PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Parc in November 2012

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, who died in November 2012 at HMP Parc, after a sudden cardiac arrest. He was 60 years old. I offer my condolences to his family and friends.

An investigation was carried out and Healthcare Inspectorate Wales (HIW) conducted a review of the man's clinical care in custody.

The man suffered from chronic diabetes and heart disease. His diabetes appears to have been appropriately controlled, but his heart disease proved more difficult to manage because of the side effects of his medication. He was found unresponsive in his cell one morning in November 2012. Staff and paramedics tried to resuscitate him, but he was pronounced dead at 8.05am.

The investigation found that the man's medical conditions were complex and difficult to treat, but the HIW was satisfied that the treatment and care he received was appropriate, timely and up to the standards expected. However, I am disappointed that health care records were not always fully and appropriately completed, a matter I have previously raised with Parc. Although it would not have affected the outcome for him, I am concerned that officers did not check on prisoners' wellbeing when they unlocked cells in the morning and an ambulance was not called as soon as he was found collapsed.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **April 2013**

CONTENTS

SUMMARY

1. The man arrived at HMP Parc on 17 February 2012, after receiving a two and a half year sentence for sexual offences. It was his first time in prison.

2. At his initial health screen, the man was prescribed medication to manage chronic diabetes and heart disease. At his secondary health screen, his medications were checked and details of outstanding hospital appointments were chased up. The clinical reviewer considers that his diabetes was satisfactorily managed using medication.

3. At about 7.30am one morning in November, an officer unlocked the man's cell, but he did not speak to him or check on his wellbeing. We have made a recommendation about this. About 15 minutes later, the same officer found him unresponsive in his cell. At 7.46am, the officer radioed an emergency code and alerted nearby staff. Two officers and two nurses went to the cell. Although there were clear signs of rigor mortis, the nurses started cardiopulmonary resuscitation (CPR). An ambulance was requested at 7.50am. When paramedics arrived at 7.58am, they examined him and pronounced him dead at 8.05am.

4. The man's conditions were complex and he was regularly assessed and reviewed and received appropriate treatment. Record keeping was not always of an appropriate standard. Although it would not have affected the outcome for him, the investigation identified room for improvement in the emergency response procedures for calling an ambulance and for guidance to staff when there are clear signs that someone has died. Risk assessments for hospital escorts need to take into account how the prisoner's physical condition affects their risk.

THE INVESTIGATION PROCESS

5. On 19 November 2012, the investigator issued notices to staff and residents at HMP Parc to inform them of the investigation process and asking anyone with relevant information to contact her. One prisoner wrote to inform her that the man had not been happy with the changes to his medication.

6. HM Coroner for Bridgend and Glamorgan Valleys District was informed of the investigation. A copy of the post-mortem report was received on 21 January 2013 which indicated that the man died of heart disease, which was related to diabetes.

7. The Healthcare Inspectorate Wales (HIW) was given copies of the man's medical records and conducted a review of his clinical care. The clinical review was received on 14 March 2013.

8. The investigator obtained and reviewed the man's prison records. On 14 February 2013, her colleague interviewed an officer and a member of the healthcare team on her behalf.

9. One of the Ombudsman's family liaison officers (FLO) contacted the man's wife shortly after his death and explained the purpose and scope of the investigation. His wife wanted to know why her husband's medications were changed and if the changes were appropriate. She received a copy of the investigation draft version of the report as part of the consultation period. She told the family liaison officer that she had found the report helpful, informative and detailed.

HMP PARC

10. HMP Parc, which opened in 1997, is run by G4S. It can hold more than 1,400 convicted male adult prisoners on remand or convicted. It also has a unit holding up to 64 young people under 18.

11. There are 24 hour primary and mental healthcare services at Parc provided by G4S. The healthcare centre has a 14 bed unit for older prisoners and those with increased health needs, which is where the man lived.

