

**Investigation into the circumstances surrounding the  
death of a man, who died at a local hospital in March 2010,  
whilst a prisoner at HMP Stocken**

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

**October 2010**

This is the report of the investigation into the death of a man, who died at a local hospital on 8 March 2010. At the time of his death he was a prisoner at HMP Stocken. The post mortem concluded that he died of natural causes, from a subarachnoid haemorrhage (a large bleed on the brain) caused by a ruptured berry aneurysm.

I extend my sincere condolences to the man's family and friends. I am pleased that the man's mother felt well supported by prison staff in the difficult weeks following her son's death.

The investigator and I would like to thank the Governor of Stocken and his staff for their co-operation with this investigation. I am particularly grateful to the senior officer who acted as the establishment's investigation liaison officer.

Leicestershire County and Rutland Primary Care Trust (PCT) commissioned a doctor to review the clinical care provided to the man while in prison. I am very grateful for his considered and timely review.

The man was sentenced to life imprisonment in 1998. Over the following years, his health was good and he rarely needed any medical attention. He was, by all accounts, a very fit and healthy man who regularly used the prison gym. A close friend said that the man often complained of headaches, although it seems he never sought medical treatment for these.

On the evening of 7 March, an officer conducting a routine check became concerned about the man. When staff went into his cell, they found him collapsed and unconscious. He was taken to hospital where he died, shortly after midnight on 8 March.

The clinical reviewer concludes that the man's death could not have been foreseen or prevented. While I make three recommendations concerning the prison's response once the man had been found, none of them would have altered the outcome.

The final version of the report has been amended to reflect the National Offender Management Service's response to the recommendations. 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

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

**October 2010**

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## SUMMARY

In 1998, the man was convicted of murder and sentenced to life imprisonment. As part of his sentence progression, he moved to HMP Stocken in July 2009. He was a fit and healthy man who frequently used the prison gym. During his time in prison, he very rarely sought medical attention and then only for relatively minor complaints.

Once at Stocken, the man began working and settled into the prison regime. Although he did not engage very much with staff, they generally described him as polite and quiet. He had a few friends on B wing (where he lived), one of whom said that the man frequently suffered with throbbing headaches. There is no indication in his file that the man ever visited healthcare or requested treatment for headaches.

On the afternoon of 7 March 2010, the man told friends that he did not feel well. He said that he had mentioned this to staff who did not take him seriously. The investigation found no evidence of staff failing to respond appropriately. Staff talked to the man at various points during the day and said he made no mention of feeling unwell. He collected his meals as usual.

At about 5.00pm, the prisoners were locked in their cells for the evening. At 7.00pm, an officer carried out routine checks on all the prisoners on B wing. On reaching the man's cell, the officer found the observation panel in the cell door covered and alerted the senior officer on duty. Staff went into the cell and found the man collapsed and unconscious on the floor. He was breathing and so was placed into the recovery position.

Initially staff tried to contact the out of hours medical service (as the prison does not have 24 hour healthcare) but could not get an answer. Subsequently, staff called 999 and requested an ambulance. Having carried out checks, the paramedics decided that the man should be taken to hospital.

On his arrival at hospital, further tests were conducted which revealed that the man was seriously unwell. Hospital staff and the police tried to contact members of his family. Unfortunately, the address recorded in the man's prison file was not correct and his next of kin could not be traced in time. Shortly after midnight on 8 March, the man died.

The post mortem revealed that he died from a subarachnoid haemorrhage (a bleed on the brain) from a ruptured berry aneurysm (an enlargement to part of an artery supplying blood to the brain). The clinical reviewer concludes that the man's death could not have been foreseen or prevented. I make three recommendations concerning the prison's response to finding the man.

