

A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of a man at Whittington  
Hospital in October 2012, while in the custody of HMP  
Pentonville**

## ***Our Vision***

*'To be a leading, independent investigatory body,  
a model to others, that makes a significant contribution  
to safer, fairer custody and offender supervision'*

This is the report of an investigation into the death of a man while in the custody of HMP Pentonville. The man died from liver failure at Whittington Hospital in October 2012. I offer my condolences to his family and friends.

The investigation was carried out by one of my investigators and the Ombudsman's family liaison officer. A clinical reviewer conducted a review the man's clinical care at Pentonville.

The man had been in custody for four months before he died and had been admitted to hospital four times to treat his liver condition. His last admission was on 24 September, and he died less than ten days later.

I do not consider that the use of restraints when the man was in hospital was fully justified by his level of risk, and the arrangements to break the news of the man's death to his wife could have been better. However, healthcare staff at Pentonville provided a good standard of care and I agree with the clinical reviewer that the medical care the man received at the prison was equivalent to that he would have received in the community.

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.

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

**April 2013**

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## SUMMARY

1. The man was born in October 1948 and in Swanage. He was convicted at Wood Green Crown Court and sent to Pentonville Prison.
2. At his initial health screen, the man reported that he was taking medication for alcoholic liver disease and was under the care of a specialist in the community. On 30 June, his condition deteriorated and he was taken to Whittington Hospital. He was discharged to Pentonville on 31 July, and was admitted to the prison's healthcare centre.
3. The man was admitted to Whittington Hospital again on 5 August for a month, and on 14 September for a week. Although his condition was not life-threatening, he was often described as bed bound and in a confused state.
4. When the man returned to Pentonville from hospital on 21 September, the prison arranged one-to-one care in the healthcare centre. He was last admitted to hospital on 24 September where he was described as increasingly confused, disorientated and semi-conscious. For most of the time, officers used an escort chain to restrain the man, despite his deteriorating condition. On 26 September, he suffered a stroke and the hospital confirmed his prognosis was terminal. An end of life care pathway was started and the restraints were removed.
5. The man was certified dead by a doctor at the Whittington Hospital. His wife was not informed of her husband's death until nine hours later by telephone when she was travelling to the hospital to visit him.
6. We agree with the clinical reviewer that the medical care the man received at Pentonville was equivalent to that he would have received in the community. The clinical reviewer considers the use of a healthcare assistant to provide one-to-one care was good practice. We are concerned about the use of restraints when the man was in hospital and consider the arrangements to inform his family of his death could have been better, and have made two recommendations about these matters.

## THE INVESTIGATION PROCESS

7. The Ombudsman was notified of the man's death in October 2012. The investigator issued notices to staff and prisoners informing them of the investigation and asking anyone with relevant information to contact her. No responses were received.
8. Another investigator visited Pentonville on 8 October, met the investigation liaison officer and the safer custody governor. He collected the man's medical and prison records.
9. A clinical reviewer was appointed to review the clinical care that the man received at Pentonville. The clinical reviewer was given the man's medical records.
10. The investigator and the clinical reviewer reviewed the man's records and conducted interviews with staff at Pentonville. The investigator provided initial feedback to the Head of Safer Custody which she confirmed in writing to the Governor on 7 November 2012.
11. HM Coroner for Inner North London was informed of the investigation and a copy of the report has been sent to him.
12. One of the Ombudsman's family liaison officers, contacted the man's wife to tell her about the investigation. The man's wife asked that the investigation address the following points:
  - Why they were not told when the man's was admitted to hospital, or when his condition deteriorated, particularly the day before he died?
  - Why was the man restrained in hospital?
  - Were the conditions in which the man was transported back to prison on 21 August appropriate?
  - Why was the man's wife told of his death over the telephone?
  - Why was the man's wife initially told that the man had died at 11.00pm on 2 October, but the time and date of death on the death certificate was given as 1.00am on 3 October?
13. The man's family received a copy of the draft version of the report as part of the consultation period. Having considered the investigation findings the man's family remained unhappy with the use of restraints and how the news was broken. The investigator reviewed the findings of the investigation and made changes where necessary to the report. Any comments that have not resulted in changes to the report, we have sought to address the issues raised by way of separate correspondence.