Her Majesty's Inspectorate of Prisons (HMIP)

12. HMIP last completed a full unannounced inspection of Parc in September 2010. HMIP found that prisoners were mostly positive about their relationships with staff. However, support for prisoners with disabilities was weak, with no clear assessment of individual needs or care plans. HMIP reported that, at the time, healthcare services were not delivered to an acceptable standard. G4S was about to take over the provision of healthcare services when the inspection occurred. The prison has not been re-inspected since.

Independent Monitoring Board (IMB)

13. Each prison in England and Wales has an Independent Monitoring Board, made up 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 last report published by the IMB for Parc, covering the period March 2011 – February 2012, noted that the prison was a well-run and safe prison. Some problems with prisoners being made aware of medical appointments were noted.

Previous deaths at Parc

14. In the last two years, there have been nine deaths from natural causes at Parc, six since the man died. We have commented on the poor standard of record keeping in his clinical record, which was also reported as an issue in investigation reports in 2011 and 2012. We have previously identified the need for risk assessments for hospital escorts to take fully into account how a prisoner's medical condition impacts on their risk.

KEY EVENTS

15. The man arrived at HMP Parc on 17 February 2012, after receiving a sentence of two years six months for sexual offences. It was his first time in prison.

16. At his initial health screen, the man told a nurse that he had diabetes and heart problems. He took a number of medications including, bumetanide[1], insulin[2], bisoprolol[3], one-alpha[4], warfarin[5], digoxin[6], eplerenone[7], temazepam[8], levothyroxine[9], allopurinol[10] and beconase[11]. She referred him to the doctor to review his medications and to chase up any outstanding hospital appointments.

17. The man was wheelchair dependent because he had fractured his ankle before going into prison. He was accommodated on the older persons' unit and had an adapted cell on the ground floor.

18. On 20 February, a doctor reviewed the man. He said that he was waiting for a pre-operation appointment for surgery to his ankle. He told the doctor that he was under the care of a renal consultant and a diabetes consultant. The doctor confirmed that his medications were appropriate, referred him for a blood test and asked for the hospital to be contacted about his outstanding appointment.

19. The man's medical history from his community general practitioner (GP) was received on 21 February. This was scanned into his medical record and a doctor recorded that he had reviewed the records.

20. On 23 February, a doctor reviewed the man. His recent blood test results had shown that he had kidney failure and over-treated hypothyroidism[12]. The doctor examined him and noted that his chest was clear, he had no ankle swelling, but his pulse was irregular. His blood pressure was recorded as very low at 73/46[13]. The doctor advised him to stop taking levothyroxine and requested an electrocardiogram[14]. The ECG confirmed that he had an irregular heartbeat. His blood pressure was low and at 11.40am he was taken to hospital for further review.

---

[1] Used to treat heart failure
[2] Used to manage diabetes
[3] A beta-blocker used to treat heart disease
[4] Used to treat vitamin D deficiency
[5] A blood thinner used in managing heart conditions
[6] Used to treat heart disease and to slow the heart rate in atrial fibrillation
[7] Used to manage high blood pressure
[8] Used to treat anxiety and insomnia
[9] Used to manage low thyroid activity
[10] Used to treat conditions such as gout and kidney stones
[11] A nasal spray for treatment of allergies such as hayfever
[12] Under-active thyroid, which can cause tiredness and weight gain
[13] An "ideal" blood pressure reading is between 90/60 – 120/80
[14] ECG, a test that measures the electrical activity of the heart

21. An escort risk assessment is completed when a prisoner goes out of the prison to determine whether handcuffs or other restraints should be used. The risk assessment should consider factors such as the risk of escape and the risk of harm to the public and hospital staff. It should be based on an assessment of the prisoner's actual risk at the time, taking into account his health and physical condition. The man's escort risk assessment indicated that he was not likely to escape and was not violent. In the medical section of the assessment, he was described as fully mobile and was considered able to escape unaided. This was despite the fact that he used a wheelchair and had a personal evacuation plan which indicated he would not be able to leave his prison unit unassisted in an emergency. He was noted as a medium risk to staff and the public. He was escorted by two officers who used an escort chain.