## **THE INVESTIGATION PROCESS**

1. The Ombudsman was notified of the man's death on 8 March 2010. The investigation was allocated to an investigator from my office. The investigator visited Stocken just over a week after the man's death to open the investigation.
2. The investigator issued notices inviting staff and prisoners to contact her with any information they thought might be relevant to the investigation. Two prisoners contacted her as a result and were interviewed. A number of other prisoners and members of staff were also interviewed in April 2010. The investigator was provided with copies of the man's prison and medical records, including those covering his time at Stocken.
3. Leicestershire County and Rutland PCT commissioned a doctor to review the clinical care the man received at Stocken. He and the investigator visited the prison together in June and spoke to staff and prisoners.
4. HM Coroner for Rutland and North Leicestershire was notified of the investigation and provided the results of the post mortem. The Coroner will receive a copy of the report to assist with his enquiries.
5. One of my family liaison officers contacted the man's mother to explain the purpose of my investigation and invite her to raise any questions or concerns. The man's mother praised prison staff for the support they had offered her following her son's death. She said that she had received letters from her son while he was in prison and that he had never mentioned having any health problems. The family liaison officer also made contact with the social worker of the man's birth mother as she and her son had re-established contact recently. The social worker asked the man's birth mother to be told the cause of her son's death and so a copy of this report will be passed to the social worker.

## **HMP STOCKEN**

6. HMP Stocken is a category C training prison in the East Midlands. It can accommodate up to 842 adult male convicted prisoners. The prison opened in 1985 and has undergone extensive expansion, with further growth planned.
7. The National Offender Management Service (NOMS) publishes quarterly performance ratings for all prisons in England and Wales. The ratings are based on a set framework and prisons can be rated from one to four (with four indicating 'exceptional' performance). Stocken has achieved a rating of three ('good' performance) for the last four published quarters.
8. Healthcare services at the prison are provided by Leicestershire County and Rutland PCT who sub-contract the services to Nottinghamshire Community Health. There are no inpatient facilities at the prison, prisoners needing inpatient facilities are taken to one of several local hospitals. The prison does not have 24 hour on-site health cover but provides a service much like a community general practice surgery.

## **HM Chief Inspector of Prisons (HMCIP)**

9. HMCIP carried out an unannounced short follow up inspection in May 2008. The inspection report noted that the prison had made improvements since the previous inspection in 2005. Relationships between staff and prisoners were found to be satisfactory. However, healthcare services had made insufficient progress and prisoners' perceptions of the services on offer were poor.

## **Independent Monitoring Board (IMB)**

10. Each prison in England and Wales is monitored by an IMB, consisting of volunteer members of the local community. It is the role of the IMB to ensure the just and humane treatment of those prisoners held in the prisoner. The Board must report annually to the Secretary of State. The latest available report for Stocken covers the period May 2008 to April 2009. The Board expressed their satisfaction that the Governor remained committed to achieving improvements across the prison.

## **Previous deaths at Stocken**

11. There have been five previous deaths at Stocken since the Ombudsman began investigating all deaths in prison in 2004. I have found no similarities between the circumstances of the deaths. However, the Ombudsman made a recommendation about the use of restraints in 2004 to the Governor at Stocken, which was accepted.

## KEY EVENTS

12. In June 1997, the man was remanded into custody at HMP Bullingdon, charged with murder. In April 1998, he was convicted of the charge and returned to Bullingdon where he spent the first nine months of his sentence. The man was shocked at the court verdict and immediately launched an appeal, which was unsuccessful.
13. Over the next few years, the man progressed through the prison system. Staff reported that he could be a difficult prisoner to manage and was “high maintenance”. He had little contact with healthcare services other than for minor complaints.
14. On 7 July 2009, the man transferred to Stocken. During a routine healthscreen on 15 July, he told staff that he smoked about eight cigarettes a day and used to smoke cannabis. He explained that he was prescribed diclofenac (a pain relief medication) for leg pain caused by a road traffic accident in 1993. He said that he needed to see the dentist to get a replacement filling, but otherwise had no health concerns.
15. The man applied for work in the prison. In September, he began working in the workshop with DHL, the company providing canteen supplies to prisoners at Stocken. (Through the canteen services, prisoners are able to buy a range of items such as food and toiletries for their personal use.) In October, staff wrote in his prison file that his behaviour was good although he rarely engaged in conversation. The man spent most of his time in his cell, or practising with his band.
16. The man apparently had no contact with healthcare services after 11 January 2010 when he attended for post-vaccination Hepatitis B tests. However, the investigator spoke to one of the man’s close friends. The close friend said he and the man had known each other for some years, having served some of their sentences together at HMP Gartree. He recalled that, after transferring to Stocken, the man frequently complained of headaches, which he described as a constant throb that he could not get rid of, no matter what he took. (At Stocken, prisoners are able to purchase limited amounts of simple pain relief medication, such as paracetamol, through the canteen service.) The friend said that the man was “not the sort of person” to seek medical advice or assistance and so he rarely went to healthcare. There is nothing in the man’s medical record to indicate that he sought any treatment for his headaches.
17. An officer that was on duty on B wing on 7 March was interviewed by telephone during the course of the investigation. The officer explained that she had returned from a period of leave that day and wanted to reacquaint herself with prisoners on the wing. As a result she chose to carry out the cell checks that morning. (Every day, each prison cell is checked to make sure that the fixtures and fittings are in working order and none of the bars or locks securing the cell is faulty.) She carried out the checks between 9.30am and 10.30am, chatting briefly with each prisoner as she worked.

