Investigation into the circumstances surrounding the death of a man in September 2010 at HMP Isle of Wight

Report by the Prisons and Probation Ombudsman for England and Wales

January 2011

This is the report into the circumstances surrounding the death of a man on 28 September 2010 at HMP Isle of Wight (Albany). Following complaints of severe headaches, the man was seen in the accident and emergency department of a hospital two weeks before he died. He was diagnosed as suffering from migraine and sent back to the prison shortly afterwards. He was found dead in his bed at 10.00am on 28 September. He was only 37 years old and his death was caused by a brain haemorrhage.

The man did not register any next of kin details with the prison. His offender manager and the police could not trace his family. I extend my condolences to his friends at Albany and those touched by his death.

One of my investigators carried out the investigation on my behalf. A review of the man's' healthcare was commissioned from the Isle of Wight Primary Care Trust (PCT). I am grateful to a doctor for carrying out that review, annexed to this investigation report.

I would like to thank the Acting Governor of the Isle of Wight, and his staff for their help and assistance with this investigation. I am especially grateful to a governor, who acted as the liaison officer and a member of staff who assisted in arranging the interviews.

I make one recommendation to the Head of Healthcare to ensure that a prisoner's former community medical practice is notified when a patient dies in prison. I am pleased that, since the man's death, a protocol is being drawn up to make sure that hospital staff pass prisoners' medical information to the healthcare units at the Isle of Wight.

This final report notes the comments received from the National Offender Management Service (NOMS) in relation to three areas of healthcare matters. I have dealt with those responses under the issues section of this report. I note that the recommendation as been accepted.

Jane Webb
Acting Prisons and Probation Ombudsman **January 2011**

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SUMMARY

1. The man was remanded to HMP Bristol on 22 March 2007 for alleged serious sexual offences. On his arrival, he told staff that he had been treated for mental health problems. However, he was in good physical health and his previous prescription of Diazepam was discontinued. The man cut his wrists in September. He declined assistance from the mental health inreach team because he claimed," it did not work". On 30 March 2008, he was sentenced to life imprisonment at Crown Court. He transferred to Isle of Wight, Albany site, on 11 March 2009.

2. On his arrival at Albany, the man was recorded as fit and well. He settled into the prison routine and worked in the print workshop. Officers described the man as "self isolating" and noticed that he rarely spoke to officers. Over the next 15 months, he seldom visited the healthcare unit.

3. A nurse was called to see the man on 15 June 2010, where he was working in the print workshop. Staff told the nurse that the man had"fallen" the previous evening. He would not allow the nurse to take his blood pressure and refused to be examined in the healthcare unit. The nurse escorted him back to his cell and advised him to contact healthcare if he felt unwell.

4. The man was prescribed paracetamol for headaches during July and August. On 14 September, he woke in the early hours of the morning with a severe headache and palpitations. He was escorted to the accident and emergency department of a hospital. Following observations and medical tests, he was discharged back to Albany three hours later, with a diagnosis of migraine. No discharge notes accompanied him on his return to prison.

5. The hospital discharge notes had still not been sent to the healthcare unit when a doctor saw the man six days later. The doctor noted that the man had been seen at the hospital and prescribed Sumatriptan (for migraine pain). However, he did not enquire as to the whereabouts of the discharge notes or take the man's' blood pressure.

6. An officer was on duty on 28 September and carried an accommodation fabric check (this is a security check of individual cells) of the man's' cell at around 8.15am. The man was in bed, seemingly asleep. The officer spoke to him but he did not respond, which was not unusual. About two hours later, a prisoner called the officer to the man's' cell. The officer found that the man was cold to the touch, with no signs of life. He alerted the healthcare unit that there was a medical emergency. A Healthcare Assistant (HCA) responded to the emergency call but she failed to find any sign of life. A doctor confirmed at 10.35am that the man had died.

7. I make one recommendation to the Head of Healthcare to ensure that a prisoners' former community medical practice is informed if they die in custody. I also suggest that the Governor considers whether staff should obtain a response from sleeping prisoners when they are carrying out cell checks. Lastly, I am pleased to note that a protocol is being created with the hospital to

transfer medical information to the healthcare units when prisoners return to the Isle of Wight.

THE INVESTIGATION PROCESS

8. The investigation into the man's' death was opened on 30 September 2010, when our investigator visited HMP Isle of Wight, Albany site. She was met by the liaison officer, who briefed her on the details of the man's' death. She reviewed his prison files and asked for copies of documents from those files to be sent to her. Later, our investigator, Liaison Officer and a Senior Officer visited the man's' cell on D wing and spoke to several of his friends.