## **HMP PENTONVILLE**

14. HMP Pentonville is a local prison serving the courts of north London and holds over 1,300 prisoners.
15. Whittington Health, Camden & Islington NHS Foundation Trust, and Barnet, Enfield and Haringey NHS Mental Health Trust provide health services, including substance misuse, mental health and psychiatric care.
16. The healthcare centre is a modern purpose-built building offering both inpatient beds and a day care facility for prisoners with mental health problems. Healthcare staff are on duty 24 hours a day.

## **Her Majesty's Inspectorate of Prisons**

17. HM Inspectorate of Prisons conducted an unannounced inspection of Pentonville from 24 February to 4 March 2011. Primary physical care was described as 'well advanced' but some prisoners had difficulty getting to nurse led clinics. There was good access to a GP and management of prisoners with long term conditions was judged to be good. A previous recommendation to introduce and regularly review palliative care policies had been implemented.

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

18. Each prison in England and Wales has an Independent Monitoring Board (IMB), of unpaid volunteers from the local community who monitor day-to-day life in the prison to help ensure that proper standards of care and decency are maintained. The latest published IMB report covered the period from 1 April 2010 to 31 March 2011. It noted that:

"The assessment of newly-arrived prisoners at Reception – in terms of their physical and mental health, their drug problems, and their risk in terms of cell-sharing – is potentially compromised by the numbers that have to be dealt with each week-day evening. It is to the credit of the staff that, despite these strains, prisoners are in general treated with respect and the relationship between officers and prisoners remains good."

## **Previous deaths at HMP Pentonville**

19. There have been four previous deaths at Pentonville in the past year, three of which were self inflicted. There are no similarities between these deaths and that of the man. Following the investigation into a death in November 2011 in similar circumstances to the man, we made a number of recommendations about clinical care and a coordinated approach to sharing information. This investigation has found that there has been improvement in these areas.

## ISSUES

### The diagnosis of the man's terminal illness

20. On 26 June 2012, the man was convicted at Wood Green Crown Court and was taken to HMP Pentonville. He was sentenced to seven years and six months imprisonment on 4 September.
21. The man told Nurse A he was prescribed medication for a liver and blood related disease and she referred him to the prison doctor for further assessment. Dr A recorded that the man had been diagnosed with alcoholic cirrhosis of the liver, and continued his prescription for medication to treat blood pressure, liver disease and to help him sleep.
22. The results of blood tests showed some expected abnormality and the man was referred to the prison doctor on 27 June. Dr B arranged for the man's medical records to be obtained from Poole Hospital, where he had received treatment.
23. On 30 June, Nurse B was called to the man's cell at 10.20am as he was reported to be having a fit. The man was dizzy and disorientated. His cell mate told the nurse that the man had become increasingly confused over the previous two days. The nurse thought the man might have encephalopathy. This is a syndrome affecting the brain resulting in a reduced level of consciousness, caused by an accumulation in the bloodstream of toxic substances that are normally removed by the liver. The man was taken to Whittington Hospital, where he was diagnosed with decompensating liver disease (acute liver failure).
24. On 26 September, the man suffered a stroke and hospital staff told Nurse C that the man's condition was terminal. The clinical reviewer notes:

“When he [the man] arrived at HMP Pentonville, the clinical assessment and investigations undertaken identified that the man had alcoholic liver disease but that his condition was stable. He became acutely unwell a few days after admission and needed hospital admission. The assessments undertaken at this point were full and complete and the clinical care provided was appropriate.

The man was diagnosed with decompensating liver disease during his first admission to the Whittington Hospital. Thus there is no need for an analysis of appropriateness of the diagnosis of a terminal illness by the prison healthcare team.”
25. We agree with the clinical reviewer that the clinical care that the man received when he first arrived at Pentonville was appropriate and resulted in his referral to hospital where he received his terminal diagnosis.