22. The man was discharged from hospital later that day. The discharge letter advised that he was either to continue taking bisporol, while having his blood pressure monitored, or to stagger his blood pressure medication. No follow-up appointments were required at hospital. There were no entries in his on-going clinical record about his hospital admission, or a summary of his discharge letter. There is no record that he was reviewed by a member of healthcare staff when he returned to Parc or that any changes were made to his medication.

23. On the morning of 28 February, a nurse went to the wing at an officer's request and found the man sitting with his head resting on a table. He told her that he had been discharged from hospital recently and had ongoing issues with an irregular heartbeat, but his medications had not been changed and he had not had any follow-up reviews. She took his blood pressure, which was 110/80, and checked his blood sugar level which was high at 11.7[15] after eating a light breakfast. She sought advice from the lead nurse and doctor on duty and a doctor agreed to see him that day.

24. A Healthcare Assistant (HCA) took the man's blood pressure again that afternoon. It had dropped to 80/50. She recorded in his on-going clinical record that a doctor had reviewed him and thought that his symptoms were secondary to his medications. It was noted that his heart "sounded normal", his bisporol was to be reduced and he was to be reviewed in a week. The doctor did not make an entry of his own in his on-going clinical record, but the prescription chart reflected that his dose of bisporol was reduced.

25. On 6 March, the man told a doctor that his head was "fuzzy" when sitting or lying down. He said he did not have any chest pain. The doctor suggested a further reduction in bisporol, referred him for a blood test and planned to review him in two weeks, or sooner if needed. His prescription chart reflects that his bisporol was reduced.

[15] The target blood sugar level for someone that has type 1 diabetes and has eaten is 9, or under.

26. At a diabetic review that day, a nurse recorded that his diabetes was being well managed using medication and he was to be reviewed again in three months.

27. On 13 March, a doctor reviewed the man. He noted that his pulse had improved, his chest was clear and his blood pressure had improved to 109/68. He said that he still felt unwell, but the dizziness had improved. He said he had discussed dialysis with his consultant seven years previously and the doctor suggested that further deterioration in his kidney function could be the result of him feeling so unwell. He had a blood test, which showed that his renal function had declined and he was now in stage 5[16] renal failure. The doctor thought he might need dialysis and wrote to his renal consultant. He explained that the man's condition had steadily deteriorated since his last renal appointment in January and his blood pressure medication had been steadily reduced because his blood pressure had dropped so much. The doctor asked if his next appointment could be brought forward.

28. On 20 March, the man said he had been feeling dizzy and was not able to pass urine very well. He was diagnosed with a urinary tract infection and started on antibiotics. A doctor agreed with a hospital registrar that he should be admitted to hospital for dialysis, but there was no bed available at the time. The doctor spoke to another hospital, who said it was not urgent for the man to be admitted that night and he would be seen at a clinic two days later. The hospital suggested taking him to accident and emergency (A&E), if there was any deterioration in his condition. His condition remained stable and he did not need to go to A&E.

29. On 22 March, the man was reviewed by his diabetes consultant. A letter summarising the appointment said that he had lost nearly four stones over the previous three years and this had helped to improve his diabetes control. The man's cardiac consultant had stopped his amiodarone and discharged him from the cardiac clinic. The consultant advised that his bumetanide needed to be reduced in light of his deteriorating renal function. He said that he sometimes felt short of breath. The consultant said that he should take a low dose of ramipril again if this continued, but this was not ideal because of his low blood pressure. There is no record that his dose of bumetanide was reduced.

30. On 29 March a doctor reviewed the man, who had another urinary tract infection, and he started a course of antibiotics. Healthcare staff were trying to get him an urgent appointment at the renal clinic and, in the meantime, his digoxin and thyroid medication were reduced.

31. The man was reviewed in the outpatient renal clinic on 18 April which was not recorded in his on-going clinical record. It was noted that his medications had not changed since his last appointment and the consultant suggested his bumetanide should be reduced. He was to be reviewed again in four months. His medical record shows that his bumetanide was reduced on 3 May.