9. Notices of the Ombudsman's investigation and terms of reference were sent to the prison. No members of the Independent Monitoring Board (IMB) or Prison Officer's Association asked to see our investigator on her visit. (The IMB are volunteers drawn from the community who monitor the life of the prison its staff and prisoners.) Our investigators contact details were made available to them should they wish to speak to her.

10. A review of the man's' healthcare was commissioned with the Isle of Wight PCT. A doctor led the review. Additionally, a review panel considered the health related circumstances surrounding the man's' death.

11. The man did not give prison staff any details of his next of kin. Enquiries were made by the prison, his offender manager in Bristol and the Hampshire Constabulary after his death. Unfortunately, no family or friends were identified. A copy of this report will be retained by my office should any of his relatives wish to see it in the future.

12. Our investigator visited Albany on 1 November to interview two friends of the man and one officer. The following day, the clinical reviewer and our investigator interviewed two members of the healthcare staff. Later that day, our investigator gave feedback on the initial findings from the investigation to Governor Smith.

13. A clinical panel review meeting, with Isle of Wight NHS PCT was held on 29 November and attended by the clinical reviewer.

HMP ISLE OF WIGHT (ALBANY)

14. HMP Isle of Wight was established on 1 April 2009. HMP Isle of Wight accommodates approximately 1,700 prisoners on the three sites, Albany, Parkhurst and Camp Hill. Each site has its own Director who reports to the Acting Governor.

15. The Albany site has five wings (A – E) that are almost identical and hold between 94 and 96 prisoners in single cells with in-cell power. Prisoners have access to electronic night sanitation (this is when the cell door unlocks for a limited time to allow the prisoner to go to the toilet). There are three small 'spurs' on each landing, with communal recesses containing showers, toilets and wash basins. There are also two 40-bed units (F and G) which consist of single cell accommodation with en-suite facilities.

16. Health services at HMP Isle of Wight are commissioned and provided by the Isle of Wight Primary Care Trust (PCT). A new Inpatient Healthcare Unit (IHU) was opened in October 2009 and is situated on the Albany site. It has 14 beds and is designed for prisoners with a wide range of mental health, general medical, surgical, rehabilitative and health-related respite needs, who require inpatient care within a prison setting.

17. Prison Healthcare General Practitioner services are provided by Beacon - a partnership between the provider arm of the Primary Care Trust and Lighthouse Medical Ltd. The GPs undertake a total of seven 3.5 hour sessions in Albany – this covers the primary care centre, segregation unit and IHU. Beacon also provides the GP cover for the walk in centre at a hospital. The same group of doctors cover the out of hours' prisoner needs – with first point triage by a GP.

18. The IMB produces an annual report. The latest report for Albany, for the year 2007/08, drew attention to limitations in the healthcare services at Albany. The report said:

> "The existing services within the prison are stretched to capacity, largely due to the age of the prison population. This can, at times lead to missed hospital appointments, and delays in issuing medication, from the pharmacy in Parkhurst, which, in itself is a time consuming problem. Unlike patients in the community, who can usually obtain a months supply of medication, many inmate patients are not suitable for a similar policy, resulting in medication being issued daily, or more frequently. This is also a security requirement, as it is not unknown for a prisoner to sell his medication to another."

19. The most recent report on Albany by the former HM Chief Inspector of Prisons, followed a full announced inspection in November 2007. (The prison was inspected in October 2010, however, that inspection report has not been completed at the time of circulation of this report.) The 2007 report noted that

public protection and the range of activities provided were good. Offending behaviour programmes were also of a very high standard.

20. There has been one other death from natural causes this year on the Albany site of HMP Isle of Wight, but it was not of similar circumstances to that of the man.

KEY EVENTS

21. The man was taken to HMP Bristol on 22 March 2007, following his remand to custody by a Magistrates' Court for an alleged charge of rape, firearms and grievous bodily harm. A first reception health screen document, to establish his current health needs and medical history, was completed. It was noted that in 1995 he had been in HMP&YOI Reading and that he had self harmed there. The man was taking Diazepam to relieve panic attacks.

22. On 11 April, a doctor reviewed the man's' mental health and his Diazepam prescription. The doctor wrote that the man was feeling well and settled and there was no sign of psychosis. The doctor decided that the man should stop taking Diazepam. Another doctor then joined the consultation and he signed the man's' medical record as supporting this decision, although the man was recorded as unhappy about it.