18. The man was sitting on his bed in his single cell when the officer reached him. She described him as chatty and he raised no concerns with her. The officer said that she knew the man quite well having worked on B wing (where he had lived since arriving at the prison) for some time. She said he was a very fit man, who generally stayed in his cell listening to or playing music. The officer said that he did not talk to staff very much, unless an issue was of importance to him.
19. At about 2.00pm on Sunday 7 March, two fellow prisoners living on B wing asked the man to play pool with them, as he often did. The man declined, telling the two men that he did not feel well. Both of them were interviewed as part of the investigation. The man told the men he had let staff in the wing office know that he did not feel well but that they had not taken him seriously. Neither of them asked the man what was wrong. One of them recalled that the man might have gestured towards his chest area when telling them he felt ill. He did not mention having a headache. The two men said that the man did not look unwell and they had no reason to worry about him. The man said he was going to collect some hot water to make tea and return to his cell.
20. The officer that carried out the cell check said she saw the man twice later during the day at meal times. He collected both his lunch and tea (which is served at about 4.30pm on Sunday). He did not tell the officer that he felt unwell. The officer said that she had since talked to the two other members of staff on duty on 7 March, who both said that the man had not approached them about feeling ill. The investigator asked the prison's investigation liaison officer to circulate an email to all B wing staff asking if they had spoken to the man on 7 March. No one responded to the email.
21. The man's close friend told the investigator that the man went to healthcare on Saturday 6 March and again on Sunday 7 March seeking help for his headache. He said that, on both occasions, the man was "fobbed off" by healthcare staff and was not prescribed any medication. As mentioned above, there is no record in the man's medical notes of him attending healthcare because of his headaches or for any other reason on 7 March. Furthermore, healthcare staff on duty on 6 March had no recollection of the man visiting healthcare or asking for any treatment. The man's close friend said that he saw him at tea time and described his friend as "scowling" and complaining of a pounding headache.
22. The clinical manager at Stocken, was asked about the provision of healthcare services at the weekend. She explained that two nurses and an assistant practitioner work weekend shifts, with someone on duty until 2.30pm. At weekends, prisoners can go to the healthcare centre for pain relief medication after being unlocked first thing in the morning (although, as explained earlier, paracetamol are available to buy through the canteen system). At other times, wing staff must contact healthcare staff if a prisoner needs to be seen by a nurse. After 2.30pm, staff can contact the out of hours service. The officer that carried out the cell check said that wing staff were aware of the correct procedures.

23. Prisoners are locked in their cells at about 5.00pm on Sunday. At 7.00pm, the officer began the roll check on B wing (when all prisoners are counted). She explained that, in order to check each prisoner, staff must look through the observation panel in the cell door. She said she began the roll check on spur 1 and finished with spur 4. The man's cell, on spur 4, was one of the last cells she checked.
24. On reaching his cell, at about 7.05pm, the officer found the observation panel blocked by a piece of paper, meaning she could not see into the cell. The officer explained that, although it is against the prison rules to block the observation panel, prisoners might do so for a number of reasons (for example, to use the in-cell toilet, or get undressed). However, she was surprised to find the man's panel was blocked. He had been in prison for a number of years and knew that the roll check would be taking place and that he would be in trouble for having covered the panel.
25. The officer banged on the man's door but he did not respond. She told the investigator that she could hear a "strange" loud snoring sound coming from his cell. The officer became concerned and returned to the wing office to telephone the orderly officer (the most senior member of staff on duty). She asked the orderly officer if she could unlock and go into the man's cell, and was told that she should wait for him and other staff to arrive. The investigator asked the officer if she had considered using her radio to alert the orderly officer. She explained that the wing was very quiet at the time and she did not want the prisoners in adjacent cells to hear her talking to the orderly officer. The officer said that she thought the man might have covered his panel because he was using a mobile phone or drugs. She did not immediately think that he might be unwell or that it was an emergency situation.
26. The orderly officer was also interviewed as part of the investigation. He said that he was collating the roll check figures in the central prison office when the officer telephoned. Having heard her concerns, he went to B wing, collecting a fellow officer from A wing on his way, so that there would be three officers present to unlock the cell. This is in line with the prison's local security protocol. On unlocking the man's cell, the staff found the man lying on the floor, breathing very heavily. The orderly officer and the officer from A wing went into the cell and tried to rouse the man, but got no response. The two officers placed the man in the recovery position and covered him with a blanket. The orderly officer told the investigator that he initially thought that the man might have had a fit. He asked the officer to get medical assistance.
27. The officer that carried out the cell check returned to the wing office and telephoned the number displayed for the out of hours service. There was no answer, so the officer contacted staff in the gate who provided a pager number instead. The officer tried this number but it was incorrect. She told the orderly officer of her difficulties and he instructed her to call for an emergency ambulance. The officer asked staff at the gate to do so. The ambulance was requested at 7.10pm.

