April, he was admitted to hospital. Although surgery on his hernia was considered, his general health was deemed to be too poor. The hernia was reduced manually after the constipation was reviewed. He was discharged on 13 April, but missed a planned Chest Clinic appointment as a result.

50. On 26 April, the man was visited by staff from the hospice. They discussed his care, and agreed to advise the nurse manager of their suggestions of how to manage his treatment. In a letter the next day, the doctor confirmed that he was aware that he had an incurable illness (COPD), but that he had a strong faith and no fears of dying. His biggest concern was his mobility, and the doctor suggested that a wheelchair be provided. She also mentioned a

pressure sore that was worrying him. A nurse changed his dressing later that day.

51. Healthcare staff continued to monitor his pressure sore. On 12 May, he signed a consent form for a wheelchair after an assessment was conducted by an occupational therapist.

52. On 24 May, he saw the Consultant. She commented that it had been some time since he last saw her, and that over the last 18 months he had lost 10kg in weight. He still had a persistent cough, and appeared to be more frail. She arranged for some antibiotics to be prescribed. The wheelchair arrived on 26 May.

53. Over the next month, he saw the doctor on several occasions. The doctor recorded that he was in good spirits, was comforted by his faith and enjoyed his hobby of feeding the birds.

54. On 5 August, he spoke to the nurse manager and asked that a nurse accompany him on a forthcoming town visit. The manager agreed to discuss this with his team. They also discussed whether he could use his wheelchair to go to healthcare, and he agreed as he said that he had not been out of his houseblock for some months except to go to hospital.

Events of 7 August

55. At 6.50am, Officer A carried out a roll check in Mercia House. When the officer got to the man's cell (cell A-07), he found him sitting on the toilet, struggling for breath and waving his arms. When he spoke to the investigator, the officer confirmed that he was well aware of him and his illness. As he was not carrying a radio, the officer ran back to the house office a short distance away to inform the Night Orderly Officer (who was in charge of the prison) that he was going into the cell.

56. The SO instructed his assistant, Officer B, to go to Mercia House to support Officer A. Officer C, who was with Officer B, also went to Mercia House. By the time they arrived, Officer A had helped the man onto his bed and helped him use his nebuliser. Both officers encouraged him to breathe normally, but he passed out and became unresponsive. Meanwhile, Officer C had returned to the office to arrange for the control room to call for an ambulance.

57. Officer B removed the man's false teeth to ensure a clear airway. At this point, he was still taking two or three breaths each minute, but the officers noticed that his lips were turning blue and he had stopped breathing. Officer B gave his face mask to Officer A, and began chest compressions. Officer A tried giving breaths through the facemask but, because of the man's beard, he could not get an effective seal. He continued giving breaths mouth to mouth until the ambulance crew arrived at approximately 7.10am.

58. The ambulance crew asked the officers to take the man out of his cell and to continue chest compressions while they set up their equipment. They had

difficulty inserting a tube to help him breath, but did manage to find a shallow pulse. Shortly afterwards, the ambulance left for hospital, escorted by two officers. No restraints were used either during the escort or after he arrived at hospital. The bedwatch was reduced to one officer on 8 August.

At hospital

59. The man was placed on a ventilator when he arrived at hospital. On 9 August, the Governor and SO were joined at the hospital by an Independent Mental Capacity Advisor provided by the Independent Mental Capacity Service, who was there to ensure his best interests were observed. They spoke to the Consultant, and the SO advised that they had been unable to trace any next of kin (the only contact details they had were for a relative in Australia, but she was not known at the contact address. Checks with various telephone enquiry agencies also proved fruitless.).

60. After this meeting, the doctor decided to conduct an EEG (an electroencephalogram, which detects electrical activity in the brain) that afternoon to assess whether the spasms the man was experiencing were voluntary or not.

61. At 1.05pm the following day, the ventilator supporting the man was turned off by a hospital doctor. Chaplains from Guys Marsh were in attendance with an officer. At 1.30pm, he died, and this was confirmed shortly afterwards by the hospital doctor. The officer informed the prison. Staff and prisoners were notified, and three prisoners who were on ACCT support (Assessment, Care in Custody and Teamwork, the main support mechanism for those at risk of harming themselves) were checked to ensure they were safe.

62. Further efforts to trace any relatives of the man were unsuccessful. The prison arranged and paid for the costs of his funeral. In his possessions, staff found an unwitnessed Will and notified the Coroner, having received legal advice that it was for the Coroner to decide whether the Will was honoured.

63. The man’s funeral was conducted by the Chaplain.

ISSUES

Clinical care

64. The local PCT was commissioned to produce a report about the standard of care that the man received while he was at Guys Marsh. They appointed a clinical reviewer to conduct the review. He finds that the man was given a good standard of care while at Guys Marsh and that this care was equal to that he would have received in the community. He also notes that, on several occasions, healthcare staff anticipated the man's needs, "at times averting a difficult situation which might have arisen if they had not." He also found that discipline staff had also done their best to help him.