23. According to the man's' medical record, he harmed himself on 7 September by cutting his wrists. He appeared to be low in mood, withdrawn and non communicative. An Assessment, Care in Custody and Teamwork (ACCT) was opened. (The ACCT process is designed to monitor and support prisoners assessed as at risk of suicide or self-harm. The prisoner is observed at pre-determined intervals according to the perceived level of risk. Each prisoner is assessed within 24 hours of the ACCT being opened, and then reviewed at intervals decided on an individual basis.) The cuts were stitched and he was transferred to a gated cell (a cell which has a barred door) in the healthcare unit where he could be observed by staff on constant supervision. (Constant supervision means that a prisoner is continually watched by a member of staff on a one to one basis.)

24. The man was seen by a Healthcare Officer (HCO the following day, when it was noted that he would not let staff tend to his injured wrist. However, he told the officer that he would not harm himself again and that it was a "one off". This was his last recorded attempt to harm himself.

25. On 12 September, the man was recorded as being "arrogant" and made threats of violence towards officers. A week later, he was placed in the segregation unit after refusing to return to the wing. He remained in the unit until 5 October, when he agreed to the transfer. There is no further evidence of the man's' disruptive behaviour throughout the rest of his time in prison.

26. A doctor saw the man on 27 February 2008, for conjunctivitis (an eye infection) and was prescribed an antibiotic eye cream. The following day it was noted that he refused a mental health assessment.

27. A mental health review was undertaken on 23 March for the man's' court appearance. The review notes record that he was "impulsive", "subject to mood shifts" and "self loathing". However, the man said he did not want mental health services to support him as, in his view, "it did not work". He appeared at Crown

Court on 30 March where he was sentenced to life imprisonment with a minimum tariff of four years and eight months.

28. On 22 December, a nurse was asked to see the man in his cell after he had complained of a tight feeling in his chest. He was not short of breath and was not coughing or vomiting. His pulse was regular at 90 beats per minute and there was no sign of a deep vein thrombosis. He was advised to take plenty of fluids and he would be seen the following day for an electrocardiograph (ECG, a device that measures the heart rate and rhythm). The outcome was not recorded in his medical file.

29. Two days later, a doctor carried out a physical examination of the man. The doctor noted that the man was experiencing tingling in his left arm. The doctor wrote that the man had no chest pain or palpitations and a good reaction in all his limbs. His blood pressure was normal at 130/80 and he had an average pulse rate of 72 beats per minute. He was prescribed Diclofenac for pain and told to ask for a further appointment if there were any more problems.

30. According to his medical record, the man transferred to Albany on 11 March 2009 accompanied by a full set of his medical notes. A nurse wrote that the man refused to have his clinical observations taken. He told the nurse that he wanted to give up smoking and had some nicotine patches in his possession from Bristol. The nurse wrote that he was fit for work.

31. From March 2009 until June 2010, the man was not a regular visitor to the healthcare unit. He was given paracetamol and indigestion medication (Gaviscon) but without an explanation being recorded.

32. On 15 June, staff at the print workshop asked for medical assistance from the healthcare centre. A nurse went to the print workshop, where he was told that the man had passed out the previous evening in his cell. The nurse tried to examine the man, who confirmed that he had fallen the previous evening. He refused to have his blood pressure taken and became very agitated when the nurse asked him to accompany him to the healthcare unit to take further observations. Eventually, he was taken back to his cell and the nurse advised him to contact healthcare staff if there were any further problems.

33. Eight days later, the man was prescribed paracetamol for headaches, by a nurse. On 26 June, it is recorded in the medical record that the man did not attend an appointment with the doctor. Four days later the man was prescribed more paracetamol by a nurse prescriber. (A nurse prescriber is a qualified registered general nurse who can prescribe certain medications without a doctor's authority. Paracetamol is a pain relief medication that can be approved by a nurse prescriber.)

34. A nurse was on duty in the Inpatient Healthcare Unit (IHU) on 14 September. At night, staff on the IHU are locked on the unit and do not have access to residential wings because they are on duty to provide care and treatment to inpatients and therefore cannot leave them unsupervised. The nurse was contacted by wing staff at 2.15am and told that a prisoner, the man on D wing,

had a severe headache. As the nurse could not get to the wings, arrangements were made for him to be escorted to the IHU.