[16] Very severely reduced kidney function.

32. It appears that the man had surgery to his ankle on 18 June. A hospital letter shows that he was discharged back to Parc on 19 June, although there is no record of this in his on-going clinical record or of him being seen by a member of healthcare staff on his return.

33. A doctor saw the man to review his medications on 31 July. All of his prescriptions were continued unchanged.

34. On 20 September, the man had a review with his diabetes consultant. It was noted that the reduction in bumetanide had improved his renal function and he was advised to increase his bisporol gently to improve control of his irregular heartbeat. If he became dizzy, it was to be reduced again. His levothyroxine was also to be reduced. A prison doctor noted the changes in his medications and advised healthcare staff to monitor him to ensure that his blood pressure did not drop too low.

35. A letter from the man's renal consultant on 2 October said that his blood pressure was well controlled and there were no further changes to his medications but his renal function had deteriorated further than expected and he was to be seen in the renal clinic in the next few weeks.

36. On 20 October, a nurse went to see the man on the wing as he said he had been suffering from shortness of breath for a couple of days. She took his blood pressure, which was 100/71. She advised him that if he felt worse, he was to let wing staff know so that he could be examined by healthcare staff. She referred him to the doctor. A doctor saw him that afternoon and noted that all his clinical observations were within normal limits.

37. On 6 November, the man had chest pain that had been alleviated with a glyceryl trinitrate (GTN)[17] spray. His blood pressure was recorded as 112/62. At an appointment later in the day, a doctor noted that he looked comfortable, but had been short of breath after walking down the corridor. He had an ECG which did not show anything significant. The doctor increased his bisporol and advised that his digoxin levels were to be checked and increased, if necessary.

38. The doctor saw the man again on 12 November. He told her that he did not think his shortness of breath had improved. His blood pressure was 112/80. She decided to wait until he had seen his consultant before changing his medication again.

39. There is no record that the man reported feeling unwell in the few days before he died. Officer A, who worked on the man's wing, said that his health did not appear to have deteriorated. During the evening of 18 November, he was checked at a roll count at around 9.00pm. The purpose of the roll count is to

[17] Used to relieve symptoms of angina by relaxing and widening blood vessels and arteries to help increase blood flow to the heart.

ensure all prisoners are present. During the roll count, officers look into the cells, but are not required to get a response from prisoners.

Events of the incident

40. Officer A was responsible for the morning roll count at 7.00am on the day of the incident. He said that he saw the man apparently sleeping on his left side in bed. He unlocked the prisoners for breakfast at about 7.30am as usual. He explained that he would say "good morning" to the prisoners and he usually got a response back, but he would not wait for a reply if the prisoner did not respond.

41. Prisoners collect their breakfast from the wing kitchen and Officer A said that if they do not appear within five to ten minutes, he goes back to their cells to check on them. He noticed that the man and another prisoner did not collect breakfast that morning, so he went to check on them. He went into the man's cell, but could not get a response when he called his name. He said the man was still lying on his left side. He touched his hand, which was cold, and realised there was something seriously wrong. His radio did not work in that part of the prison. He ran to the adjoining wing to get help from staff and radioed a code red emergency[18] at 7.46am. Two officers went to the cell. They said his skin had a marbled look to it, his complexion was blue and his eyes were fixed open.

42. A nurse was on the landing above and responded to the code red, taking an emergency bag (containing life saving equipment) and a defibrillator with her. Another nurse also responded and they arrived at the cell at around the same time as the officers. They moved the man from his bed onto the floor and started cardiopulmonary resuscitation (CPR), and attached a defibrillator[19]. We have not been able to establish who requested an ambulance, but the communications log shows that an ambulance was called at 7.50am. Paramedics arrived shortly after, at 7.58am. He did not respond to CPR and was pronounced dead by the paramedics at 8.05am. The report form filled out by the paramedics says that he had obvious rigor mortis and it appeared that he had died during the night.

[18] A code red signifies a medical emergency, where someone is not breathing
[19] A life saving machine that gives an electric shock to the heart in some cases of cardiac arrest.