## **Informing the man about his condition and treatment**

26. The man knew of his illness before entering HMP Pentonville but his condition was not thought to be terminal at that time. The clinical reviewer writes:

“The man spent most of the time between the 26<sup>th</sup> June 2012 and the 3<sup>rd</sup> October 2012 as an inpatient [in hospital]. It was evident from the interviews with the prison staff that during the brief spells where he returned to HMP Pentonville, he was confused and disorientated. An appropriate level of nursing and personal care was provided. However, communication with him in a way that would have allowed a discussion about his clinical condition, the treatment being provided and his prognosis was not possible.”

27. Due to the man's disorientation we accept it was not possible to tell him about the deterioration in his condition and the terminal prognosis.

## **The man's medical appointments and treatment**

28. After he was diagnosed with liver failure, the man was discharged from Whittington Hospital and returned to Pentonville on 31 July, when he was admitted to the healthcare centre. The man went to Whittington Hospital on 5 August and stayed there until 6 September, and for another week on 14 September to 21 September. Following a brief return to Pentonville, he was admitted to Whittington Hospital for the final time on 24 September.

29. The man was in hospital for much of his time in the custody of Pentonville, and no hospital appointments were cancelled. We criticised communication between the hospital and Pentonville, after the death of a prisoner with a similar condition in November 2011. The investigation into the man's death found that communication had improved. Nurse C regularly visited and maintained contact with Whittington Hospital about the man's condition.

30. A multi-disciplinary team meeting (attended by all those responsible for the man's care, including Pentonville staff) was held at Whittington Hospital on 22 August. The meeting agreed that although the man was not going to recover from his illness, he was not yet in a terminal phase and a 'do not resuscitate' order was in place should he have a cardiac arrest.

31. The clinical reviewer notes:

“The only area of concern is around his clinical condition at the point at which he was discharged from hospital. On each occasion, he was re-admitted after a few days. The decision to discharge the man from hospital was not within the control of the prison healthcare staff. However, from both the medical records and the interviews undertaken, it is evident that his clinical condition was carefully assessed on each occasion he returned from hospital and re-admission was appropriate when it occurred.”

32. The man's treatment options were limited to managing his symptoms, rather than curing his underlying illness. Communication with Whittington Hospital about his care and admissions to hospital was appropriate. Pentonville reacted promptly when they assessed that they were not able to meet his care needs. We agree with the clinical reviewer that the man's treatment at Pentonville was equivalent to that he could have expected in the community.

### **The man's pain relief and medication**

33. The man was prescribed medication as directed by the hospital consultant. When he was at Pentonville, healthcare staff regularly reviewed his care plan and the man was made as comfortable as possible. The clinical reviewer notes about the man's pain relief and medication:

"The medical records show appropriate medication was provided to the man while he was at HMP Pentonville. There was no need for pain relief in his case. The records do note the occasional use of simple analgesia [pain relief]."

34. In light of the clinical reviewer's comments, we conclude that the man's medication and pain relief was managed appropriately.

### **Palliative care**

35. The man's needs were regularly reviewed while he was at Pentonville. He was given a pressure mattress and an agency healthcare assistant was employed specifically to look after his physical needs. The provision of social care for older prisoners or those who are very ill has previously been identified as problematic in PPO investigations. Dr A said that the man's needs would normally have been met by existing healthcare staff, but there was a shortage of staff at the time. It is positive that the need for such provision was quickly identified and organised to ensure the man had good continuity of care.
36. The NHS document 'The route to success in end of life care – achieving quality in prisons and for prisoners' sets out how an end of life care pathway might be implemented in prisons. It helps carers to plan when and how care will be delivered, and helps patients make choices about how they are cared for towards the end of their lives. An end of life plan was not implemented for the man while he was at Pentonville as his condition was not thought to be terminal until 26 September. A formal end of life care plan [Liverpool Care Pathway] was started in his final days when he was a patient at Whittington Hospital. The man's death was certified at 1.00am on 3 October.
37. In his clinical review, the clinical reviewer comments:

"The prison healthcare team attended a multidisciplinary team meeting at the Whittington Hospital. At this meeting, the man's clinical condition and prognosis were considered. The reported outcome of the meeting was that the man was for active treatment and not for end of life care. [...] In

summary, the clinical care, however it is described, was completely appropriate to the man's condition."