35. On his arrival at IHU, a nurse saw him and took his blood pressure, which was high at 176/115 (an average reading is 130/80). He had a regular pulse rate and good oxygen levels. The man told the nurse that he had woken with a severe headache and palpitations. An ambulance was called. When the paramedics got to his cell, it was agreed that the man should be taken to the Accident and Emergency department at a hospital. He was escorted by two officers using an escort chain. (An escort chain is 1.8 metre in length with one cuff attached to the prisoner and the other to an officer. It is used routinely as part of the measures to prevent prisoners escaping.)

36. The man returned to Albany at 5.47am, following blood tests and a full examination. He had been diagnosed with migraine and prescribed Diclofenac for pain relief. The hospital discharge notes were not sent back to the prison's healthcare unit following his visit to hospital.

37. A nurse saw the man on 18 September and recorded that the man told him that the hospital had diagnosed him as suffering from a migraine. The Diclofenac prescription had finished so ibuprofen and paracetamol were prescribed. An appointment was made for him to see the doctor. During this time, friends of the man told my investigator that he would ask other prisoners for their pain relief medication because his headaches were severe. His friends advised him to seek medical help but the man did not do so.

38. A doctor saw the man two days later on 20 September. The hospital discharge notes were not available although the medical record contained a note that the man had been to the hospital. He told the doctor that he had been diagnosed with migraine and he prescribed Sumatriptan. (Sumatriptan is a migraine pain relief medication.) No medical observations were taken of the man's' temperature, pulse or blood pressure.

28 September

39. An officer started his shift on D wing at 7.20am on 28 September. Following a briefing by an SO he started his accommodation fabric checks of cells on the fourth landing at 8.15am. (Accommodation fabric checks are daily security checks of a prisoner's cell.) About ten minutes later, he entered the man's' cell and saw him lying on the bed with one arm over his face. The officer spoke to him but did not get a response. This was not unusual as the man did not usually speak to officers. The officer checked the cell's lights, observation hatch and bell, as per the requirements of a fabric check, and then left.

40. At around 10.05am, a prisoner, went to the wing officer and spoke to the officer. He told the officer that he was concerned as he had not got a response from the man's' cell when he knocked on the door. The officer and prisoner went to the man's' cell and the officer knocked on the door then went into the cell.

41. The officer saw dried saliva around the man's' mouth and noticed that he was cold to touch. The officer immediately left the cell and went to the wing office. He telephoned for the orderly officer and healthcare to attend D wing straight away. Together with another officer, the officers returned to the man's' cell. One of the officers tried to get the man to respond by gently rocking him and calling his name.

42. A Healthcare Assistant (HCA) arrived at the man's' cell at 10.10am and examined him. The HCA found the man to be cold, with no pulse and stiff limbs. Resuscitation was not started and the HCA asked for the doctor to attend, as she thought that the man had been dead for some considerable time. Two officers then assisted by returning prisoners to their cells on the wing.

43. A doctor confirmed at 10.35am that the man had died. The doctor noted that the man's' pupils were dilated and fixed with early signs of rigor mortis. No empty medication boxes were found and there were no apparent wounds or injuries.

44. A Governor made arrangements for the prison's Listeners to be escorted to D wing to support prisoners. (Listeners are Samaritan trained prisoners who support other prisoners in times of crisis.) Prisoners closest to the man's' cell were told of his death by a Governor in a small group. Later all the prisoners on D wing were asked to assemble in the television room where they were told of the man's' death. The print workshop was closed that afternoon as a mark of respect for the man. The IMB and chaplaincy also spent a considerable amount of time on D wing to support prisoners and staff along with the staff support team.

45. Extensive enquiries were made to trace the man's' next of kin, however they were unsuccessful. A funeral was arranged by the prison chaplaincy department and attended by a Governor and Acting Governor I. A memorial service was held in the chapel.

46. Upon receipt of the man's' medical record to consider for the clinical review, the clinical reviewer entered the man's' details on the National Health Service (NHS) database. The clinical reviewer found that the man was still listed as a patient at a community medical practice in Bristol. The doctor contacted the medical practice and informed them of the man's' death, so that his medical record could be updated.

ISSUES

Clinical care

47. A review of the man's' clinical care whilst at Isle of Wight was commissioned with the Isle of Wight NHS PCT. The clinical reviewer who carried out that review is a general practitioner.