28. While the officer from A wing remained with the man, the orderly officer contacted the duty governor. The orderly officer knew that an officer who was working on another wing was first aid trained and asked for him to come to the man's cell. The first aid trained officer told the investigator that he reached the cell at about 7.30pm. He realised that the man was unconscious, his legs were rigid and there was blood and mucus coming from his nose. His breathing was laboured, but on checking his pulse, the officer found it to be strong and regular.
29. Staff remained in the man's cell until the paramedics arrived at 7.35pm. They assessed the man in the cell before deciding that he needed to be transferred to hospital. The officers helped move the man into the ambulance. The orderly officer asked the first aid trained officer and another officer to escort the man to hospital. The orderly officer directed that no handcuffs or other restraints be used, because the man was very ill. However, in interview, the orderly officer said that he telephoned the duty governor again who directed that staff restrain the man with an escort chain. (This is a length of chain approximately eight feet long with a handcuff at each end, one placed on the prisoner and the other on a prison officer.) The duty governor could not recall their conversation or her decision that restraints should be applied. When the ambulance reached the prison gate, the orderly officer told the escorting officers to apply restraints. The ambulance left Stocken at 7.52pm, arriving at the local hospital's accident and emergency department at 8.10pm.
30. Hospital staff asked for the restraints to be removed from the man so that they could examine and treat him more effectively. The officer qualified in first aid telephoned the duty governor again, who agreed that the restraints could be removed.
31. At about 9.30pm, the man underwent a brain scan after which hospital staff said his condition was very serious. He was placed on a ventilator (which mechanically moves air into and out of the patient's lungs). Another officer arrived at the hospital at 10.00pm to relieve the officer that was trained in first aid. He told the investigator that hospital staff and the police were trying to find members of the man's family to inform them that he was unwell, but were unable to locate any contact details. At 11.15pm, after hospital staff had discussed the situation with neurosurgeons at another local hospital, the man was taken off the ventilator. At 12.15am on 8 March, hospital staff confirmed that he had died.
32. The Coroner provided the results of the post mortem, which concluded that the man's death was caused by:
  - 1a. Subarachnoid haemorrhage
  - 1b. Ruptured berry aneurysm

### **Contact with the man's family**

33. On 8 March, prison staff located contact details for the man's adoptive mother. The prison's family liaison officer and the Reverend visited her that afternoon to break the news. The following day, the prison's family liaison officer spoke to the social worker of the man's daughter, who agreed to break the news to her. The prison's family liaison officer spoke to the man's daughter several days later and arranged to pass some of her father's personal possessions to her. The prison made an offer to contribute to the cost of the man's funeral, in line with guidance in Prison Service Order (PSO) 2710 Follow up to deaths in custody. Several members of prison staff attended the funeral.
34. In conversation with one of my family liaison officers, the man's mother praised prison staff and expressed her appreciation for the way they had kept in touch with her in the weeks following her son's death.