38. We are satisfied that healthcare staff provided a good standard of care, with attention to the man's needs when he was at Pentonville. An appropriate end of life plan was implemented by the hospital.

### **The man's location**

39. The man initially lived in the vulnerable prisoner unit at Pentonville due to the nature of his offending. After his discharge from Whittington Hospital on 31 July, the man was given a place in the prison's healthcare centre, where he subsequently returned each time he was discharged from hospital.
40. On 21 August, the man briefly returned to Pentonville. However, when he arrived he was very disorientated, and had been vomiting. Dr C wrote a letter to Whittington Hospital stating that they could not adequately care for the man in that condition and he was readmitted to Whittington Hospital the same day. At the multidisciplinary meeting the next day, it was agreed that any further plan to discharge the man back to the prison should be discussed in advance with healthcare staff at Pentonville. In respect to his location the following was recorded:

"As his condition is not treatable from a medical opinion his placement in an acute medical bed is not the most appropriate and a discharge has to be planned for. A nursing care home would be considered the most appropriate choice of residence if not serving a prison sentence ... As his home address is in Dorset, Prison Healthcare will need to link with Commissioners from that area to explore possibility of placement."

41. Pentonville's local care home would not accept the man because he was a serving prisoner. At the multidisciplinary meeting on 22 August it was recorded that funding for continuous care would not be awarded at that time as he was not deemed terminally ill, but that contact with Dorset Prison Healthcare would need to be established to explore other options. While staff considered moving the man to an area closer to his home, Dr A explained to the investigator that even if funding had been available, the man was assessed as too ill to attend court, so was not well enough to travel to Dorset.
42. The clinical reviewer notes

"After his first discharge from the Whittington Hospital, the man was placed on the [prison] in-patient unit. This was a suitable location. However, at interview, Dr A, the lead GP at HMP Pentonville, made it clear that managing patients with physical health problems of this nature is a challenge. Most of the patients on the unit tend to be younger and with severe mental health problems. In addition to being placed on the in-patient unit, the man also had 1:1 care from a healthcare assistant who was contracted from an agency on a short term basis to look after his physical care needs."

43. We conclude that the man's location in the healthcare centre in the prison was appropriate, as he was unable to be admitted to a care home.

### **Compassionate release**

44. Early release on compassionate grounds (ERCG) is a means by which prisoners who are seriously ill can be permanently released from custody before their sentence has expired. The criteria for early release for determinate sentenced prisoners are set out in Prison Service Order (PSO) 6000 and prisoners are usually expected to have less than three months to live. The criteria include that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) within the National Offender Management Service (NOMS).
45. The multidisciplinary meeting on 22 August agreed that the man's condition was not at end stage in its terminal phase. It was not until 26 September, after he had had a stroke, that he was considered terminally ill and in the end stage of his illness, and the Liverpool Care Pathway was implemented. Although the circumstances of the man's condition do not suggest it is likely that an application for compassionate release would have been successful there is no evidence that Pentonville considered or applied for ERCG on behalf of the man at this point, even though he was terminally ill.

**The Governor should ensure that the possibility of early release on compassionate grounds is considered and documented for all terminally ill prisoners with a short time left to live.**

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

46. Officer A was appointed as the prison's family liaison officer, but there is no record from what date. On 4 July, the man's wife visited her husband at the prison, and was upset to be told that he was critically ill in hospital where he had been taken on 30 June. The officer apologised to the man's wife on behalf of the prison that she had not been told, from then on the officer maintained contact with the man's wife throughout his illness. She arranged for the man's wife to visit him in his cell when he was in prison, and Nurse C met her several times when she was visiting her husband at the hospital to offer additional support.
47. Prison Rule 22 says that:
- "If a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of a mental disorder, the governor shall, if he knows his or her address, at once inform the prisoner's spouse or next

of kin, and also any person who the prisoner may reasonably have asked should be informed.”

48. The man was in a confused and disorientated state when he was taken to hospital in June, and there is no evidence that staff considered contacting his wife, in line Prison Rules.