48. The doctor evidenced his review from the man's' medical record and interviews with healthcare staff. He attended a panel review meeting at the Isle of Wight with healthcare staff and members of the PCT. As part of his review, the doctor listed a full chronology of the man's' medical interventions.

49. The man was taken to hospital on 14 September with a severe headache, high blood pressure and palpitations. The reviewer comments that these symptoms might have been the first sign of the haemorrhage that caused his death. However, his symptoms were not entirely typical of a haemorrhage and his recovery after this date made this diagnosis less likely.

50. According to the clinical reviewer, the diagnosis of a subarachnoid haemorrhage is particularly difficult when presented as a severe headache. The doctor referred to an article recently published in the British Medical Journal.

> "Severe headache represents 2% of all visits to Emergency Departments, and subarachnoid haemorrhage accounts for only 1-3% of these cases. Investigation with computerised tomography scan CT scan takes images of the body tissues expensive and involves a high dose of radiation. If the scan is normal, a lumbar puncture is performed, and this can itself result in a more severe headache than the original headache resulting in their initial presentation."

51. The man did not lose consciousness or say that he had vomited, and so his symptoms did not prompt further investigation. He was subsequently treated for migraine, which the clinical reviewer deemed to be appropriate. However, the hospital did not send any discharge notes back to the prison's healthcare unit for their information.

52. The doctor did not take a blood pressure reading from the man on 20 September. The clinical reviewer commented that the doctor might have taken this observation given the high blood pressure reading when the man was taken to hospital. However, the doctor told the clinical reviewer that he believed that the high blood pressure reading was a response to the severe head pain. Furthermore, the clinical reviewer concluded it was not unreasonable that the doctor did not try to trace the discharge notes.

53. The clinical reviewer was concerned that the hospital's discharge process did not ensure that these notes follow a patient back to prison. At the panel review meeting it was agreed by those present and my investigator, that the clinical

reviewer and the Senior Commissioner of Offender Health, Isle of Wight NHS PCT, will write to the Chief Executive of Isle of Wight NHS PCT:

> "… to remind all clinicians involved in the care of prisoners from HMP Isle of Wight of the importance of timely and accurate clinical information back to prison healthcare when they are returned to custody."

54. An agreed protocol has been developed and attached to the clinical review, which is annexed to this report. Furthermore, the clinical lead for healthcare at HMP Isle of Wight will consult with staff at the hospital to provide training for new hospital staff on the special requirements of prison health care. In the light of these actions, I make no formal recommendation in this regard.

55. When considering the man's' medical history, the clinical reviewer realised that his previous community medical practice was not aware of his death. The doctor was concerned that community medical practices could try to contact the deceased unaware that they have died. Such correspondence can be distressing for families and open to fraud. The clinical reviewer was keen to ensure that such mistakes do not happen in the future. I therefore make the following recommendation, and whilst acknowledging that the clinical reviewer made this for the attention of Offender Health, in this instance I direct the recommendation to the Head of Healthcare

The Head of Healthcare should ensure that systems are in place to notify a prisoner's former community medical practice in the event of a death in custody.

56. The clinical reviewer concluded his review by noting,

> "The man had received care at least equivalent to that he would have received had he been in the community when he was acutely unwell. Indeed, he was screened by a Healthcare Professional before being transferred to hospital as an emergency in the early hours of 14th September, which was better than would have been available, had he dialled 999 from home."

Security checks on of cells

57. An officer carried out an accommodation fabric check of the man's' cell at about 8.25am on 28 September. The officer entered the cell and saw the man lying in bed, with one arm over his face and the other by the side of the bed. The officer spoke to him but did not get a response. From an interview with an officer, who knew the man, it was noted that he was a prisoner who did not readily interact with officers. The officer told my investigator that it was not unusual for officers to speak to the man and not get a response.

58. The security check of the cell was completed by an officer and he left the cell without any reaction from the man. A friend of the man told our investigator that accommodation fabric checks are carried out daily. It is not uncommon for

prisoners to be in bed asleep when the checks are made and they do not always appreciate being woken. Officers often leave the prisoner sleeping when completing the checks.

59. Around 90 minutes later, a prisoner could not get an answer from the man when he knocked on his door. He alerted an officer who went into the man's' cell, but found him unresponsive.

60. I understand that there are good relationships between prisoners and staff on D wing and not waking prisoners during an accommodation fabric check contributes to that. However, the man's' death may well have been discovered earlier if his wellbeing had been established during that first check. I therefore ask the Governor to consider whether officers should obtain a firm and positive response from prisoners when they are carrying out accommodation fabric checks of cells.