Support for prisoners

43. Notices were displayed in the prison to let prisoners know of the man's death and the support that was available to them. All prisoners subject to suicide prevention monitoring were reviewed in case they had been affected by his death.

Support for staff

44. The duty director held a debriefing session to support to the officers and nurses who had been involved in the incident.

Family liaison

45. A prison family liaison officer (FLO) was appointed. At 10.45am on 19 November, the FLO and the Director visited the man's wife who was his listed next of kin. The Director broke the news of her husband's death and offered her condolences. In line with national guidance, the Director offered a contribution to the funeral costs. The funeral was held on 30 November.

Post-mortem

46. The post-mortem report indicated that the man died of dilated cardiomyopathy[20] and coronary artery atherosclerosis[21], secondary to diabetes. The report says that he had a significant history of dilated cardiomyopathy, irregular heartbeat, high blood pressure and kidney disease, for which he took appropriate medication. The combination of pre-existing dilated cardiomyopathy and the coronary artery atherosclerosis would have meant that the oxygen supply to his heart was weak.

[20] A disease whereby the heart becomes weakened and enlarged, so can not pump enough blood around the body.
[21] A disease whereby the arteries narrow and harden, which can cause life-threatening blockages.

ISSUES

Clinical care

47. The man suffered from chronic diabetes and heart disease. His diabetes appears to have been appropriately managed using medication. Management of his heart disease was problematic in that the medications used to treat his heart disease affected his kidney function. He also began to suffer with very low blood pressure and many changes to his medication were needed to try and control this. Health Inspectorate Wales (HIW) concludes that his clinical care was complex but well managed, and his medication was appropriate.

Emergency response

Calling an ambulance

48. The Director of Offender Health and the Chief Executive Officer of the National Offender Management Service wrote to all prison Governors and Directors and prison healthcare managers on 17 February 2011 to reiterate previous guidance about the importance of calling an ambulance as soon as possible in an emergency. Any delays can have a significant impact on the patient's chances of survival, so staff should not wait for healthcare to attend. HMP Parc's emergency ambulance protocol reflects the guidance sent to prison managers, and states that the first person at the scene can take the decision to call an ambulance; particularly in instances such as if the patient has excessive blood loss or is not breathing.

49. The man was found unresponsive in his cell on 19 November. A code red emergency was called at 7.46am, but an ambulance was not requested immediately. The records indicate that one was called at 7.50am. Officer A said that he thought only healthcare staff could call an ambulance. A nurse said that an ambulance is called automatically when a code red is called, but it does not appear that this happened. Although the delay was not long and did not affect the outcome for him, as a code red emergency signifies a life threatening situation, we consider that this should trigger an ambulance to be called automatically. We appreciate that staff do not always know the extent of the patient's condition, but the national guidance makes clear that requests for ambulances can be cancelled if it is later found that they are not needed.

The Director should ensure that an ambulance is requested whenever there are grave concerns about the immediate health of a prisoner.

Cardiopulmonary resuscitation

50. HMP Parc's policy on discovery of a possible death says that CPR should be attempted if appropriate, and that the senior nurse or doctor on scene can make the decision. When the man was found unresponsive in his cell, he was cold to touch and his complexion was blue. The nurse said that she did not think CPR was going to be successful, but Officer A said that all staff have

been instructed to carry out CPR in every emergency. The paramedics' report says that rigor mortis was clearly present and he appeared to have died during the night. We appreciate that the decision of whether or not to attempt resuscitation is a difficult one to make, but it can be distressing for staff to try and resuscitate someone who is already clearly dead. The European Resuscitation Council Guidelines for Resuscitation 2010 state that "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile …"

The Director and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is not appropriate.

Record keeping

51. The Nursing and Midwifery Council (NMC) and the General Medical Council (GMC) have clear guidelines about record keeping and good record keeping is seen as essential to the provision of safe and effective care. A principle of good record keeping outlined by the NMC is:

> "You should record details of any assessments and reviews undertaken, and provide clear evidence of the arrangements you have made for future and ongoing care. This should also include details of information given about care and treatment."