**The Governor should ensure that, unless there are properly documented serious and over-riding security implications, families should be informed when a prisoner is in hospital with a suspected serious medical condition.**

49. Hospital records indicate that the man died at 11.30pm on 2 October. We understand that it is standard practice to have the death confirmed by a doctor and his death was not formally certified until 1.00am on 3 October. The duty governor A and the night orderly officer (NOO) attempted to contact the man’s wife by telephone to break the news. Neither were able to make contact with the man’s wife that night, and there is no evidence that they considered going to her home, or arranging for someone from a nearby prison to go in person, to break the news.
50. Officer A returned to duty the next morning and eventually spoke to the man’s wife at 9.15am. Unfortunately, the man’s wife was on a train to visit her husband in hospital, unaware that he had died. The officer initially asked to meet the man’s wife at Whittington Hospital, but as she was asked for an explanation, she told the man’s wife that her husband had died.
51. Officer A and the duty governor B arranged to meet the man’s wife at the hospital when she arrived. The man’s property was returned to her, and the funeral expenses were paid.
52. PSI 64/2011 states in Chapter 13:
- “Wherever possible, the FLO and another member of staff must visit in person the next of kin or nominated person to break the news of the death. Time will be of the essence in order to try to ensure that the family do not find out about the death from another source.*
- Where the prisoner had been located a long distance from their next of kin, consideration must be given to requesting the assistance of a FLO from the nearest prison.*
53. Duty Governor A told the investigator that he did not contact the Officer A for advice on breaking the news to the man’s wife, nor did he consider contacting a prison near to her home to break the news of the man’s death on Pentonville’s behalf. During interview the officer explained that she was currently the only operational FLO.

**The Governor should ensure that there are sufficient trained family liaison officers and that where possible the news is broken to a prisoner's family, in person as soon as possible, after a prisoner dies.**

### **Restraints, security and bed watch**

54. The Prison Service has a duty to protect the public when escorting prisoners to hospital and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes into account factors such as the prisoner's health and mobility. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion regarding the prisoner's ability to escape must be considered as part of the assessment process. It deemed that handcuffing a prisoner receiving chemotherapy (and, by implication, other life saving treatment) was degrading and that such restraint would be likely also to be regarded as inhumane unless justified by other relevant considerations.
55. On 30 June, when the man was first taken to Whittington Hospital, he was escorted by two officers who used an escort chain (a two metre chain with a cuff at either end), which was removed for treatment. The man was still mobile and was assessed as a medium risk of harm to others. An operational manager reviewed the level of restraints on 2 July, and concluded that the escort chain could be removed for treatment, but otherwise should remain unless the man's condition deteriorated further.
56. The man remained restrained by an escort chain until 28 July, when he became unresponsive and was admitted to the intensive care unit (ICU) at 2.00pm. At 2.10pm, escort staff sought permission for restraints to be removed, which was granted by a prison manager. Staff were advised to reapply restraints when the man regained consciousness. At 6.05pm on 29 July, the prison manager told bed watch officers that the escort chain should be reapplied, even though the man was reportedly "still not aware what is happening". The man was moved out of ICU at 7.40pm and restraints were reapplied at 11.30pm.
57. Dr A said in interview, that when the man returned to Pentonville on 31 July, he was mobile with the use of a walking stick; but by his second admission on 5 August, he was unable to walk unaided. The risk assessment completed on 5 August, states that the man was unconscious when admitted and restraints were not necessary for his transfer by ambulance, but that if there was any change in his circumstances, a single cuff (or an escort chain) should be applied. The man was escorted by two prison officers. The next day this risk assessment was reviewed and due to an improvement in the man's level of consciousness, an escort chain was applied.