### **Support for prisoners**

35. The man's close friend found out his friend had died on the morning of 8 March when another prisoner told him. The Governor issued a notice to all prisoners that day, formally telling them of the man's death. The close friend said he had been offered support by staff on the wing. A memorial service was held in the prison at which the man's close friend gave a reading.
36. However, following the man's death several prisoners on B wing were concerned that staff had not taken the man seriously when he complained of feeling unwell on 7 March. One prisoner made a formal complaint which was investigated internally by a manager at the prison. The internal investigation concluded that the man had not told staff that he felt ill and that staff who had contact with him during the day had no concerns about him. This independent investigation has found no evidence to suggest that staff acted inappropriately either.

### **Support for staff**

37. PSO 2710 directs that, immediately after the death of a prisoner, a hot debrief must be held. (A hot debrief provides staff involved an opportunity to talk through the incident. Its purpose is to provide reassurance and support.) When he left the prison, the man was alive and so a hot debrief was not held on the evening of 7 March. Staff involved in responding to the emergency said that there was no hot debrief the following day. However, they were all contacted by the prison's Care Team and offered support. Several weeks after the man's death a formal debrief was held. All staff interviewed said they had received sufficient support after the man's death.

## ISSUES

### Clinical care

38. The man arrived at HMP Stocken in July 2009, in good physical health. His medical record shows that he had very little contact with healthcare staff while at the prison. However, a close friend of the man said that he often had painful headaches, including over the weekend that he died. There is no indication in the medical records that the man ever sought medical attention because of the headaches.
39. The clinical reviewer concludes that the man died of natural causes, and that his death could not have been predicted by prison or healthcare staff. The clinical reviewer notes the man's history of headaches and concludes that, on the available evidence, they were most likely caused by tension. He writes:

“My view is that it would be very unwise to link this history of headaches with his eventual cause of death which ... was a tragic but unpredictable and catastrophic event. The headache that occurs with a subarachnoid bleed is an extremely sudden and severe event, often described as a ‘thunderclap headache’, which is usually felt at the back of the head. In the case of the man the subarachnoid bleed would have led to almost immediate collapse and unconsciousness.”

### The staff response on 7 March

40. On the afternoon of 7 March, the man apparently told fellow prisoners that he had approached B wing staff on duty and told them that he did not feel well. He said that the staff had not taken him seriously. One prisoner was concerned that, had staff responded appropriately, the man might have received medical treatment that could have prevented his death. As a result, the prisoner made a formal complaint about the staff response. The complaint was investigated internally by a manager at the prison who concluded that staff who had contact with the man during the day of 7 March described him as seeming well. None had any concerns about him or had been told that he was ill.
41. As part of the Ombudsman's investigation, the officer was interviewed. On 7 March, she saw the man in the morning, at lunch time and again when he collected his tea. She said that, on each occasion, he seemed his normal self and did not mention feeling unwell. Other staff working on B wing on 7 March were asked, by email, if the man had told them he felt ill. No one responded to the email, however, they told the prison's family liaison officer that the man had not approached them that day. I have found no evidence that the man told staff he felt unwell. On the basis of the clinical reviewer's review, even if the man had informed staff he felt unwell, it is unlikely to have changed the final outcome.
42. The officer made a routine check on the man shortly after 7.00pm and found his observation panel covered with paper, which is against the prison's rules. She described hearing a “strange” snoring sound coming from the cell. The officer telephoned the orderly officer and was told to wait for him and other staff to arrive

before entering the cell. This approach was entirely appropriate. Not only is it in line with the prison's local security policy but it also ensured staff safety, given that the officer had no idea what she might find on opening the cell door.

43. Once staff had unlocked the man's cell and found him collapsed, they checked he was breathing and then placed him in the recovery position. The orderly officer instructed the officer that found him to seek medical assistance. The officer first called what she thought to be the out of hours service number. When she got no reply other than an answer phone, the control room gave her a pager number to try, which was incorrect. At this point, she asked the control room to call 999 for an ambulance.
44. The clinical reviewer concludes that the prison did not have the correct number for the out of hours service on display. He explains that the service is operated by a staffed call centre at all times, and it is not possible to reach an answer phone. He also notes that the out of hours service is not contactable by pager. Staff notice 411/2009, issued in December 2009 sets out the correct protocol (and gives the correct contact telephone numbers) for the out of hours service.