52. The man's clinical record was not kept to a good standard. There were times when he had returned from hospital, but his discharge summary (which would have included information about his future care and medications) was not summarised in his record, and there is no record of him being assessed by healthcare staff when he returned. Good, clear record keeping ensures that all healthcare professionals who care for patients can see a comprehensive account of their medical history, examinations, medication changes and any changes in physical health, to ensure continuity of care. We are concerned that this is an issue that has been commented on in three previous investigation reports at Parc.

The Head of Healthcare should ensure that all healthcare staff fully adhere to the requirements for clear and accurate records made at the time events occur or as soon as possible afterwards, in line with the required standards of the General Medical Council and the Nursing and Midwifery Council.

Morning unlock

53. Officer A was the officer unlocking prisoners on 19 November. He said that he talks to the prisoners as he unlocks them, but it is not a requirement to get a response from them. It was not until he realised the man had not come out of his cell for breakfast and went to check on him that he realised something was wrong.

54. Prison Service Instruction (PSI) 10/2011, indicates that when officers are unlocking a cell when the prisoner is not expected to come out at that time:

> "Staff will need to check on their wellbeing, for example by obtaining a response during the unlock process."

It is important that prison staff ensure that they gain a response from prisoners when they unlock their cells. While Officer A might well have greeted the man that morning, the requirement of the PSI to gain a response to check on their wellbeing was not fulfilled. We make the following recommendation:

The Director should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

Escort risk assessments

55. Prisons have 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. 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.

56. When the man went to hospital on 23 February, he was escorted by two officers and an escort chain was applied. The risk assessments indicated that he was not likely to escape and was not violent. Unaccountably, it is recorded in the medical section that, despite being in a wheelchair and requiring a personal evacuation plan which indicated that he was unable to leave his wing unaided in an emergency, he was apparently "fully mobile" and was considered able to escape unaided. He was noted as a medium risk to staff and to the public, should he escape.

57. The risk assessments for the man's outpatient appointments varied and some said he was not able to escape unaided. None of the risk assessments stipulated how his physical condition would have affected his level of risk. There was also no recorded consideration of his chronic illnesses and the impact they would have had on his risk. All the risk assessments concluded that he was a risk of escape, a risk to the public, and an escort chain should be used. It is apparent that his health and mobility were not given sufficient consideration during the risk assessment process.

The Director should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances, including their health and mobility, and are based on the actual risk the prisoner presents at the time.

RECOMMENDATIONS

1. The Director should ensure that an ambulance is requested whenever there are grave concerns about the immediate health of a prisoner.

   Accepted - *A Director's Order has been issued which advised the Control Room to automatically call 999 when any Code Red or Code Blue is called over the net by prison staff.*

2. The Director and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is not appropriate.

   Accepted - *The Director will ensure that staff are given guidance about the circumstances in which resuscitation is appropriate / not appropriate*

3. The Head of Healthcare should ensure that all healthcare staff fully adhere to the requirements for clear and accurate records made at the time events occur or as soon as possible afterwards, in line with the required standards of the General Medical Council and the Nursing and Midwifery Council.

   Accepted - *The Head of Healthcare has instructed the Healthcare Administration Team to ensure that a detailed entry is made on the prisoner record on return from an external appointment, even in cases where a referral letter accompanies the individual. In addition to this it will be necessary for operational staff returning from a bed watch to advise Healthcare staff that they have returned so the prisoner can been seen by a member of the Healthcare team and have their clinical record updated- prisoners should not leave admissions until they have been seen by a nurse.*

4. The Director should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

   Accepted - *A Director's Order to be issued reminding staff that they should satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.*

5. The Director should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances, including their health and mobility, and are based on the actual risk the prisoner presents at the time.

   Accepted - *A review will be undertaken of how Healthcare Medical Services accurately stipulate how a prisoner's physical condition affects his mobility and as such his level of risk whilst on escort.*