Availability of escort officers for routine appointments

65. On several occasions, the man failed to attend hospital appointments. This was usually for one of two reasons. The first was that he refused to go, saying that he had not been given enough notice to prepare for the appointment (for example, on 2 August 2009 and 12 January 2010). Healthcare staff liaised with security staff to ensure that different arrangements were put in place to ensure that this problem did not arise again.

66. However, there were also occasions when appointments were missed because there were not enough escort officers to accompany him to hospital. This occurred on 18 October 2008 and 5 April 2011, and it is likely to have been the reason for the cancelled appointment on 31 August 2010. We note that the IMB, in their 2009-10 report, also raise this issue and state that they fear that "this problem may become more acute" because of both NHS and prison budget cuts. If a prison is to offer a decent standard of care to prisoners, it is imperative that routine outpatient appointments are not missed whenever possible. Any missed appointments also have cost implications for the NHS.

    The Governor should ensure that escort officers are available for all routine outpatient appointments in the community. The Governor should also ensure that, if appointments need to be cancelled, a robust system is in place for Security to inform Healthcare with as much notice as possible, and for Healthcare to inform the hospital or clinic of the cancellation.

Staff response on 7 August

67. The man was found in his cell on 7 August by Officer A after he pressed his cell bell because he was having difficulty breathing. The officer acted quickly and appropriately by informing the Night Orderly Officer that he was entering the cell, and he was soon joined by colleagues.

68. When the man's condition deteriorated, and he was no longer able to use his nebuliser, two officers immediately began cardiopulmonary resuscitation

(CPR). Officer B removed the man’s false teeth to ensure his airway remained clear of obstruction. Officer A gave mouth-to-mouth resuscitation without a facemask once he realised he could not obtain a proper seal around the man’s mouth.

69. In his clinical review, the clinical reviewer commends the officers for their prompt actions, which ensured that the man remained alive until paramedics reached the prison. The investigator spoke to Officer A when he visited Guys Marsh. It was clear that he knew the man well, and that he immediately realised how serious his condition was. We agree that the response of staff to his collapse on 7 August was very well handled.

Use of restraints

70. When the man was taken to hospital on 7 August, no restraints were used because of the seriousness of his condition. This decision was reviewed the next day, and it was decided to reduce the escort staff to one officer. These decisions were proportionate and appropriate.

Family liaison and the man’s Will

71. The man had no named next of kin. A SO pursued several leads while attempting to locate any next of kin, including calling telephone numbers in Australia and contacting the Australian Embassy, and speaking to the man’s solicitor and probation officer. She also wrote to several contact addresses found in his documents to inform them of his death. We are satisfied that appropriate measures were made to inform any interested persons of his death.

72. He also made a Will, albeit unwitnessed. The SO sought legal advice as to the status of this Will, and was advised to approach the Coroner. Again, the SO acted appropriately, and in the best interests of him.

CONCLUSION

71. The man had been in custody for most of his adult life and, on this occasion, for almost 30 years. He arrived at Guys Marsh in 2008. At his first health screening interview, it was identified that he had COPD and had difficulty with his mobility.

72. On 7 August 2011, he used his cell bell to call for staff. Officer A responded and, after being joined by colleagues, gave CPR. He was taken to hospital, but died three days later when his ventilator was switched off.

73. In his clinical review, the clinical reviewer notes that the care given to the man was of an equivalent standard to that he would have received in the community. He also commended staff for their response to his collapse. However, on several occasions, appointments at local hospitals were cancelled because of a lack of available escort officers. The lack of escort officers had also been raised by the IMB in 2010. We make a recommendation to the Governor to address this issue.

RECOMMENDATIONS

1. The Governor should ensure that escort officers are available for all routine outpatient appointments in the community. The Governor should also ensure that, if appointments need to be cancelled, a robust system is in place for Security to inform Healthcare with as much notice as possible, and for Healthcare to inform the hospital or clinic of the cancellation.

   NOMS accepted this recommendation and commented:

   Hospital appointments are only cancelled as a last resort. This message has been reiterated to Orderly Officers and authority for cancellation to be sought from the Duty Governor before cancellation. Completed December 2011

   This decision will only be taken in communication with Healthcare, and therefore they will be advised at the earliest opportunity, enabling them to take the appropriate action. Completed 2011

   We are currently looking into a system whereby hospital appointments can be notified safely to a prisoner prior to the appointment allowing them time to prepare for the appointment. For discussion at the Security Meeting 28th December 2011. Target date for completion – December 2011