58. On 8 August 2012, the escort chain was removed for a scan, but reapplied afterwards and not removed for a later ultrasound. On 11 August, the escort risk assessment was reviewed and restraints remained in place. The man returned to Pentonville on 21 August, but went back to hospital three hours later due to his poor condition. The risk assessment concluded there was “no need for removal of restraints”, despite indicating that the man had impaired mobility and was “very frail and weak”. An escort chain was applied.
59. After the multidisciplinary meeting on 22 August 2012, escort staff contacted the duty governor to ask to remove restraints because the man’s condition had deteriorated and he struggled to move. Concerns had been raised at the meeting about the restraints bruising the man’s wrists. Deputy Governor A, agreed that restraints could be removed, but that he should still be accompanied by two officers. When he was discharged on 6 September; the duty governor C assessed that restraints were unnecessary for the return ambulance journey.
60. Duty Governor C completed the escort risk assessment when the man was taken back to hospital on 14 September. At interview he told the investigator that while he considered the medical information recorded on the form (that the man was ‘bed bound’ and that his ability to escape unaided was restricted due to his medical condition), he saw the man moving independently on the bed in the ambulance, could sit up and move his legs, so he concluded that an escort chain was appropriate. He asked that double cuffs should be applied if his condition was to improve (although double cuffs were never applied).
61. The following day, duty governor D reviewed the escort risk assessment and at 4.55pm told bed watch staff to remove restraints. She recorded, “The man is seriously ill, bed bound and previously been out without restraints. I am now authorising restraints to be removed & if the man situation changes, staff are to contact Duty Governor”. Restraints were not reapplied and the man returned to Pentonville on 21 September, after being treated for encephalopathy and a urinary tract infection.
62. An escort chain was used again and two officers accompanied him when the man was taken to hospital for the last time on 24 September, despite the medical section of the form recording that he was bed bound with no mobility. The same day, a Staff Information Notice (SIN – GO 20/2012) was issued reminding staff of the need to make careful consideration when restraining a terminally ill or seriously ill prisoner.
63. Restraints were removed for just two hours at the hospital doctor’s request, when the man was choking on 25 September. On 26 September, the man’s wife visited and at 12.10pm complained about the man being restrained. Bed watch officers contacted the prison and duty governor B then authorised the removal of restraints after consulting the Governor. A review of the escort arrangement was made on 29 September and the escort was reduced to one member of staff.

64. Each time the man was taken to hospital, the risk assessment was reviewed and medical opinion was sought. While information regarding the man's health, physical condition and the impact this had on his actual risk was recorded, it was not given sufficient weight. Authorising managers overlooked clear evidence that the man was unable to escape. Duty Governor C, when asked by the investigator, confirmed that he was aware of the SIN issued on 24 September, and said with hindsight he would still conclude that restraints were necessary.

65. The clinical reviewer comments:

“Looking at the available information about the man's clinical condition, the clinical reviewer cannot see that there was any prospect of the man absconding from the ward and it is unclear that there was any real need for physical restraints for any of his inpatient stay.”

66. We acknowledge that public protection is paramount, but security measures must be proportionate to a prisoner's individual circumstances. We do not consider this was done in this case and all the available evidence would suggest that the man's risk of escape was low. When he was taken to hospital on 14 September he was very seriously ill, yet was still restrained. Restraints were not fully removed until 26 September, following his terminal diagnosis. The man's physical health was not taken into account sufficiently in the escort risk assessments which did not justify the level of restraints used.

**The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents.**

## RECOMMENDATIONS

1. The Governor should ensure that the possibility of early release on compassionate grounds is considered and documented for all terminally ill prisoners with a short time left to live.

**Accepted:** *Safer custody will ensure that they work with Healthcare to submit information to relevant department if a prisoner is terminally ill, so Early Release can be considered. Target date for completion: May 2013.*

2. The Governor should ensure that, unless there are properly documented serious and over-riding security implications, families should be informed when a prisoner is in hospital with a suspected serious medical condition.

**Accepted:** *The Safer Custody team ensure that all prisoners' have their Next of Kin details recorded on CNOMIS. They liaise with Healthcare, who will inform them if someone falls into this criterion. At this point an FLO will be appointed and family contact will be made. A review of this process will take place to ensure systems in place are sufficient. Target date for completion: May 2013*

3. The Governor should ensure that there are sufficient trained family liaison officers and that where possible the news is broken to a prisoner's family, in person as soon as possible, after a prisoner dies.

**Accepted:** *More FLO's are being sought within the establishment, and all are informed during training about the method of communication in these circumstances. We will endeavour to have a full compliment of FLO's on a rota system. All Duty governors have been informed of appropriate action to take. Target date for completion: May 2013*

4. The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents.

**Accepted:** *This recommendation is accepted as a matter of principle. Target, completed.*