Support to staff and prisoners

61. Our investigator spoke to two friends of the man. Both said that all the prisoners closest to the man's' cell were told of his death by a Governor. Wing staff, together with the IMB and chaplaincy then spent the rest of the day on the wing to support prisoners.

62. I am pleased to be able to repeat that the two friends were complimentary about the Governor and the wing staff and their thoughtful actions following the man's' death. The visible presence of the IMB and Chaplaincy supported both staff and prisoners, and I note this good practice.

Response to draft report

63. A response from NOMS to the draft report in reference to paragraph 20 noted that a Memorandum of Understanding (MOU) was placed on 19 May 2010 and circulated to staff on 28 May that gives 24 hour access by nursing staff to patients in the IHU. NOMS accepts that staff told our investigator that there was no access to patients during interviews. I have therefore withdrawn that section from paragraph 20. Furthermore, I have amended the number of in patient beds from 12 to 14.

64. Paragraph 21 has been amended to accurately reflect the general practitioner services operating in the Isle of Wight prison cluster.

65. The following response from NOMS to paragraph 38 said:

> "We cannot dispute that this may be a reflection of what a nurse had said however, it does not accurately reflect the situation and processes in place regarding nurses based in the IHU accessing the wings. Whilst it is true that at night nurses require an escort if incidents take place outside the IHU, this does not mean that nurses cannot physically get to the wings. The reason that night nurses do not routinely leave the unit is because

they are on duty to provide care and treatment for the inpatients and therefore their “core” responsibilities are with the inpatient group.

This understanding has been in place since the Unit opened in October 2009 – at that time (and up until July 2010) there was only one qualified nurse on duty at night. This would have made it highly inappropriate and unsafe for the nurse to leave the patient in his/her care to attend the wings.

Since July 2010 – there have been two qualified nurses on duty at night in the IHU. This has meant that consideration can be given to one nurse being able to leave the Unit for the purposes of administering planned care (e.g. to a prisoner requiring regular pain relief for cancer) and where the absence from the Unit is for short periods only.”

66. I note that in the early hours of the morning on 14 September, the man’ was deemed to be in need of medical attention for a severe headache. In light of the response from NOMS as quoted above, there should have been two nurses on duty in the IHU that night. Whilst the visit to see the man’ was not for planned care, it would have been possible for one of those nurses to be taken to the wing to see him in his cell rather than escorting him to the IHU.

CONCLUSION

67. I am told that the man rarely conversed with prison staff. His mental health was noted to be problematic during his early days in custody however, on his transfer to the Isle of Wight he seemed to settle into the regime of the prison.

68. No serious health problems were brought to the attention of the healthcare staff until 15 June, when a nurse saw him following a "fall" the previous evening. A diagnosis of migraine wad made when he was examined at hospital on 14 September. Six days later a doctor prescribed migraine relief medication.

69. The clinical reviewer noted that the man received equitable care to that in the community. I am satisfied that his death from a subarachnoid haemorrhage on 28 September could not have been foreseen by the prison or healthcare staff. However, his death might have been discovered earlier if a response from the man had been obtained when the accommodation fabric check had been undertaken early that morning.

70. I endorse one recommendation by the clinical reviewer to ensure that a prisoner's former community medical practices is notified if they die in custody. I am reassured that a protocol is being put into practice for staff at the hospital, to pass prisoners' medical information to the healthcare staff at the Isle of Wight.

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RECOMMENDATIONS

Head of Healthcare

1. The Head of Healthcare should ensure systems are in place to notify a prisoner's former community medical practice in the event of a death in custody.

Accepted

"Prison Healthcare Services are provided by NHS Isle of Wight and are covered by a full range of policies and procedures. Notification of the death of any patient in hospital is made to his/her General Practitioner (where this is known) by the Hospital Bereavement Advisor by telephone on the day of death (or the next working day if the death occurred out of hours). This is followed up by an email confirmation. These arrangements would apply equally to any prisoner who dies in hospital.

However, some prisoner deaths occur in prison and so would not automatically be known to the hospital services.

In such cases (and where this information is known) Prison Healthcare staff will undertake to advise the prisoner's former General Practitioner or community medical practice of the individual's death within the same parameters as those of the hospital. A guidance note to this effect has been provided to Prison Healthcare staff.

In addition the local Registrar of Births, Deaths and Marriages will register and notify all deaths to the appropriate authorities."