**The Governor should ensure that the correct telephone number for the out of hours service is displayed throughout the prison and all staff are reminded of the contents of staff notice 411/2009.**

45. However, the clinical reviewer also notes that, on finding the man unconscious in his cell, staff should have called 999 for an ambulance. Staff notice 411/2009 instructs staff to do so. In addition, in June 2010, following the man's death, a Governor's order was issued to all staff reminding them that an ambulance should be called if a prisoner is found unconscious. On that basis, I make no formal recommendation.
46. The orderly officer at the time told the investigator that he could not recall when he had last received refresher first aid training. By chance, an officer was also on duty who had the appropriate training. Given that Stocken is not covered by 24 hour healthcare, I think it would be sensible for the Governor to ensure that all senior officers (one of whom is always on duty at the prison) receive updated training, particularly in emergency life support techniques.

**The Governor should introduce a rolling programme of refresher first aid training for all senior officers.**

47. When the paramedics decided that the man needed to be taken to hospital, the orderly officer initially concluded that the man did not need to be held in handcuffs or an escort chain. However, he said that the duty governor directed that the man be restrained and so the escort chain was applied while the man was in the ambulance. The duty governor explained to the investigator and clinical reviewer that decisions about the use of restraints are made on a case by case basis following a risk assessment. Ideally, the risk assessment is carried out before the prisoner leaves the prison, however it can be completed at the earliest suitable opportunity (for example, once the prisoner has arrived at the hospital).

48. The duty governor said she could not recall telling the orderly officer that the man needed to be restrained before he left the prison. She said that, from the outset, it was clear that it was an emergency situation. The duty governor thought that she had told the orderly officer to prioritise getting the man to hospital. The restraints were removed, at the request of hospital staff, once the man had arrived at a local hospital.
49. Both the clinical reviewer and I are concerned that the man was restrained on his journey to hospital. He was unconscious and unresponsive, and all those involved in responding to the incident agree that he was clearly very poorly. I understand the difficulties of making quick decisions about the risk a prisoner might pose. I also understand that the man was a life sentenced prisoner, convicted of murder, who had not been at Stocken for very long. However, I think that, on this occasion, the decision to restrain him was overly cautious.

**The Governor should issue guidance to governor grade staff on the application of restraints in emergency escorts to hospital.**

50. Once the man had arrived at a local hospital, both the police and hospital staff tried to trace his next of kin to inform them he was unwell. Unfortunately, the details noted in the man's prison file were no longer correct. Sadly, no family could be traced before the man died. After the man's death, the Governor introduced a system to check the next of kin details of all prisoners at Stocken. In addition, reception staff check the next of kin details of all newly arriving prisoners.

## **CONCLUSION**

51. The man arrived at HMP Stocken in July 2009, having been convicted of murder in 1998. Throughout his time in prison, the man had enjoyed good health, seeking medical attention on very few occasions. He was a fit and healthy man, who frequently used the prison gym. According to a good friend, the man often suffered headaches but there is no record of him requesting or receiving any medical treatment for them.
  
52. At about 7.00pm on 7 March 2010, during a routine check, the man was found collapsed and unconscious in his cell. An ambulance was called and the man was transferred to a local hospital, where he died shortly after midnight on 8 March. The post mortem confirmed that he died from a subarachnoid haemorrhage caused by a ruptured aneurysm. I make three recommendations concerning the response to the emergency. However, I am satisfied that the man's death was neither foreseeable nor preventable.

## RECOMMENDATIONS

1. The Governor should ensure that the correct telephone number for the out of hours service is displayed throughout the prison and all staff are reminded of the contents of staff notice 411/2009.

*The National Offender Management Service (NOMS) accepted this recommendation: "Notice to staff 411/2009 – re-issued. A folder has been set up on the Z drive – 'Healthcare Out of Hours Service'. This contains all the information that staff require. All staff have access to this folder. All managers have been reminded of this by global email. A Governor's Order 027/10 was also published reminding the Orderly Officers that in the event of a medical emergency they should dial 999 and request an ambulance. Out of hours contact number is now permanently displayed on the Daily Briefing Sheet."*

2. The Governor should introduce a rolling programme of refresher first aid training for all senior officers.

*NOMS has accepted this recommendation. The Stocken Training Department have contacted a company named Nuco, who deliver first aid training courses, and they have agreed to deliver a one day emergency first-aid training course to senior officers.*

3. The Governor should issue guidance to governor grade staff on the application of restraints in emergency escorts to hospital.

*NOMS has accepted this recommendation. The Governing Governor has issued written guidelines to all governor grades.*